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# CASE MANAGEMENT IN HOME CARE: SELF-MANAGED CARE AND DIRECT CASE MANAGEMENT FROM THE CASE MANAGER'S PERSPECTIVE

by

Jane Ji Hyun Yi 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science

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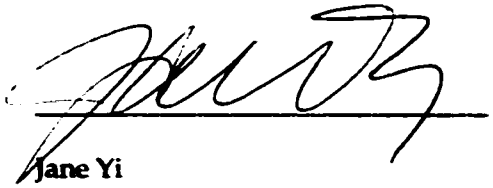

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## Abstract

The Edmonton Home Care Program and other home care programs are continually challenged to provide quality care that addresses the needs of an increasing number of clients within limited resources. The purpose of this study was to describe and compare the tasks that case managers performed in Direct Case Management (DCM) and Self Managed Care (SMC) as well as the case managers' work environment. A survey with open and close-ended questions was used to collect the data. The results showed that the steps of case management were followed in both SMC and DCM, however, the process by which case management proceeded in these two contexts was different. These differences helped to explain why the case managers were less empowered when case managing SMC than they were when case managing DCM. Implications of the results for case managers and the Edmonton Home Care program and recommendations are presented.

## Acknowledgements

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# Chapter 1: Introduction

The introductory chapter will begin with a description of the general context of the study and the Edmonton Home Care Program. The following section will list the definitions of terms that are specific to this study. The chapter will end with a chronicling of the significance of the questions this study plans to address.

## General Context of the study

In the context of health care trends and health care reform, home care programs must maintain and improve quality while at the same time accommodate increasing demands and limited resources. When the quality of health service delivery is evaluated, the traditional focus has been on the client outcomes and the financial costs. However, home has been established in many studies as the preferred place to receive health care (Kambouris, 1996; Mayo, Wood-Dauphinee, Cote, Gayton, Carlton, Buttery & Tamblyn, 2000) and as a more cost effective alternative to delivering care in institutions (Anderson & Parent, 1999; McManus, Topp & Hopkins, 1994; Pryor & Williams, 1989). Therefore, in order to complete the picture of home care quality, the next step is to focus upon the home care professional. How do they deliver services? Does the work environment provide sufficient support? Does the service model affect the home care professional? "When organizations examine the quality of services, they should focus on the satisfaction of both the customers receiving services and the workers providing services." (Eisenberg, Bowman & Foster, 2001). By developing an understanding of the elements that affect the home care professional's work satisfaction, the quality of home care services can be improved using all the possible influencing factors.

The quality of home care is in jeopardy due to many present-day issues that affect the health care professional's quality of work life. The first issue is the evolution of the role of home care in the system of health care provision. Home care programs perform three functions: a) substitution for institutional care of acute and chronic medical conditions, b) maintenance of people in their homes and c) prevention of conditions that could, in the long term, be costly (Anderson & Parent, 1999, Arundel & Glouberman, 2001). In the past, home care focused upon people with chronic conditions. Recently, there has been an increase in the number of home care clients who require acute and sub-

acute care for short- lived medical conditions. In addition, funding to long term care facilities has not kept pace with their needs and societal shifts have dispersed family member and community supports. As a result home care services are extending more and more into the traditional practice parameters of acute care and long term care, as well as substitute for family and informal care providers in the community. The increase in the number of people needing home care results in a proportionate increase in the work load of home care professionals and necessitates an increase in the number of professionals in home care. This leads to the second issue facing home care; the challenge of retaining and recruiting staff.

The retention and recruitment of staff is not an issue unique to home care, but in recent years, it has become increasingly problematic. "The human resource area is the most serious issue in home care at present across the country. From a policy perspective the concerns focus on reported staff shortages, inadequate compensation, retention and recruitment difficulties, and conditions in the work place." (Parent & Anderson, 2001, p.14). The severity of these factors are appreciated in light of national trends (CIHI, 2001). 1) Health care providers are a large portion of the Canadian work force (1 in 10). 2) They are 1.5 times more likely to miss work due to illness and disability than workers in other industries. 3) The job satisfaction experienced by health providers is 85% compared to 90% in the general work force. 4) Health care professionals are retiring at a younger age than they used to (62 in 1995 vs. 65 in 1980). There are also trends developing that foreshadow potential problems. 1) The general population is aging and older people are one of the largest users of health care and home care. 2) The people working in health care are aging and retiring at a younger age. 3) Life spans will increase with the development of better technology. 4) Better technology increases costs of health care. 5) Health care professionals are presently in demand and there are no indications that their numbers will increase substantially in the future. In home care the shortages in nurses and therapists have already affected the quality of care and increased workload (Parent & Anderson, 2001). These working conditions have perpetuated the shortages by making recruitment and retention of home care staff difficult (Parent & Anderson, 2001).

The third trend that is influencing the quality of work life is the development of services that acknowledge the power of the client without preparing the professional to

provide the services. Health care consumers request services that empower them and incorporate the health care values of equity and quality. "Home care is based on an empowerment model-one that helps people help themselves" (Furrie, Nahmiash & Larsen, 1999, p.6). Labonte (1993) asserted that empowerment had two meanings: "bestowing power" and the seizing of power by individuals or groups. Case management has been used for many years to negotiate complex community resources to meet clients' needs and the case manager bestows power on the clients. Self-managed care has become a favored home care option for clients who want increased control over their care and would prefer that the case manager encourage the seizing of power. An alternative definition of empowerment would be the state of being or process of becoming able or allowed to do some unspecified thing and being responsible for that ability or control (Rappaport, 1987). Unfortunately, little work has been done to describe how services are provided by the case manager in the two case management scenarios. In order to be accountable, as well as determine where improvements can be made to affect the quality of services, the black box of case management needs to be described.

The majority of literature on the use of case management and self- managed care focuses upon the advantages and disadvantages for the client. Very little literature investigates the professional's role or point of view when providing case management or self managed care. This gap has implications in the context of the work life literature, trends in health care and increased vigor of quality assurance in the health care. The purpose of this study is not to advocate for or eliminate self managed care or case managed programs. This study is focused upon influencing the programs so that they can be implemented with an increased awareness of case managers' activities and with more attention to creating a healthy if not beneficial work environment, while providing the already proven benefits to the client. "A healthy workplace is one in which workers will be able to deliver higher quality care and in which worker health and patients' high quality care are mutually supportive" (Eisenberg, et al, 2001, p. 85). Ultimately, the sustainability of home care and its partnership in the health care system relies upon a better understanding of home care from the case manager's point of view.

**Definitions**

For the purpose of this study the following definitions will be used.

Direct case management (DCM)- Case management provided to EHCP clients who are in the long term care program but not on SMC. This includes coordination and responsibility for professional services which are offered by the EHCP (for example, occupational therapy, social work and nursing), personal services (for example, bathing and dressing assistance) and linking to community services (for example, transportation, and day programs).

Self-Managed care (SMC)- The Long term care Self-Managed Care program is "part of the existing Home Care program and is designed to be an option for Home Care clients who wish to manage their support services, which include personal care and home management"(Alberta Health, 1992, p. 1). Professional services continue to be provided by Home Care and organized through the case manager.

Self-Managed care case management- Case management services provided only to clients who are on the SMC program. This includes coordination and responsibility for professional services and linking the client to community services. The monitoring of the need for personal services done by the case manager, but the financial and acquisition of personal care is given to the client.

Case manager- In the Edmonton Home Care Program (EHCP), the case manager is a nurse, occupational therapist or social worker who is the coordinator of services (professional and personal care) and resources from community agencies for the Home Care client. In the SMC program, the case manager does not coordinate the personal care services.

Client- A person who is receiving home care services or personal assistance from Home care.

Self care manager- A person designated (legally or informally by the client) to manage the financial and human resource aspects of SMC for a SMC client.

Personal (care) assistant- "A paid employee who provides regular in-home physical assistance with the essential [non-medical] activities of daily living to a disabled person who is unable to perform those activities alone." (Alberta Health, 1993, p. 27)

**Significance of study**

The quality of care has been a concern throughout the health care system. "Our focus should be on meeting patient needs for high quality care, not on the buildings in which those needs are met." (Alan Rock quoted in Patriquin, 1998). With these words Health Minister Allan Rock recognized the expansion of health care into the home and that this did not preclude the high standards of care that Canadians value. "Because health care has lagged behind other sectors of industry in trying to understand its own culture, many gaps remain in the current knowledge of what works and what needs to be changed to enhance the quality of the healthcare workplace in ways that would improve performance" (Eisenberg, et al, 2001, p.451). Despite attempts to improve the quality of care by adding services, incorporating technology and spending more money, if the basic building block, (health care provider) and its connection to the organization and client is not scrutinized, home care quality will be difficult to achieve.

The gaps addressed by this study will be a) a comparison of what case managers do in DCM and SMC , such that best practice parameters can be established in place of broad definitions of the activities of case managers, thereby providing some consistency of expectations and decision guidelines and a basis to evaluate performance, and b) the extent to which the case managers are provided with the support necessary to empower their clients. Haugh and Laschinger (1996) state that in order to empower the client there must be a concomitant empowerment felt by the case manager. Therefore, the organizational structure and activities of the EHCP should empower the case managers such that they can engender the empowerment principles necessary to deliver services to DCM and SMC clients.

Academically, this study is significant for three reasons. This study is likely the first Canadian study that describes and compares DCM and SMC in a home care setting. This study will also add to the research done by Micco, Hamilton, Martin & McEwan (1995) and Scala, Mayberry & Kunkel (1996) to move toward a more conclusive answer to the question of whether self-managed care is a benefit to case managers or a hindrance. In addition, the assessment of the work environment will add another dimension to Laschinger's body of work, which up to now has not included the home care environment or professionals other than nurses.

Lord (1991) states that every person with a disability relies upon support and finds this support significant to their lives. The health care system is increasingly asked to provide that support. If the support is to be provided in a way that promotes the public's health, the method by which it is delivered and the person who delivers that support needs to be empowering and empowered. By highlighting the Edmonton Home Care experience, lessons may be learned that could benefit other home care programs and hopefully address the many trends that are pushing home care to the forefront of political and societal concerns. "Home care in Canada is currently a system-by-default. The Canadian public, governments, policy makers and care providers must become engaged in developing a comprehensive home care system by design, based on the values of Canadian society." (Parent & Anderson, 2001, p. 40).

## Chapter 2: Literature Review

### Introduction

The literature review will start with a brief introduction to the history of case management and self-managed care as well as how case management manifests itself in a self-managed care forum. Then, the work life literature of health care workers will be inspected along with a highlighting of the few articles written about the characteristics and working conditions of case managers. The theoretical foundation that will guide the investigation of the condition of work life in this study will be described. Finally, the setting of this study, the Edmonton Home Care Program, will be described.

### Case management

Case management started approximately 100 years ago with a focus on service coordination and accountability. There has been a gradual introduction of the terms quality, efficiency and cost-effectiveness in the existing mix of case management activities. " Case management is a set of logical steps and a process of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient, and cost-effective manner." (Weil & Karls, 1985, p. 2). Another element that has become a key part of case management as the case manager coordinates, counsels and advocates, is that all these roles serve to empower the client while providing services. "At the core of case management is the question of what is the most effective, most expeditious and most cost-effective method of restoring a client to a state of equilibrium, that is, ideally to a state where the client can arrange for his or her own care through the existing health and social services institutions of our society." (Weil & Karls, 1985, p. 3).

Due to the complexity of the health systems and the health system users "case management is emerging as a key component of long-term care service delivery" (Geron & Chassler, 1994, p. 93). The complexity necessitates that the once simple definition of case management has become a definition with many incarnations. " Case management is...neither inherently or definitively defined. It derives its definition in large part from

the nature and needs of a system whose component parts it will be coordinating and integrating." (Beatrice, 1981, p. 124). The diversity of case management is the result of permutations in the case manager's profession, the receiver of the case management, and the purpose/environment of the case management.

Historically, case managers have been social workers, nurses, mental health workers or physicians with training in health care management (Powell, 2000). Recently, occupational therapists and people trained solely to be case managers have contributed to the expansion of case management applications and staff diversity. Case management is practiced in the community, in health institutions, by health insurance companies and in situations where continuity of services is needed, and complexity of the clients is the norm.

Bower (1992) describes three groups of people who traditionally receive case management. 1) Chronically disabled people, many of whom are elderly. 2) People who require long term, complex and costly care. 3) People experiencing an acute illness or flare up of a chronic condition. These groups encompass a vast majority, if not all people who need health services.

There are two overlapping ways to define case management. 1) By the purpose of case management which can be grouped into three themes: continuity of care, effective use of institutional and community resources, and cost-containment. The tasks that are emphasized and the purpose that is prioritized by the case manager or the case management organization will determine the course taken and the expected outcome. 2) By the three categories of case management proposed by Smith and Smith (1999). The first category is according to the main purpose of the case manager, for example, to coordinate services or manage costs. The second is the setting of the case management. The third goes further and distinguishes whether the case manager is within one facility (or organization) or the case manager is coordinating between facilities.

One commonality of case management is the basic process of providing the services. Most case management experts (Beatrice, 1981, Cohen & Cesta, 1997, Powell, 1996, Smith & Smith, 1999 ) agree that case management involves tasks, or variations of the tasks proposed by Bower (1992). These tasks are: assessment and problem identification, planning, procurement, delivery and coordination of services and

monitoring to assure that the service needs of the client are met. Lamb and Stempel (1994) described the transformation of the client and the case manager as they progress through the above tasks as the "process of growing as an insider-expert". This process consisted of three phases. 1) Bonding which described the time span when the client recognizes the case manager as an "expert" in the area of health care and that the case manager will be able to meet the client's needs. Simultaneously, the case manager is seen as understanding the client and their situation, thus building a trusting relationship and establishing the case manager as an "insider". The expert role was identified more when physical/medical needs were addressed and the insider role was identified more when emotional and spiritual needs were addressed. 2) The working phase was when the client started thinking differently about themselves and their ability to control their medical condition and the environment. This phase could only start when the "consistency and dependability" of the case manager was established. The clients began developing "a sense of mastery" which allowed them to try to change their behaviors. 3) The changing phase consisted of the client "doing more for themselves and accepting help when needed." (Lamb & Stempel, 1994, p. 11). The case manager would act as a facilitator who would confirm the client's beliefs and actions. In providing the feedback to the client's increasing skill and knowledge for managing their health, the case manager supported the client's development to be their own insider expert.

Case management is practiced with a diversity of purposes, providers, clients and environments which lead to many problems but also provides many advantages. First, it is difficult to construct a universal best practice model of case management. "There are no uniform state or federal standards for [case management] practice" (Geron & Chassler, 1994, p. 91). The standards created by some American case management regulation bodies are "generally broad, do not appear to be empirically based, and are not clearly related to criteria for measurement" (Geron & Chassler, 1994, p. 92). Second, the case manager is often put into a dilemma of being a gatekeeper for finances and services while at the same time being an advocate for the client's best interests. Third, Alcock, Edwards & Morris (1998) found that case managers experienced difficulties specifically associated with their role, such as their work life, tough decisions, their clients, and management's lack of support and lack of resources. Case managers also need to stay

abreast of resources that would benefit their clients, and are at the mercy of whatever resources are available.

The advantages of case management are continuity of care, integration of resources, cost-effectiveness of service provision, timely service delivery and discharge (Guinan, 1996) and a complexity that has the potential of meeting a variety of individual needs. Professionally, the case managers in the study by Alcock, et al (1998) enjoyed the ability to work independently and the ability to follow a client through the health system. Finally, case management has become established in the health system, leading to some uniformity and commitment to create coherent practice. It is now supported by publications dedicated to its development such as The Journal of Case Management and accreditation bodies in the United States. Academic programs specifically for case management training in Canada and the United States have been developed.

## Self managed care

Self managed care evolved out of the independent living movement of the 1970's. It incorporates independent living with a recognition that personal care needs to be provided, such that people with disabilities can live independently in their communities. The process of achieving this goal involves the removal of social and environmental barriers which prevent the person from realizing maximum independence in their community (Batvia, DeJong & McKnew, 1991, DeJong, 1983). Providing personal assistance eliminates some of those barriers. From the independent living movement arose the independent living model. This model considers the disabled person as

> "an active recipient of services [who] recruits, selects, manages and directs his or her own service provider... The personal assistant typically is not trained as a health care professional and is not supervised by a professional....The personal assistant is accountable to the consumer, not to a supervising nurse or agency. The personal assistant who provides services to the disabled person acts, in a sense, as an extension of the disabled person and follows the individual's directions as to how to meet his or her needs." DeJong, Batavia & McKnew, 1991, p. 527

The independent living model needs to be considered within the spectrum of people's needs and abilities. The Ontario Advisory Council for Disabled Persons (1988) described three general groups of people. 1) those who can direct and/or manage their own assistance; 2) those who, with development of their skills, can direct and /or manage

their own assistance; and 3) those who, for whatever reason, are unable to direct or manage their own assistance. For the first two groups of people, self managed care is one method of addressing the need for flexibility and options in long term health care. " The individualized focus of self managed care is of particular importance and relevance to people with disabilities, many of whom have very specific needs to ensure that they can maintain, to the greatest extent possible, an independent life style." (Anderson & Parent, 1999, p. 56). For the last group of people, case managed care needs to provide the support to actualize the opinions and personality of the person needing assistance. A problem with this tailoring of services to clients needs is that there is no empirical evidence which describes the effects of matching case management services to certain client groups, let alone how to determine the best match of services to client (Geron & Chassler, 1994).

Just as case management has become a normal part of the health care delivery spectrum with the associated formation of educational programs, certification and governing bodies, self – managed care or versions there of, are being supported with more fervor and frequency. The Canadian Home Care Association cites that one of the trends that influences home care in Canada is that consumers are becoming more informed and are demanding to be "heard for more service options that provide opportunities for participation" ( Canadian Home Care Association, 2000). The terms of home care delivery are becoming increasingly defined by the client. In 1999, the same association began collecting data across Canada for a study called "Best-Practice Models of Self- Managed care: Their application for seniors". In their rationale for this study they state that "self-managed care models especially those that contribute to increased knowledge and support for decision making and care management, impact the broader determinants of health." (Canadian Home Care Association, 1999). The research team (Nahmiash, Delisle & Carrier, 2000) did not concentrate on the case managers but did focus upon the study with the purpose of generating improvements to and guidance for a SMC program that would address the needs of Quebec's seniors. They gave the seniors the choice of three grades of SMC and measured empowerment concepts (choice, control, decision making and access to resources). The results were not generalizeable due to the small sample size and the study's focus on the experience of seniors.

However, it is worthwhile noting that they did find that the SMC program model that provided a centralized service clearinghouse (service co-op) or took financial responsibility for the client's caregiver choice raised self-confidence, created positive attitudes towards solving their problems and helped the clients assert their autonomy. For the practitioners (similar to case manager), SMC required more time and energy than traditional home care services delivery. The practitioners found that they did not have enough time to make psychosocial interventions.

Martin (1999) summarized the many advantages of SMC from across North America. The main advantage for the client was increased satisfaction with services due to the increased control by the client, the increased flexibility in the services, and the choice of care provider. The disadvantage of the time consuming nature of managing their own care decreased with time, as the activities became more familiar.

In a recent Edmonton Journal (2001) article titled "Long-term care seniors need autonomy", Dr. Alister Browne asserted that the "main problem with Canadian long-term care is the lack of residents' being able to make choices which make life worth living." The solutions Dr. Browne suggested were education of staff and better funding. Since many important philosophical and ethical principles, such as equity, self-determination, flexibility and freedom underlie self managed care, it is important to uncover how the home care system is interpreting the abstract ideals into pragmatic activities that address the current trends and public demands.

## Case management in Self-managed care

In the literature, case managers roles in self-managed care seem to have two extremes. One is to stay involved with the client. In this case, the case manager needs to be aware that he or she can enhance or diminish consumer empowerment, "depending on the assigned responsibilities [and the case manager's] individual beliefs, biases and skills" (Sabatino & Litvak, 1992, p. 5). The responsibilities, beliefs, biases and skills of the case manager are, in whole or in part, determined by the program's philosophy and objectives. When the philosophy of the client being more directly in control of the services delivered infiltrates all levels of staff and the activities they perform, it is more likely that a client-controlled program is successful (Sabatino & Litvak, 1992).

Conversely, a "poor match between case manager roles and program objectives will ensure dissatisfaction with the case management intervention." (Applebaum & Austin, 1990, p. 157)

The other extreme of case management in self-managed care is to conclude the involvement with the client. Quinn (1995) states that case management is terminated when the consumer has learned to manage their care or have family who can take on the case management responsibilities. Practice questions arise with these two, equally logical alternatives, what role do case managers play in self-managed care? If it is a matter of adopting a supportive role to the more independent client, then how do the case managers adapt their activities and beliefs from their directly case managed clients who require more guidance? If it is a matter of withdrawal or transferring of case management services, then do the interactions and case managers' perception of workload lessen relative to their directly case managed clients?

## Work life

The quality of work life has a direct relationship to the quality of work performed by the case managers. "A healthy workplace is one where workers will be able to deliver higher quality care and one in which worker health and patients' care quality are mutually supportive. That is, the physical and emotional health of workers fosters quality care, and vica versa, being able to deliver high quality care fosters worker health." (Eisenberg, et al, 2001). Although this relationship has been supported by studies set in the manufacturing business, little has been done from the health provider's point of view in the health care setting (Eisenberg, et al, 2001). The studies that have been done have focused upon the stressors and supports of work. Kanter (1977) and subsequently Laschinger (1996) has organized the stressors and supports into elements of an organization that empower workers. As mentioned previously, empowerment can foster increased quality of life.

**Health care providers**

Working in the health care field is both stressful and rewarding. Of the professions that work as case managers in the Edmonton Home Care Program (EHCP) (nursing, occupational therapy, social work) nurses have been the subject of the most research in the area of health care work conditions. This body of research includes nurses in the community setting. The amount of research done on occupational therapists and social workers is not as extensive and is primarily in the institutional setting. As in most industries, some elements of stress and reward are universal, whereas others are specific to a profession practicing in the industry and the setting in which the practice occurs.

The common stressors are, lack of time to do all of the work, complex cases (Fletcher, Jones & McGregor-Cheers,1991, Sweeney, Nichols & Cormack, 1993, Jones, Fletcher & Ibbetson, 1991), amount of paperwork and lack of knowledge or technical skills (Walcott- McQuigg & Ervin, 1992). Social workers and occupational therapists also include lack of financial or promotional reward as another stressor (Sweeney, Nichols & Cormack, 1993, Seifert, Jayaratne & Chess, 1991). Walcott- McQuigg & Ervin (1992) found with community health nurses that "age, education background, family responsibility, place of employment, coping skills and previous experience may be mediators in the stress response" p. 70.

The common rewards are building peer and client relationships (Stewart & Arklie, 1994), and support from colleagues (Fletcher, Jones & Mcgregor-Chess, 1991). Interesting diverse work and autonomy (Salvatori, Williams, Polatajko & Mackinnon, 1992, Fletcher, Jones & McGregor-Chess, 1991) were recognized by the nurses in the community and the occupational therapists.

The Canadian studies in this area include occupational therapists and nurses, and it is only the nursing population that has been examined from the community perspective. Madill, McNab, Brintnell, Stewin & Fitzsimmons (1987) sampled occupational therapists from various settings and found that "higher levels of job satisfaction were associated with higher occupational levels. Generally, front line service personnel demonstrate lower levels of job satisfaction" (p. 77). The higher occupational levels had associated

greater control, authority and status within their work. Madill, Brintnell, Stewin, Fitzsimmons & McNab, (1985) surveyed an Alberta sample of occupational therapists and found that therapists sought more flexibility, autonomy, challenge and opportunity to influence the decisions that affected their work. In both of these studies, job satisfaction was positively related to retention of occupational therapists. Stewart & Arklie (1994) studied community health nurses in Nova Scotia and found that the key sources of support were spouse, family, friends, and work associates, where as the three main sources of stress were insufficient time for client care, poor work environment, and difficult clients. The support provided by the work environment was directly related to job satisfaction. The stress experienced by the nurses was inversely related to job satisfaction.

**Case managers**

In addition to their professional roles, the case manager role needs to be considered as a contributor to the overall quality of work life in the EHCP. Alcock, Edwards & Morris (1998) studied case managers providing services in the Canadian home care setting. They found that the case managers were expected to juggle responsibilities, "to be prepared for and deal with the unexpected" p. 16. Alcock, et al (1998) also highlighted some difficult and positive aspects of the case managers' work life. The difficulties were in the areas of routine stress, tough decisions, difficulties related to clients, management and resources. Sixty-four percent of the case managers were reported to be either moderately or extremely over worked. The positive aspects of work life were enthusiasm and personal satisfaction with their role, the opportunity to work independently, personal interaction and ability to follow through with the clients and seeing benefits in "helping clients negotiate the health system in the most cost effective manner" p. 171.

Nufer & Rosenberg (1998) itemized the expectations of worker rehabilitation case managers and their clients for case managers. The case managers were expected to provide services that were timely, met the needs of the clients, were provided with enthusiasm, motivation, thoughtfulness and respect, and were comprehensive. This of

course creates a need to " have a manageable case load to allow sufficient time for each [client]" p. 44.

In the literature regarding the characteristics of case managers, case management training was deemed essential. "When the case manager should be trained is still under debate. Everyone is in agreement that solid training is imperative. Without training, many potentially talented case managers have quickly burned out" (Powell, 2000, p.34). It is possible that only through training and becoming a competent, confident case manager that the true work life benefits of case management are realized. "Case management models integrate many of the elements associated with greater job satisfaction, including autonomy, a feeling of connectedness on the job, and professional status"(Cohen & Cesta, 1997, p. 240).

**Case managers in self-managed care**

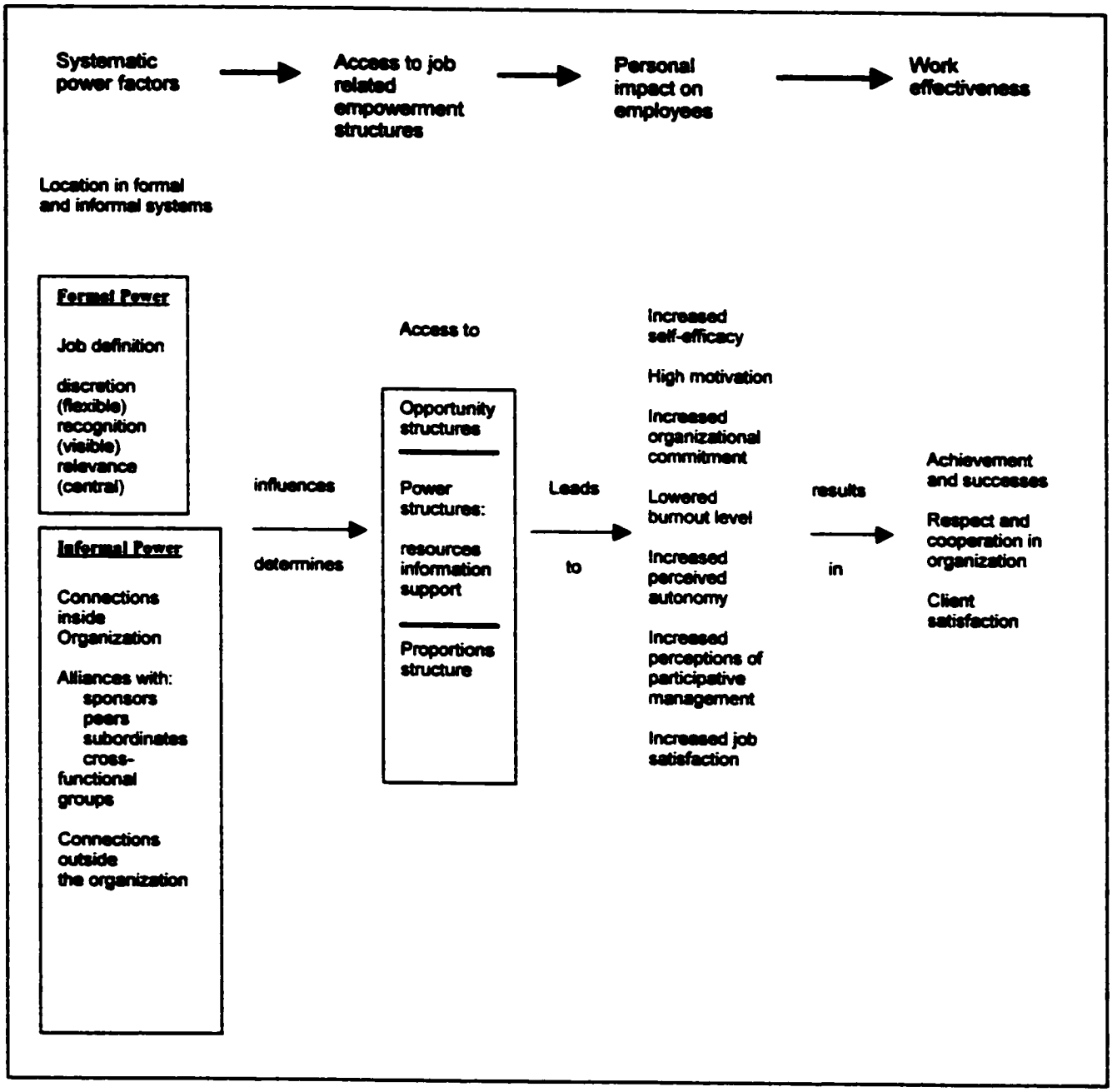
When considering delivery of self-managed care, two studies presented ramifications of self-managed care for case managers. Scala et al (1996) found that the case managers predicted an increase in their stress levels because they "would have less control over and greater worry about their clients' well-being" p.9. Micco et al (1995) argued that, "historically, clients who experience difficulties with the structured delivery of services provided by a home support agency frequently contact their case manager with requests for the case manager to intervene and help resolve problems" p. 96. Therefore, if these clients organized their own services, they would not have to contact the case managers as much to intervene. "Independent Provider Care (IPC)[self-managed care in British Columbia] has the potential to decrease staff work loads by reducing interactions with and problem-solving for clients" p. 96. Another proposed benefit of IPC was the client's increased subjective quality of care which can positively influence the case manager. Micco, et al's (1995) survey of the case managers' views of IPC's potential impact was in agreement with the researcher's hypothesis that work load would decrease, but 39% believed that there would be an increase in paper work and client interactions. The majority of case managers also predicted they would be more concerned about the quality of care provided to the client, the potential of abuse of the

client or the employee. Obviously, there needs to be more research conducted to determine if case managers' amount of work and nature of their work actually changes when working with SMC clients.

## Kanter's theory on work life

In 1977, Kanter provided a perspective on organizations and how the people of that organization interact to create empowerment or disempowerment within the work environment. She proposed that the organization, not the worker's personality should be the focus of study when trying to understand the determinants of work effectiveness and attitude. Power, (who has it, how to get it and how it is used) is one of the cornerstones of Kanter's theory. She defines power as " the ability to get things done to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet" (Kanter, 1977, p. 166). By distributing this power to others it then enables more people to achieve their work goals. The effects of available power is outlined in Figure 2.1.

Figure 2.1: Kanter's Theory of Structural Power in an Organization (Kanter, in Laschinger & Havens, 1996)




Brown & Kanter (1982) outlined the three sources of power in an organization, which they have termed lines of supply, lines of information and lines of support.

Respectively, these lines refer to resources to perform tasks, information from every level of the organization and any relevant person, and allowance to use discretion and be creative. They warn of the consequences of powerlessness. The lack of power produces a work force that is apathetic, burnt out and not productive. Kanter (1997) described another organizational structure that is important to consider in this study. The opportunity structure allows/supports growth and mobility. In a sense, this structure is the opportunity to develop professionally and to contribute to the development of the organization.

Much research , focusing on nurses' work life, has drawn inspiration from Kanter's work and has validated Kanter's theory. Laschinger & Havens (1996) found a strong correlation between "access to empowerment structures and overall work satisfaction and perceived work effectiveness" p.31. Control over practice was also a very strong predictor of work effectiveness. Hatcher & Laschinger (1996) studied the relationship between perceptions of power and burnout. They found that nurses who had access to empowerment factors had low levels of emotional exhaustion and depersonalization and high feelings of personal accomplishment. Sabiston & Laschinger (1995) investigated the relationship between autonomy and job-related empowerment. The results found a "positive relationship between the nurses' perceptions of job-related empowerment and autonomy" p. 47. The other contributing factors to perceptions of job-related empowerment were, whether the nurse thought his/her job was relevant, flexible and visible and if the nurse had informal alliances. Wilson & Laschinger (1994) hypothesized that "staff nurses' perceived job empowerment [was] related to their perceptions of the presence of empowering organizational structural characteristics" p.42. They found results that encouraged nurses' work environments to be more accessible to support, information, resources and opportunities to increase perceptions of overall job empowerment, resulting in greater organization commitment. Very recently, Turnbull (2001) studied nurses and residents in assisted living and conventional long term care settings in Edmonton. The investigation measured the empowerment and autonomy felt by the nurses in the two settings and found that the levels of empowerment and autonomy was higher in the assisted living setting than in the conventional long term care setting. The autonomy of the residents was also measured and the results found the

residents were more autonomous in the assisted living setting. An implication of Turnbull's study is that the philosophy of care delivery may have an impact upon the quality of care provided to and perceived by the residents.

## Setting for the Study: The Edmonton Home Care Program

The Edmonton Home Care Program (EHCP) serves the whole Capital Health Region which has a population of 816 334 (Capital Health, 2000). In the 1999/00 year 21 702 people were served by the EHCP through all of its programs. Home care is publically funded primarily by the Capital Health region with resources received from Alberta Health and Wellness. The EHCP consists of six offices that divide the service area according to postal code. The offices are North East, North West, South East, South West, Leduc and Strathcona. Home care is also divided into specific service teams: pediatrics (city wide), palliative (North and South ), short term intervention (North East, South East and South West) and long term care (North East, North West, South East, South West, Strathcona county and Leduc). One Home care service that covers the City of Edmonton only is the Capital Health Aids to Daily Living office that deals strictly with people who have only equipment needs. Self-managed care is a program option within long term care and thus operates from all 6 offices in the region. The EHCP provides professional services and personal care. The professional services include occupational therapy, physiotherapy, social work, nursing, respiratory therapy, mental health services, and case management.

A client can be referred to the EHCP by anyone in the community ranging from a health care facility to the client themselves. The referrals are first fielded by the EHCP's central Information and Intake (I and I) department. In I and I, the client is assessed by phone to determine if the EHCP can meet their needs. If not, the client is routed to a community agency or resource that can meet their needs. If the client is appropriate for the EHCP, he/she is routed to the appropriate EHCP office based on the client's postal code. In each office, the client is further assessed to determine which professional should be the case manager and which service team should be assigned the client. When the case manager receives the new referral, a home visit is arranged and a functional/needs assessment is done in the client's home. This is the last step of the intake process. If the client is assessed to have needs that the EHCP cannot meet, the client is referred onto

other resources or services. If the client is assessed to be appropriate for the EHCP, the needed professional services and personal care services are arranged and community resources are accessed.

In 1997, the EHCP introduced case management to its employees (who were up to that point called case coordinators) for three reasons (Capital Health Home Care, 1997a). The timing was right with regards to the public need for the most appropriate service in a timely manner, a need for increased emphasis on quality and fiscal accountability by the EHCP, and a fiscal window of opportunity was present. The EHCP defined case management as involving " both advocacy on behalf of clients and families, and fiscal responsibility for resource management" (Capital Health Home Care, 1997b, p. 3). The EHCP case manager's principal functions are: intake/screening, alternate planning and referral, assessment, goal development/care planning, service and resource management and community relations (Capital Health Home Care, 1997b). Essentially, the case management functions itemized in the literature review apply here. The concept of case management is introduced to new staff during their initial orientation to the EHCP.

The Self-Managed Care program began in 1991 in response to recommendations made to Alberta Health from consumers and stakeholder organizations such as the Premier's Council on the Status of Persons with Disabilities and the Premier's Commission on Future Health Care for Albertans (Alberta Health, 1992). The recommendations supported a health care option that provided funding directly to the client which they would use to purchase the personal services they felt were required. The Self-Managed Care program was found to support Alberta Health's philosophy of "promoting individual initiative, self-reliance and responsibility" (Alberta Health, 1992, p. 2).

After a client has been admitted to the EHCP's long-term care service, the case manager assesses if the client could be considered for Self Managed Care. The requirements are 1) The client's care needs (professional and personal) approaches or exceeds $3000/month. 2) The client will need services for at least one year. 3) The client is medically stable. 4) The client is able to undertake the responsibilities of self managed care or has someone who could be considered to be the self-care manager. 5) The client would like to use self-managed care (Alberta Health, 1993). The amount of control a

client has over his/her care can vary along a continuum. The client can manage everything (accounting and human resources) or he/she can have various private or publicly funded assistance or the client can give all his/her accounting and human resource responsibilities to a self-care manager. Of a total of 6 806 clients on long term care, 273 clients are on SMC. Of the SMC clients, 179 manage their care independently or with informal assistance from family or friends and 94 clients have their funds and personal assistance coordinated by a legal guardian or by someone with power of attorney. The average age of the SMC client is 54.9 years compared to the average age of an EHCP client which is 71.5 years. The top four diagnoses of people served by SMC are: nervous system & sense organs (55), musculoskeletal system (54), Multiple Sclerosis (29) and cerebrovascular disease (24). The top four diagnoses of the people served by the EHCP's Long Term care program are: Musculoskeletal system (1 740), cancer (575), cardiovascular disease (511) and cerebrovascular disease (484).

Since the implementation of the SMC program in 1991, several policies and practices have changed. 1) The client can no longer have a family member or friend as the self-care manager unless they obtain legal guardianship or trusteeship. 2) People on self managed care can no longer live together and combine their funding into one lump sum to hire personal assistance that would service everyone in the group. 3) The intended purpose and target population of self managed care has changed. All of the case managers who have SMC clients on their case loads also have direct case management clients. The proportion of SMC to DCM clients varies from case manager to case manager.

Over the past eight years the numbers of people that the EHCP serviced has increased. This increase can be attributed to the growth of the Capital Health Region's population, the increase in seniors in the population, the expansion of the EHCP's mandated serviced population in 1991 to include people under 65 years old (Alberta Health, 1993) and the decrease in the length of stay in the hospital. The expansion of Home Care's staff has not been able to keep pace with the population growth ( Home Care Evaluation and Research Centre, 1999). These trends necessitate an increase in the effectiveness of the case managers through expansion of present programs such as long

term direct case management and self managed care as well as addressing conditions that prevent staff from attaining their full potential.

> The environment in which case management is practiced, and thus, case management itself, is in transition. The healthcare climate has changed dramatically in the 1990's , necessitating a change in the way case management is viewed and practiced.... Its role in the education and empowerment of the patient as well as its proactive and preventative nature have increased.
>
> Case Management Society of America, 2000, p. 30

**Conclusion**

Every day the media, politicians and the general population can cite concerns they have with the health care system. One of the most pressing concerns is how to manage the growing senior population that have traditionally been the largest group served by health care programs and the increasing numbers of survivors of traumatic injuries who tend to be younger and thus demand more autonomy. The health care management of these two groups of people present the problem of complexity of care within fiscal restraint. A widely used solution has been case management and more recently, through impetus of the independent living movement, self-managed care.

Case management has a relatively long history which has culminated in governing bodies and academic institutions that are developing a case management knowledge base. Unfortunately, in Canada, for most health care professionals and in community settings, case management remains an area with little empirical evidence for best practice. Presently case managers experience tough decisions, difficulties related to clients, management and resources (Alcock, et al,1998). Couple this with present community health care conditions such as increased complexity of care, increased acuity of the health condition and increased clients' demands, the case manager faces a challenge that is sometimes overwhelming. By understanding the tasks that are done by case managers, they may be able to reflect on their practice to address how to resolve some of their most common difficulties as well as project into the future to better match their standards of practice to health care trends.

Self- managed care has been a health care option that has gathered momentum in the United States and has been endorsed by the disabled community in Canada. It is seen to be a solution for some of the client demands and needs for autonomy. SMC is a

magnification of the elements of case management that emphasize client-centeredness and empowerment. In doing so, SMC shifts some case management responsibilities to the client. SMC is relatively new in the Canadian home care context, therefore it is important to study the way SMC is translated into case management tasks. By contrasting the case managers' tasks and attitudes in SMC and DCM, light may be shed upon how, or if, case managers change their practice to accommodate the more independent client.

As empowerment has become a staple of clients' entitlements, in many work environments empowerment has also become an entitlement of the workers. In the past, various factors have been found to contribute to work efficiency and work satisfaction. Some of them can be grouped into the concept of empowerment, that is the empowerment needed to do the job at hand. Kanter based her empowerment work in the business realm. Laschinger has translated empowerment of workers into the health care field , specifically nurses. This study recognizes the importance of empowerment in its many forms/definitions, as a measure of work satisfaction and efficiency. Especially in case management and SMC, empowerment of workers seem to be a requirement. "It is reasonable to assume that self-empowerment in the work place is a necessary prerequisite for empowering clients" (Haugh & Laschinger, 1996, p. 44).

Case managers are the interpreters of Home Care's policies. The tasks they perform and the support they receive in performing them combine to provide services that strive to be individualized, empowering and to use resources effectively. "[T]he impact of the working environment on quality and the degree to which it can be adapted to improve patient outcomes by enhancing workers' health and satisfaction is generally unexplored by critical and rigorous research" (Eisenberg et al, 2001). Consequently, understanding case managers and their perspectives of work life now can provide knowledge that is imperative when entering an age of ever more complex and demanding health care.

## Chapter 3: Research Design and Methods

The purpose of this study was to describe and compare the tasks case managers performed in Direct Case Management (DCM) and Self-Managed Care (SMC). It also evaluated the type and amount of support that the work environment provided case managers. As the literature review indicated, empirical data has not explored case managers' tasks beyond what has been accepted as the case management process. The literature has also been deficient in case manager work life studies, especially in home care settings and self - managed care programs. A quantitative, descriptive research design was chosen. The intent of this design was to provide a broad, yet relatively detailed understanding of DCM and SMC from the case manager's point of view. This chapter will review the purpose and objectives of the study, the sample, data collection process, data collection tools and data analysis.

### Purpose and Objectives of the study

**Purpose** : The purpose of this study was to describe and compare the tasks case managers perform in the two programs the Edmonton Home Care Program provides for long term care clients, specifically, direct case management (DCM) and self-managed care (SMC). It also evaluated the type and amount of support the work environment provides for case managers in both of these programs. Recommendations will address the improvement of client services and case manager work environment.

**Objectives**:

1) To describe (general demographics and training background) the group of case managers who have a case load mix of direct case management and self-managed care. This objective was fulfilled by investigating the following:
   a) age
   b) gender
   c) highest level of education
   d) employment status

e) profession
f) number of years with Home Care
g) number of years with Self-managed care (SMC)
h) number of direct case management (DCM) and SMC clients

2) To describe and compare the tasks case managers completed in DCM and SMC and outline the advantages and disadvantages to clients and case managers. This objective was fulfilled by investigating the following:
   a) type and preparedness of case managers
   b) description of activities within the case management process
   c) the amount of time to complete and the level of difficulty of each step within the process
   d) case managers' perceptions of their impact on the client's happiness, sense of control, perception of health, and well-being
   e) the advantages and disadvantages of the program from the case managers' perspective

3) To compare the SMC and DCM programs in general terms. These terms were:
   a) case management time
   b) case manager satisfaction
   c) managers' perception of the elements of the job that is most stressful
   d) case manager preparation
   e) case managers' evaluation of client empowerment

4) To determine whether SMC as a program or service concept could be expanded to include more Home Care clients. This objective was addressed by determining:
   a) If the case managers believed that any of their clients receiving DCM could have been in the SMC program. If this group of DCM clients existed, then how did the case management provided to them differ from the general group of DCM clients.
   b) What barriers the above clients faced which prevented them from being in the SMC program.

c) What case managers saw as the similarities and differences of each program.

5) To determine if case managers could be assigned to just one program. This study provided preliminary information about case managers' preferences.

6) To describe and compare the level of support the work environment provides for case managers in DCM and SMC. The support will be investigated along Kanter/Laschinger's job-related empowerment structures (opportunity, information, support and resources).

## Method and Procedures

### Introduction

This study surveyed the home care case managers who had both SMC and DCM clients on their case load. The data was collected through a distributed survey that had both open and close ended questions. The statistical analysis was primarily descriptive, but comparisons of DCM to SMC case management was done. The open ended questions were analyzed using content analysis.

### Sample

Of the approximately 185 case managers in Home Care, who potentially could be assigned SMC clients, there are 100 case managers, as of January 26th , 2001, that did have SMC clients. All of these 100 case managers were asked to participate in this study. It was possible that during the data collection portion of this study some of the case managers not in this group of 100 would be assigned an SMC client. It was also possible that case managers may have discharged all of their SMC clients during the study's duration. Both of these groups of case managers were included in the sample. The latter group of case managers were recruited during the recruitment presentation when the inclusion criteria was presented. The former group of case managers was recruited during the reminder voicemails. A return rate between 33% and 60% was predicted if the body of research using the Conditions of Work Effectiveness Questionnaire (CWEQ) was any indication. For the purposes of this study, the CWEQ was referred to as the

Conditions of Work Questionnaire (CWQ). The range of response rates was 33% for mailed surveys to American hospital nurses (Laschinger& Havens, 1996) to 60.6 % for Canadian hospital nurses (Sabiston & Laschinger, 1995). Of the 5 studies cited in this proposal that use the CWEQ, the four done in Canada all had over 50% return, whereas the American one was below 50%. The one study done with public health nurses in Canada (which is closest to this study's sample) had 52.2% of surveys returned.

Data collection process

The Case Manager Task and Conditions of Work Survey was used to collect the data. The survey was accompanied by a stamped, self- addressed return envelope. The survey was be distributed by the investigator to all long term care case managers' mailboxes in each Home Care office. Although not all case managers met the inclusion criteria, the investigator had no reliable record of those case managers who had SMC clients in the 6 months before the survey was distributed or who received SMC clients during the study time frame. Therefore, all long term care case managers were given a survey package. The investigator requested that supervisors of each team of case managers obtain the case managers' approval for the investigator to do a short presentation about the proposed research. Once obtained, a presentation was made by the investigator in each office to explain and recruit for the study. To ensure that all potential case managers received the invitation to participate, a broadcast voice mail (Appendix 3) was done in each office. These two recruitment methods notified the potential participants who were not listed on the SMC case manager list provided by the Capital Health Home Care accounting department. A follow-up reminder broadcast voice mail (Appendix 4) was made two weeks after the initial distribution. Additional surveys and return envelopes were provided as necessary. The returned surveys were received by the investigator and kept at the University of Alberta in a locked cabinet. Completion and return of the survey was considered as consent to participate.

An information letter (Appendix 1) was attached to the survey. This letter emphasized the anonymity and confidentiality of the survey results. It also requested that no personal identification be made on the survey. If the investigator received surveys with identifiers, such as names, these were removed and the survey was used.

Data collection tool

The Case Manager Tasks and Conditions of Work Survey (Appendix 2) was employed. This survey was pilot tested for clarity, length and content validity by two case managers who had direct case management and self-managed care experience. The survey was predicted to take 30 to 45 minutes to complete, which was confirmed during the pilot test. The survey was divided into six sections:

1) Demographics
2) Case manager tasks
3) Comparison of DCM and SMC
4) Overlap of DCM and SMC
5) Case manager preference for program
6) Conditions of Work (from Laschinger)

Appendix 5 summarizes the data collection methods that were used in this study.

The demographic section of the survey was created by the researcher and provided a profile of the case managers, which included age, gender, education, employment status, profession, number of years with Home Care, number of years with SMC, and number of DCM and SMC clients. The case manager tasks section was created by the researcher and addressed objective two of this study. This objective was measured by first asking the case managers to describe their program specific training. This was followed by an open-ended question that asked what they did in the assessment, planning, procurement, delivery and coordination of services and monitoring steps of case management (as described by Bower, 1992). Then, the time requirement and difficulty of each step was ranked. The next set of questions related to Home Care's objective to have a positive impact on the clients they serve. The questions used a 5 point- Likert scale ranging from significant impact to no impact, to respond to statements involving the client's sense of control over their lives, how good the clients feel about themselves, how healthy and happy the clients feel. The last part of this section was an evaluation of the programs that consisted of having the case manager list what they believed to be the advantages and disadvantages of DCM to the client and themselves.

The above questions were repeated with the SMC program. Comparisons were done question by question from the DCM and SMC data in section 2 (case manager tasks)

The comparison section (section 3) addressed objective three of this study. The case managers were asked to respond to which program required the most case management time, gave the most satisfaction, was the most stressful, was the program that the case manager was most prepared to case manage and had the client group that was the most empowered.

The next section corresponded to objective four where the overlap of DCM and SMC case management was determined. The overlap was investigated by asking a series of four questions. When the case manager answers yes to whether they believe that some DCM clients could be on SMC, they were then asked to list the barriers that prevented these clients from moving to SMC, whether they managed this group of clients differently than the other DCM clients and what they did differently. Then the case manager was asked to list what was the same and what was different when comparing the two programs.

Objective five was addressed by asking which group of clients the case manager preferred and why. This information was useful in determining if case managers would be more effective if they were assigned to one program only.

Objective six was measured in section six of the questionnaire. This section consisted of parallel DCM and SMC versions of Laschinger's CWEQ. Consent was received from Laschinger to use this questionnaire as part of the survey used for this study. Minor changes were done, specifically, a) changing references to "health institutions" to "the home care program", b) replacing "nursing in a health institution" to "case manager in the Home care program" in the open ended questions, and c) deleting the demographic section. The CWEQ was originally created by Chandler in 1986 to test Kanter's theory amongst hospital nurses. Laschinger (1996) adapted the CWEQ through her numerous (18) studies aimed to empirically support Kanter's theory. Laschinger's version of the CWEQ that is used in this study consists of 30 items, all formatted as 5-point Likert scales divided into sections that measure " perceived access to opportunity, information, support and resources in one's work setting" (Laschinger, 1996, p. 23). There were 7 items in the opportunity section, 5 items in information, 9 items in support,

7 items in resources and 2 items in global empowerment. Based on the 18 studies of nurses done by Laschinger the Cronbach alpha (internal consistency) for the subsections of the CWEQ are 0.73-0.91 for opportunity, 0.73-0.98 for information, 0.73-0.92 for support and 0.66-0.91 for resources. The study that most closely resembled the home care setting was the one done with public health nurses (Hatcher & Laschinger, 1996). The alpha reliabilities were, 0.87 for opportunity, 0.98 for information, 0.91 for support, 0.81 for resources and 0.83 for empowerment. The "predictive validity has been supported in studies hypothesizing expected relationships derived from the theory" (Laschinger, 1996, p. 24). Overall empowerment has been found to be a predictor of commitment, autonomy, control over nursing practice, work satisfaction, burnout, occupational stress and work effectiveness (Laschinger, 1996). Section 6 was scored as per Laschinger's scoring method. Each subscale was computed by summing and averaging the items in each section. Overall empowerment was computed by summing the four subscales (range 4-20). High scores represented a strong access to opportunity and power structures. The two items in the global empowerment section were a validity check. Section 6 was used to measure both the DCM and the SMC programs. A comparison was done question by question and with the total scores.

Open-ended questions were used to capture the details of the activities of each case management step and to provide an opportunity for the respondent to express opinions that were relevant to the question topic, but not captured by the close-ended questions. Close-ended questions were used to quantify empowerment which traditionally would be captured by qualitative methods. Quantifying empowerment provided results that were more likely to be understood by the EHCP. The more the EHCP understood the results, the higher the likelihood they would have accepted and incorporated the results and recommendations of the study. The other reason to quantify empowerment was to use a valid and reliable quantitative test of empowerment that was perceived by the respondents as quick, as opposed to a relatively time consuming open-ended question. By quantifying empowerment, the study did not capture any indication of what the respondents defined as empowerment or factors other than organizational structures that affected their empowerment. However, the open-ended question in the

empowerment section of the survey provided an opportunity to identify factors that were not included in Kanter's theory.

Data analysis

The independent variable in this study was the context in which case management is delivered (DCM and SMC). The dependent variables were the case managers' perceptions of their tasks and their work environment. The data consisted of mostly quasi-interval data for the close -ended questions with detail provided by the open-ended questions.

Data analysis was done with the assistance of the SPSS statistical program. The frequency, standard deviation, and mean of the quantitative data was calculated and for the majority of this data the analysis was done using the Wilcoxon test and paired t- test. The open-ended questions were analyzed through content analysis methods. Refer to Appendix 5 for the details regarding the data analyses that was done in this study. Please note that in sections 2, 5 and 6 of the survey, matched data was generated from the DCM and SMC programs.

Strengths and Limitations

The strengths of this study's methodology were:

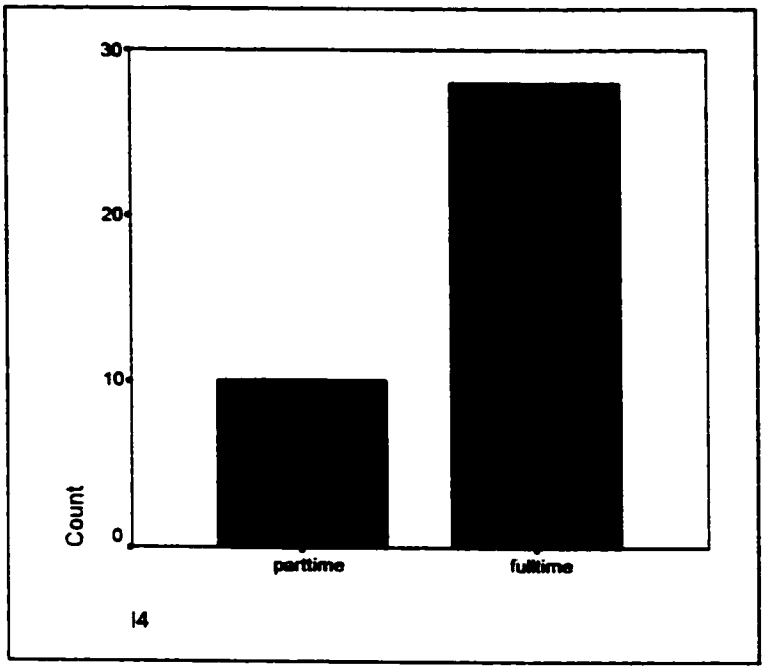
1) the case managers were their own control thus excluded confounding issues such as different educational background and family life stressors.
2) The qualitative questions provided some substantiation of the quantitative questions. They also provided details that the quantitative questions could not generate.
3) the work life questions from Laschinger have been tested frequently for validity and reliability.
4) This study was the first to measure empowerment of the case manager in Home Care using Laschinger's CWEQ.
5) The number of case managers allowed for statistical comparisons.

The limitations of this study's methodology were:

1) The sample was not large enough to stratify according to profession, ratio of SMC:DCM in the past year. These two descriptive characteristics could be variables that effect the type of responses generated by the survey.

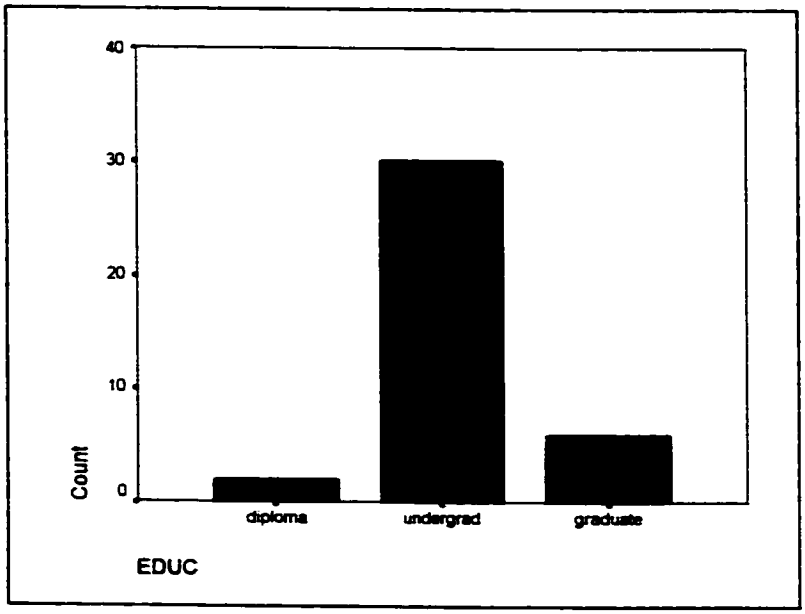
There were no physiotherapists or respiratory therapists who were case managers for SMC clients.

Figure 4.4: Distribution of Work Patterns



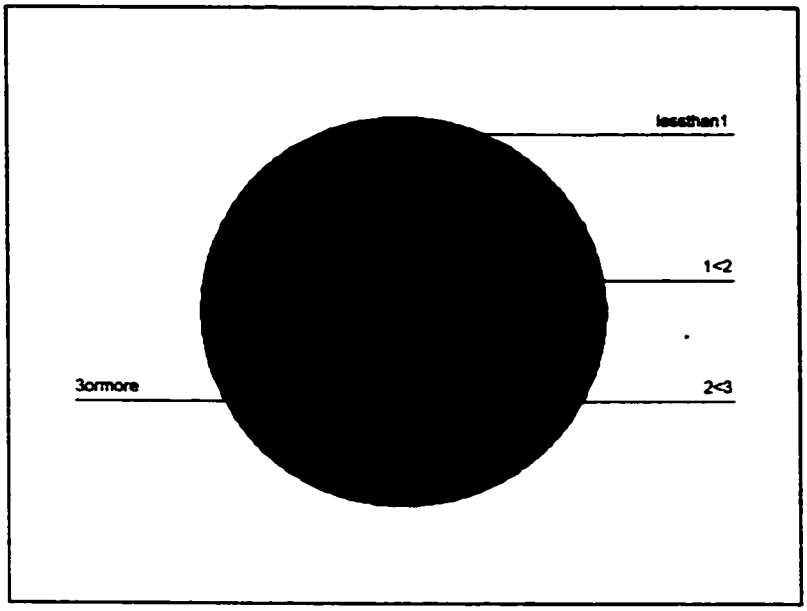

| Distribution of Work Patterns | N | % |
|---|---|---|
| Part time | 10 | 26.3 |
| Full time | 28 | 73.7 |
| Total | 38 | 100 |

Figure 4.5: Education level of sample




| Level of education | N | % |
|---|---|---|
| Diploma | 2 | 5.3 |
| Undergraduate | 30 | 78.9 |
| Graduate | 6 | 15.8 |
| Total | 38 | 100 |

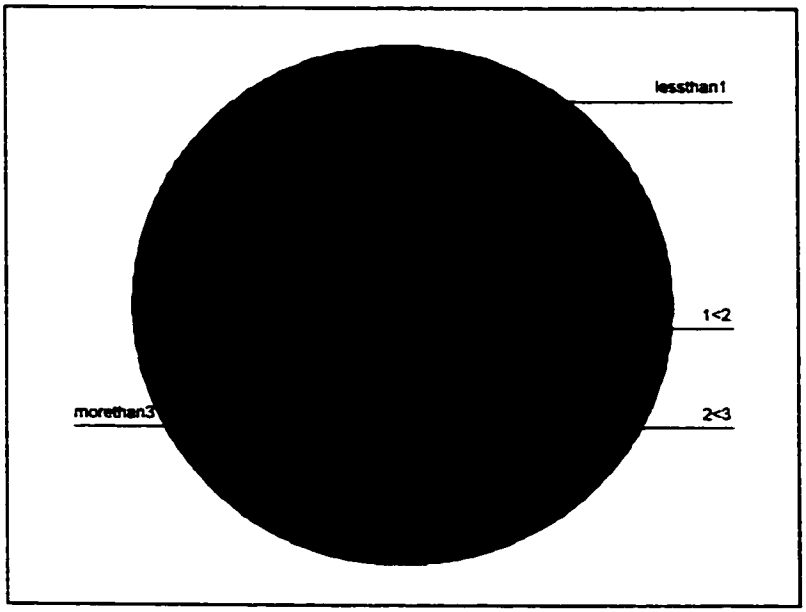
Figure 4.6: Number of years working as a case manager in the EHCP




Case manager home care experience

| # of years | N | % |
|---|---|---|
| less than 1 | 5 | 13.2 |
| 1< 2 | 7 | 18.4 |
| 2< 3 | 1 | 2.6 |
| more than 3 | 25 | 65.8 |
| Total | 38 | 100 |

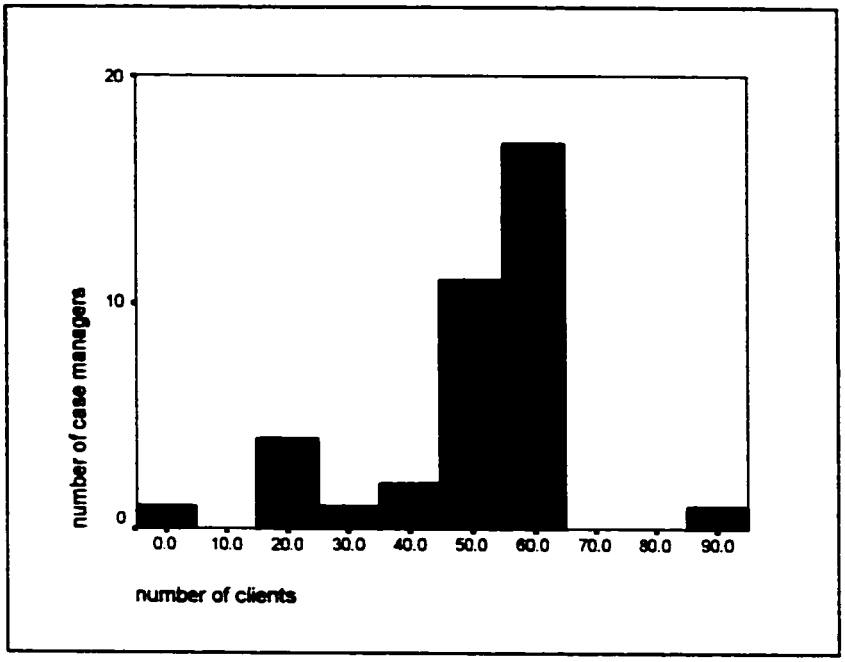
Figure 4.7: Number of years working with Self- Managed Care in the EHCP




Case manager self-managed care experience

| # of years | N | % |
|---|---|---|
| less than 1 | 8 | 21.1 |
| 1< 2 | 4 | 10.5 |
| 2< 3 | 1 | 2.6 |
| more than 3 | 25 | 65.8 |
| Total | 38 | 100 |

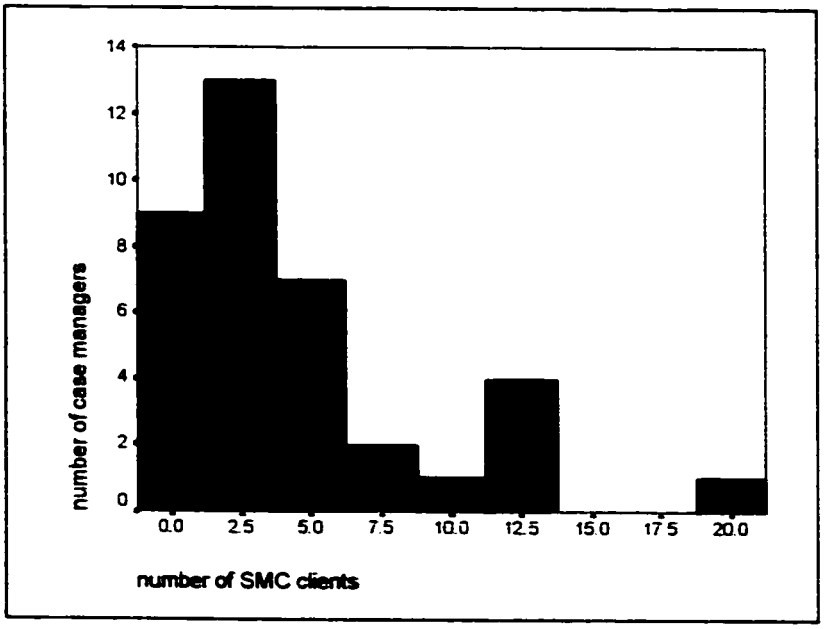
Figure 4.8: Distribution of the number of clients per case manager




| Statistical characteristics | |
|---|---|
| Mean | 49.0 |
| Median | 54.0 |
| Mode | 55.0 |
| Skewness | - 0.979 |

The number of clients on the case loads of the sample was within the range of 0 – 90. The most common number of clients on a case load was between 55 and 65.

Figure 4.9: Distribution of the number of SMC clients per caseload




| Statistical characteristics | |
|---|---|
| Mean | 4.6 clients |
| Median | 3 clients |
| Mode | 1 clients |
| Skewness | + 1.577 |

The number of SMC clients of the case loads of the sample was within the range of 0-20. The majority of case managers had between 2-3 SMC clients on their case load.

**Representativeness**

At the time of data collection (June – August, 2001) there were 88 case managers with SMC clients. The number of SMC clients on each case manager's case load for the general population of eligible case managers is from the statistics available on January 29, 2001.

Table 4.1 Demographic representativeness

| | | Respondent Sample | Eligible population |
|---|---|---|---|
| Profession | RN | N=16 %=42.1 | N=55 %=59.8 |
| | OT | N=7 %=18.4 | N=15 %=16.3 |
| | SW | N=15 %=39.5 | N=22 %=23.9 |
| Gender | Male | N=8 %=21.1 | N=13 %=14.1 |
| | Female | N=30 %=78.9 | N=79 %=85.9 |
| Work pattern | Part time | N=10 %=26.3 | N=34 %=37.4 |
| | Full time | N=28 %=73.7 | N=57 %=62.6 |
| Total case load/CM | mean | 49.0 | 43.8 |
| | median | 54 | 46.5 |
| | mode | 55 | 58 |
| | skewness | -0.979 | -0.444 |
| # SMC clients/CM | mean | 4.6 | 3 |
| | median | 3 | 2 |
| | mode | 1 | 1 |
| | skewness | 1.577 | 2.666 |
| #SMC/# Total case | mean | 10.9 % | 7.8 % |
| load | S.D. | 7.93 | 12.6 |
| | min | 1.67 % | 1.67 % |
| | max | 50.0 % | 60.0 % |

**Comparison tests for representativeness**

Paired T-test ($\alpha<0.05$)

1) Total case load: 2-tailed significance = 0.059
t-score = - 1.952 (df = 36)

2) # SMC clients: 2-tailed significance = 0.193
t-score = - 1.332 (df = 30)

3) ratio of # SMC/ # caseload: 2-tailed significance = 0.645
t – score = 0.466 (df = 29)

| Wilcoxon test | | Signed ranks test |
|---|---|---|
| Total case load: | sample<population = 15 | Z = -1.992 |
| | sample>population = 22 | asymp. Sig. = 0.046 |
| | Tie = 0 | 2-tailed |
| #SMC clients: | sample<population = 7 | Z = - 2.180 |
| | sample>population = 18 | asymp. Sig. = 0.029 |
| | Tie = 6 | 2-tailed |

The study sample was found to be representative of the total eligible population. The relative proportion of the three groups of professionals was similar. Nurses were the biggest group, followed by social workers and occupational therapists. However, the number of people in the three professional groups were not similar. A lower number of nurses responded and a higher number of social workers responded. The proportion of part time and full time respondents was similar to the general eligible population. There were roughly ½ as many part time case managers as full time case managers. The proportion of male to female case managers was not the same between the sample and the eligible population. The sample was made up of 27% male and the eligible population was 16% male. However, both groups had much more female case managers than male case managers. When the total case load per case manager, the number of SMC clients per case manager and the proportion of SMC clients to the total caseload were tested for representativeness, the statistics indicate that the sample is comparable to the general population of eligible case managers. The skewness of the total caseload and the number of SMC clients were in similar directions; high numbers of total cases and low numbers of SMC clients. The percentage of SMC clients that the case managers had were on average 7% in the sample and 10% in the eligible sample. The upper limit of the proportion of SMC clients was 50% and 60% respectively. According to a newsletter released by Capital Health Authority (Oct, 2001), the average age of registered nurses in the community programs (including Home Care) is 41.07. This is comparable to the sample which had its largest age group between 41 and 50.

**Objective 2: Tasks of case managers in DCM and SMC**

Table 4.2: Type of on the job training received by a case manager

| Type of on the job training | Number of responses in each program | |
|---|---|---|
| | DCM | SMC |
| Formal work shops | 26 | 12 |
| Peers | 32 | 32 |
| Resources from employer | 26 | 25 |
| Other * | 1 | 2 |

* The other resource for DCM was "by doing", for SMC it was "learned by experience" and an unspecified resource.

Table 4.3: Combination of on the job training resource (s) received by a case manager

| Combination of on the job training resource(s) | Number of responses in each program | |
|---|---|---|
| | DCM | SMC |
| Formal workshop only | 1 | 1 |
| Peers only | 2 | 8 |
| Resources from employer only | 2 | 1 |
| Other resources only | 0 | 2 |
| Formal workshop and peers | 7 | 1 |
| Formal workshop and resources from employer | 1 | 1 |
| Peers and resources from employer | 6 | 14 |
| All the possible resources | 1 | 0 |
| Formal workshops, peers and resources from the employer | 16 | 8 |

When the sample commented on the type of "on the job" training they received for DCM and SMC, peers, resources from the employer and other types of training were identified in equal numbers in DCM and SMC (Table 4.2). The one difference was the number of times formal workshops were identified. Formal workshops were mentioned less often SMC than in DCM. When the combinations of the types of training were itemized for each respondent (Table 4.3), many differences were seen. 1) The respondents relied upon their peers alone for training 4 times more in SMC than in DCM.

2) The respondents relied upon peers combined with resources from the employer twice as much when case managing SMC than when case managing DCM. 3) When formal workshops are combined with peers and employer resources, the respondents were half as likely to identify this combination of training for SMC than for DCM case management. 4) The training for DCM did not include "other resources only", but 2 respondents identified "other resources only" as their training for SMC. These results indicate that informal training such as peers, other resources and employer resources are the primary sources of training for SMC, whereas for DCM, the case managers primarily rely upon formal training.

**Do the case managers feel the training prepared them for case management?**

Table 4.4: Training adequacy for case management

| Value assigned | DCM | | SMC | |
|---|---|---|---|---|
| | Frequency (f) | Percentage (%) | Frequency (f) | Percentage (%) |
| St. disagree (1) | 1 | 2.8 | 5 | 13.5 |
| 2 | 5 | 13.9 | 10 | 27.0 |
| Neither disagree or agree (3) | 9 | 25.0 | 11 | 29.7 |
| 4 | 16 | 44.4 | 10 | 27.0 |
| St. agree (5) | 5 | 13.9 | 1 | 2.7 |
| Missing values | 2 | | 1 | |
| Mean | 3.53 | | 2.78 | |
| S.D. | 1.00 | | 1.08 | |

Legend: St. = strongly

Table 4.5 Wilcoxon ranks of training adequacy

| SMC-DCM | | N | Mean Rank | Sum of ranks |
|---|---|---|---|---|
| SMC < DCM | Negative Ranks | 17 | 11.38 | 193.50 |
| SMC > DCM | Positive ranks | 3 | 5.50 | 16.50 |
| SMC = DCM | Ties | 15 | | |
| | Total | 35 | | |

Wilcoxon Signed Ranks Test

| SMC – DCM (based on positive ranks) | |
|---|---|
| Z | - 3.371 |
| Asymp. Significance (2-tailed) | 0.001* |

*= $\alpha < 0.05$

There was a significant difference between how well training (by employer or from school) had prepared the case manager to case manage SMC and case manage DCM. The results indicate that the case managers felt that their training had not prepared them as well for SMC as DCM.

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**The following sections will report what was done in the case management steps for direct case management and self managed care. A detailed account of the open ended responses for this section is available in Appendix 6**

The number in brackets indicates how many responses were made in the category.

Table 4.6: Summary of case management steps

| CM steps | DCM | SMC |
|---|---|---|
| Assessment | | same as DCM (13) |
| | Collect information (34) | Collect information (17) |
| | Paper work (30) | Paper work(3) |
| | Establish relationship (19) (rapport, home visit, one to one interview) | Educate client on SMC(2) |
| | Match Home care to client (client's wants and needs, client/family ability, Home Care's capabilities) (25) | Match client to SMC(12) |
| | Observation (3) | |
| Planning | With client and family (17) | same as DCM (7) |
| | Needs assessment (5) | |
| | Match Home Care to client's requests and needs (15) | Match client to SMC(6) |
| | Explore client's options (3) | Educate client (1) |
| | Complete care plans (9) | Prepare client for SMC(14) |
| | Priorize needs (4) | |
| | Paper work (2) | Paper work (8) |
| | Discuss with peers (3) | Discuss with peers (4) |
| | Obtain services (3) | |
| Obtaining services | Waitlist (4) | same as DCM (3) |
| | Paper work (4) | Paper work (13) |
| | Phone calls (8) | Phone calls (1) |
| | Make referrals (3) | Make referrals (3) |
| | Determine required services (4) | Educate(12) |

| | | |
|---|---|---|
| | Arrange services (24) | Client responsible for hiring staff and outlining duties(10) |
| | Access resources other than Home Care (21) | Connect client to resources (6) |
| | Discuss with other professions (20) | Review case with SMC team(1) |
| Delivery and coordination | Make referrals (5) | same as DCM (3) |
| | Coordinate and confirm services and professionals (8) | Coordinate professional services (10) |
| | Ensure and monitor (20) | Support and ongoing teaching(7) |
| | Problem solving (3) | Monitor match between client and SMC(1) |
| | Paper work (3) | Paper work(5) |
| Monitoring | | same as DCM (3) |
| | When: at set times (11) as needed (10), CM determined (10), depends on client (3), re-assessment (1), maintain contact (1) | When: at set times(22) as needed(6), when there are changes(4), continuous(6), CM determined(1), depends on client(3), contract renewal (5) |
| | What: needs(7), changes (4), services (6), client's progress (5) | What: problem solving(3), review of assessment items(7), audits by accounting(4) |
| | Who initiates: client (10), family (7), agency (5), Hospital(1), manager(10) | Who initiates: client(6), case manager(15) at anniversary date |
| | How: phone(14), home visit(10), case conference(1), other disciplines (1) | How: phone (5), home visits(2) |

Assessment: A large number of respondents stated that this step was the same in DCM and SMC (13). Collecting information was the primary purpose of the case manager during the assessment step for both DCM (34) and SMC(18). One needs to keep in mind that SMC clients are assessed twice, first upon initial contact with Home Care, which is the same as DCM and then when the client is assessed for the SMC program.

For DCM clients, the case manager collected information primarily regarding client's needs (10) and medical needs (11). Other significant information related to the client's functional status (6), medical history/condition (6) and support system (5). This information was recorded in paper work that consisted of the initial assessment called the Adult Functional Assessment Tool (14), a medication list (5) and other discipline or diagnosis specific evaluations (5). The information was collected mostly from the client (17) and the family (7), although other medical professionals, old charts, and other involved parties were also identified as information sources. The information collected established the client's wants and needs (17), their ability to manage in the community (4) and how Home Care could help (4). This step in DCM was conducted in a manner that developed a relationship through home visits (14) and face to face interviews (4). As one case manager said, he/she "establish[es] rapport with [the] client, ask questions regarding all aspect of client's daily life to determine the client's areas of need."

For SMC clients, the information collected related to the client's needs (6), identification of services (3), support network and resources (3) and whether the client was stable (1). Only three sources of information were identified; the client (5), family (4) and professionals (1). Compared to DCM, the range of people and the number of times they are mentioned are lower in SMC than in DCM. The case manager also completed paper work (3) and educated the client about SMC (2). The skills or qualities required by the client to be assessed as appropriate for SMC were the ability: to direct care (3), to manage finances (2), to recruit caregivers (2), problem solve, meet deadlines, communicate needs and teach (1) and be willing to comply with the conditions of the contract (1). The case manager collected information to "assess how best to address needs (DCM or SMC)" and to "assess client's and/or family's ability to meet SMC requirements and contract agreement and ability to obtain private care". Generally, the case manager was assessing to determine if the client met the SMC requirements (18). Both programs match program and clients' needs (which continues into the planning step). A subtle but notable difference was that the language used or implied in DCM was that Home Care was matched to the client and in SMC the client was matched to SMC. This reflects an overall pattern across the 5 steps. DCM seems to change, match or bring

the environment to the client, whereas in the SMC program, efforts were made to change the client to fit the program (through education and support).

Planning: In the DCM program many case managers completed this step with the client and family (17). The client (21) continued to be the largest focus and/or contributor to the activities that occurred in this step. Families (8) were involved to a lesser extent. Agencies (2) and other disciplines (7) including peers were mentioned for the first time as contributors to the planning step. In this step, the case manager primarily continued to match what Home Care could provide to what the clients requested (15). One respondent stated that he/she "[determined] how best to provide [the] client with the appropriate services within Home Care's scope and limitations". Two other activities; needs assessment (5) and setting down the client's options (3) were also similar to the activities done in the assessment step. The case manager also began to use the information to priorize needs (4) and complete care plans (9) which then led to the obtaining of services (3). The exploration of resources and meeting of needs involved discussion with peers (3) and completion of paper work (2).

Many similarities were seen between DCM and SMC in the planning step. Seven respondents stated that their activities were the same in SMC and DCM. Other similarities included the determination of needs, service gaps and urgency, as well as finding the "actual client functioning" (9), community services and funding. There was also overlapping of the assessment step with the matching of the client to the SMC program (6). "The suitability of SMC as the choice for the client". Education of the client (1) about SMC also continued. It was the preparation of the client for SMC that predominated the case manager's activities. The preparation included defining roles and time lines (2), financial components (3), general SMC process education (6) which could be time intensive, and ensuring that the client could find and hire staff (3). Akin to DCM, paper work and discussion with peers, continued in this step. The people involved in this step were mostly the client (14) and family (6). Unique to the SMC program was the involvement of accounting (1) and payroll assisting agencies (1). The highlights from comparing DCM and SMC were: 1) Matching services and client was continued and peer consultation was started in this step for both programs. 2) In the DCM program,

obtaining services started in this step and assessment and determining required services tasks were continued. 3) The DCM program completed care plans, but in SMC program care plans were not mentioned.

Obtaining Services: This step in DCM was best described as the "[identification of] who is the best service provider and refer". Some assessment and planning activities that determined required services and resources (4) continued. All of the other activities related to finding and referring to a service provider. Arranging services with agencies (24) was the most common activity. This was followed by discussing (6) and making referrals to other professionals (14). Resources (21) such as funding, government and family were also accessed. The case manager would access these services and resources through paper work (4), phone calls (8), making referrals (3) and wait listing (4).

Five case managers stated that their activities in SMC and DCM were the same. For SMC clients, one respondent described how the work involved in this step varied. "[This step] can be simple or complex depending on client's needs and resources and/or informal caregivers". The activities could be organized according to who was involved. The client or SMC manager was responsible for hiring staff and outlining duties (10) and they may use community resources for assistance (4). The case manager educated (18) and assisted (2) the client. Alone, the case manager made referrals to professionals, made phone calls, talked to peers and did paper work. In general, although the client in the SMC program arranged their own personal services, the case manager still provided support in the form of resources and education. In the DCM program, client education was not identified, but resources were accessed. Wait listing of services existed in DCM but not in SMC. In both programs peers were again consulted in this step. When resources were one of the primary concerns (planning and obtaining services steps), peers were consulted and played a significant role.

Delivery and coordination : In DCM, the delivery and coordination of services involved service providers/agencies (25), peers (14), other disciplines (13) and the client's family (8). These people made use of phone calls (3), faxes (1), face to face meetings (2) and home visits (3). The activities required to deliver and coordinate services were: referring

to professionals and the community (5), coordinating and confirming professional services (8), problem solving (3) doing paper work (3), and ensuring and monitoring personal services (3) which involved keeping in contact with the client, family and agencies to check the suitability, appropriateness and reception of the services.

Although three case managers stated they performed the same activities in SMC and DCM, the activities were primarily performed by and were the responsibility of the client (11). This resulted in less involvement by the case manager in the SMC client's care. The case manager continued to do paper work (5), provide and coordinate professional services, provide support and ongoing teaching (7), and monitor the match between the client and SMC (2). To summarize, for the DCM program, making referrals was continued from the obtaining services step. Coordination occurred in both programs, but SMC did not include personal services since they were the client's responsibility.

Monitoring: In DCM, monitoring was primarily done yearly (5), or more frequently at the beginning and then less frequently (3). The time periods that were mentioned only once by the respondents were: every 2 months, monthly or at the beginning . Time periods were not the only determinants of the monitoring schedule. Some case managers also mentioned time periods which suggested that there were no set time periods for monitoring, instead they determined the timing , such as, regularly (7), occasionally, ongoing and appropriate interval (1). Other case managers monitored at the client's request (3). The reasons to monitor were need (7), regarding services (6), measure the client's progress (5), changes in the client's condition (4) to address issues that arise (3), or to just maintain contact (1). The client (10) was the most common person to contact the case manager to perform the monitoring step. Other contacts were the family or informal support (7), the agency (5) or the hospital (10. Monitoring was performed by phone (14), home visit (10), case conference or updates from other disciplines (1).

In SMC, monitoring was done less often "as the client manages the care" (4). When monitoring was done, the majority were completed yearly (18) with a couple of responses citing every 6 months (2) or every 3-4 months (2). Four respondents stated they monitored more often at the beginning then decreased the frequency. "Initially, every 2 weeks for 6 weeks to establish that SMC is working and continues to be the best

option for the client or family, then yearly." Although there was only one respondent who stated he/she monitored at indeterminant periods of time, there were 6 who stated they monitored continuously. Three respondents decided to monitor based on the client (3). "Some clients still need contact every month or few months to address specific discipline needs or to link with other community services". Monitoring was done to address changes (10), fulfil yearly assessment requirements (7), renew the contract (5) or perform audits (3). Clients (6) and the accounting department (4) initiated some monitoring, but the majority were initiated by the case manager (15) for the required yearly reassessment. The monitoring sessions were conducted by phone (5) or home visit (2).

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**What is the relative amount of time required to perform each step of case management?**

**1) Direct case management (DCM)**

Table 4.7: The relative amount of time required to perform case management steps in DCM.

| Value | Assessment | | Planning | | Obtaining... | | Delivery... | | Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| 1 | 17 | 53.1 | 2 | 6.3 | 3 | 9.4 | 8 | 25.0 | 2 | 6.3 |
| 2 | 6 | 18.8 | 10 | 31.3 | 4 | 12.5 | 7 | 21.9 | 5 | 15.6 |
| 3 | 6 | 18.8 | 6 | 18.8 | 10 | 31.3 | 5 | 15.6 | 5 | 15.6 |
| 4 | 3 | 9.4 | 8 | 25.0 | 10 | 31.3 | 10 | 31.3 | 1 | 3.1 |
| 5 | 0 | 0 | 6 | 18.8 | 5 | 15.6 | 2 | 6.3 | 19 | 59.4 |
| Mean | 1.84 | | 3.19 | | 3.31 | | 2.72 | | 3.94 | |
| S.D. | 1.05 | | 1.26 | | 1.18 | | 1.33 | | 1.41 | |
| Missing values: 6 | | | | | | | | | | |

Value: 1= the most time

5= the least amount of time

1a) Table 4.8: DCM ranking patterns for the time required to perform each step of case management

| | Ranking patterns (Total N = 22) | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Assessment | 1 | 1 | 1 | 1 | 2 | 3 | 4 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 4 |
| Planning | 2 | 2 | 2 | 4 | 3 | 4 | 5 | 2 | 3 | 3 | 3 | 4 | 5 | 1 | 1 | 4 | 4 | 4 | 5 | 5 | 5 | 3 |
| Obtaining.. | 3 | 4 | 4 | 3 | 4 | 5 | 1 | 5 | 2 | 4 | 5 | 2 | 3 | 3 | 4 | 3 | 5 | 1 | 2 | 4 | 4 | 2 |
| Delivery... | 4 | 5 | 3 | 2 | 1 | 1 | 2 | 4 | 4 | 2 | 4 | 3 | 4 | 4 | 3 | 1 | 3 | 2 | 1 | 1 | 2 | 1 |
| Monitoring | 5 | 3 | 5 | 5 | 5 | 2 | 3 | 3 | 5 | 5 | 2 | 5 | 2 | 5 | 5 | 5 | 1 | 5 | 4 | 2 | 1 | 5 |
| Number | 4 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

**2) Self Managed Care**

Table 4.9: The relative amount of time required to perform case management steps in SMC

| Value | Assessment | | Planning | | Obtaining... | | Delivery... | | Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| 1 | 21 | 70.0 | 6 | 20.0 | 1 | 3.3 | 1 | 3.3 | 1 | 3.3 |
| 2 | 8 | 26.7 | 19 | 63.3 | 0 | 0 | 1 | 3.3 | 2 | 6.7 |
| 3 | 0 | 0 | 4 | 13.3 | 12 | 40.0 | 2 | 6.7 | 12 | 40.0 |
| 4 | 1 | 3.3 | 0 | 0 | 13 | 43.3 | 12 | 40.0 | 4 | 13.3 |
| 5 | 0 | 0 | 1 | 3.3 | 4 | 13.3 | 14 | 46.7 | 11 | 36.7 |
| Mean | 1.37 | | 2.03 | | 3.63 | | 4.23 | | 3.73 | |
| S.D. | 0.67 | | 0.81 | | 0.85 | | 0.97 | | 1.14 | |
| Missing values: 6 | | | | | | | | | | |

Value: 1= the most time

5= the least amount of time

2a) Table 4.10: SMC ranking patterns for the time required to perform each step of case management

| | Ranking patterns (Total N= 12) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Assessment | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 1 | 2 | 2 | 2 | 4 |
| Planning | 2 | 2 | 2 | 1 | 3 | 1 | 2 | 2 | 1 | 3 | 3 | 5 |
| Obtaining... | 4 | 3 | 3 | 3 | 5 | 4 | 5 | 5 | 4 | 4 | 4 | 1 |
| Delivery... | 5 | 4 | 5 | 4 | 4 | 5 | 3 | 4 | 3 | 1 | 5 | 2 |
| Monitoring | 3 | 5 | 4 | 5 | 2 | 3 | 4 | 3 | 5 | 5 | 1 | 3 |
| Number | 8 | 6 | 3 | 3 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |

Table 4.11: Wilcoxon test comparing the time required to perform each step of case management in DCM and SMC

| SMC - DCM | Ranks | N | Mean Rank | Sum of Ranks |
|---|---|---|---|---|
| SMCA<DCMA | Negative Ranks | 10 | 7.75 | 77.50 |
| SMCA>DCMA | Positive Ranks | 3 | 4.50 | 13.50 |
| SMCA=DCMA | Ties | 16 | | |
| SMCP<DCMP | Negative Ranks | 15 | 12.83 | 145.00 |
| SMCP>DCMP | Positive Ranks | 2 | 4.00 | 8.00 |
| SCMP=DCMP | Ties | 12 | | |
| SMCO<DCMO | Negative Ranks | 6 | 5.50 | 33.00 |
| SMCO>DCMO | Positive Ranks | 9 | 9.67 | 87.00 |
| SMCO=DCMO | Ties | 14 | | |
| SMCD<DCMD | Negative Ranks | 2 | 6.75 | 13.50 |
| SMCD>DCMD | Positive Ranks | 19 | 11.45 | 217.50 |
| SMCD=DCMD | Ties | 8 | | |
| SMCM<DCMM | Negative Ranks | 9 | 10.39 | 93.50 |
| SMCM>DCMM | Positive Ranks | 7 | 6.07 | 42.50 |
| SMCM=DCMM | Ties | 13 | | |
| | Total responses | 29 | | |

Legend: A= Assessment
P= Planning
O= Obtaining services/resources
D= Delivery and coordination of services
M= Monitoring

Table 4.12: Wilcoxon signed ranks test of the significance in the differences for the relative amount of time taken for each step of case management in SMC and DCM

| | a)SMCA-DCMA | a)SMCP-DCMP | b)SMCO-DCMO | b)SMCD-DCMD | a)SMCM-DCMM |
|---|---|---|---|---|---|
| Z | - 2.300 | - 3.287 | - 1.565 | - 3.579 | - 1.346 |
| Asymp.sig. (2-tailed) | 0.021* | 0.001* | 0.118NS | 0.000∞ * | 0.178NS |

Legend: a = based on positive ranks
b = based on negative ranks
* = $\alpha < 0.05$
NS = not significant

There is a significant difference in the ranking of time the assessment, planning, and delivery steps take when case managing SMC and DCM clients. The assessment and planning steps take more time in the SMC program. The delivery step take less time in the SMC program. There is no significant difference in the relative amount of time case managers spend in the obtaining services and resources and monitoring steps.

The ranking patterns of the case management steps show that there is more variety in the patterns in the DCM program (N=22) than in the SMC program (N=12). Along with the lower amount of variety is more of a concentration of patterns around two patterns in the SMC program (Assessment, planning, monitoring, obtaining, delivery (N=8) and assessment, planning, obtaining, delivery and monitoring (N=6).

**What is the relative difficulty of each case management step?**

1) **Direct case management**

Table 4.13: The relative difficulty of each case management step in DCM

| Value | Assessment | | Planning | | Obtaining... | | Delivery... | | Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| 1 | 8 | 25.0 | 3 | 9.4 | 8 | 25.0 | 4 | 12.5 | 9 | 28.1 |
| 2 | 8 | 25.0 | 8 | 25.0 | 6 | 18.8 | 10 | 31.3 | 0 | 0 |
| 3 | 6 | 18.8 | 8 | 25.0 | 4 | 12.5 | 6 | 18.8 | 8 | 25.0 |
| 4 | 4 | 12.5 | 9 | 28.1 | 7 | 21.9 | 8 | 25.0 | 4 | 12.5 |
| 5 | 6 | 18.8 | 4 | 12.5 | 7 | 21.9 | 4 | 12.5 | 11 | 34.4 |
| Mean | 2.75 | | 3.09 | | 2.97 | | 2.94 | | 3.25 | |
| S.D. | 1.46 | | 1.20 | | 1.53 | | 1.27 | | 1.63 | |
| Missing values: 6 | | | | | | | | | | |

Value: 1= easiest step
5= hardest step

1a) Table 4.14: DCM ranking patterns of the relative difficulty of each step

| | Ranking patterns (Total N= 20) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Assessment | 5 | 4 | 3 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 4 | 5 |
| Planning | 4 | 3 | 5 | 2 | 2 | 2 | 3 | 3 | 2 | 4 | 1 | 1 | 5 | 4 | 2 | 4 | 4 | 5 | 3 | 1 |
| Obtaining... | 1 | 2 | 4 | 3 | 5 | 4 | 4 | 5 | 5 | 5 | 3 | 4 | 3 | 5 | 1 | 1 | 2 | 2 | 2 | 2 |
| Delivery... | 2 | 1 | 2 | 4 | 3 | 3 | 5 | 4 | 4 | 2 | 4 | 3 | 4 | 1 | 4 | 2 | 5 | 1 | 5 | 3 |
| Monitoring | 3 | 5 | 1 | 5 | 4 | 5 | 1 | 1 | 3 | 3 | 5 | 5 | 1 | 3 | 5 | 5 | 1 | 4 | 1 | 4 |
| Number | 5 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

2) **Self managed care**

Table 4.15: The relative difficulty of each case management step in SMC

| Value | Assessment | | Planning | | Obtaining... | | Delivery... | | Monitoring | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| 1 | 6 | 20.0 | 4 | 13.3 | 9 | 30.0 | 5 | 16.7 | 6 | 20.0 |
| 2 | 3 | 10.0 | 7 | 23.3 | 6 | 20.0 | 12 | 40.0 | 2 | 6.7 |
| 3 | 2 | 6.7 | 3 | 10.0 | 11 | 36.7 | 4 | 13.3 | 10 | 33.3 |
| 4 | 4 | 13.3 | 13 | 43.3 | 3 | 10.0 | 5 | 16.7 | 5 | 16.7 |
| 5 | 15 | 50.0 | 3 | 10.0 | 1 | 3.3 | 4 | 13.3 | 7 | 23.3 |
| Mean | 3.63 | | 3.13 | | 2.37 | | 2.70 | | 3.17 | |
| S.D. | 1.65 | | 1.28 | | 1.13 | | 1.32 | | 1.42 | |
| Missing values: | | | | | | | | | | |

Value: 1= easiest step
5= hardest step

2a) Table 4.16: SMC ranking patterns of the relative difficulty of each step

| | Ranking patterns (Total N= 18) | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Assessment | 5 | 5 | 5 | 1 | 1 | 2 | 4 | 1 | 1 | 2 | 3 | 3 | 4 | 4 | 5 | 5 | 5 | 5 |
| Planning | 4 | 4 | 4 | 2 | 2 | 1 | 3 | 2 | 5 | 1 | 2 | 4 | 5 | 5 | 1 | 2 | 3 | 4 |
| Obtaining... | 3 | 1 | 2 | 3 | 3 | 4 | 1 | 5 | 4 | 3 | 1 | 1 | 3 | 2 | 2 | 1 | 1 | 2 |
| Delivery... | 2 | 2 | 1 | 4 | 5 | 5 | 2 | 4 | 3 | 4 | 4 | 2 | 1 | 1 | 3 | 3 | 2 | 3 |
| Monitoring | 1 | 3 | 3 | 5 | 4 | 3 | 5 | 3 | 2 | 5 | 5 | 5 | 2 | 3 | 4 | 4 | 4 | 1 |
| Number | 5 | 3 | 3 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

Table 4.17: Wilcoxon test comparing the difficulty of each case management step in DCM and SMC

| SMC - DCM | Ranks | N | Mean Rank | Sum of Ranks |
|---|---|---|---|---|
| SMCA<DCMA | Negative Ranks | 5 | 5.90 | 29.50 |
| SMCA>DCMA | Positive Ranks | 13 | 10.88 | 141.50 |
| SMCA=DCMA | Ties | 12 | | |
| SMCP<DCMP | Negative Ranks | 7 | 8.57 | 60.00 |
| SMCP>DCMP | Positive Ranks | 9 | 8.44 | 76.00 |
| SCMP=DCMP | Ties | 14 | | |
| SMCO<DCMO | Negative Ranks | 13 | 8.31 | 108.00 |
| SMCO>DCMO | Positive Ranks | 4 | 11.25 | 45.00 |
| SMCO=DCMO | Ties | 13 | | |
| SMCD<DCMD | Negative Ranks | 9 | 9.44 | 85.00 |
| SMCD>DCMD | Positive Ranks | 7 | 7.29 | 51.00 |
| SMCD=DCMD | Ties | 14 | | |
| SMCM<DCMM | Negative Ranks | 11 | 8.09 | 89.00 |
| SMCM>DCMM | Positive Ranks | 7 | 11.71 | 82.00 |
| SMCM=DCMM | Ties | 12 | | |
| | Total responses | 30 | | |

Legend: A= Assessment
P= Planning
O= Obtaining services/resources
D= Delivery and coordination of services
M= Monitoring

Table 4.18: Wilcoxon signed ranks test of the significance in the differences for the ranking of the difficulty of each case management step in SMC and DCM

| | b)SMCA-DCMA | b)SMCP-DCMP | a)SMCO-DCMO | a)SMCD-DCMD | a)SMCM-DCMM |
|---|---|---|---|---|---|
| Z | -2.467 | -0.430 | -1.513 | -0.889 | -0.155 |
| Asymp.sig. (2-tailed) | 0.014* | 0.667NS | 0.130NS | 0.374NS | 0.877NS |

Legend: a = based on positive ranks
b = based on negative ranks
* = $\alpha < 0.05$
NS = not significant

The only step that showed a significant difference in the relative difficulty between DCM and SMC was the assessment step. The assessment step was considered

to be more difficult to perform in SMC than in DCM. All the other steps were of the same difficulty.

The DCM program had more of a variety of ranking patterns (N=20) than the SMC program (N=18). The number of repetitive patterns were similar in both the programs.

Comparing the difficulty of the steps to the time required, the DMC and SMC program both had similar ranking of planning and assessment when the most frequent patterns were compared. These two steps were considered the most difficult and the most time consuming. In DCM, the delivery step was ranked the same, but monitoring and obtaining were in reverse order. Obtaining was the easiest step but took a relatively large amount of time. Monitoring took the least amount of time, but was relatively difficult. In SMC, there was no apparent relationship between the difficulty and amount of time for any of the three steps when the most common pattern (N=8) was used. The second most common pattern (N=6) showed an identical pattern, where monitoring was the easiest step as well as the least time consuming and assessment was the most difficult and the most time consuming.

**What is the case managers' perceptions of their impact on their clients?**

1) **Direct case management**

Table 4.19: The case manager's perception of their impact on DCM clients

| Value | Sense of control | | Good they feel | | Feel healthy | | Feel happy | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| 1 | 5 | 14.7 | 1 | 2.9 | 0 | 0 | 1 | 2.9 |
| 2 | 13 | 38.2 | 14 | 41.2 | 11 | 32.4 | 12 | 35.3 |
| 3 | 13 | 38.2 | 15 | 44.1 | 19 | 55.9 | 17 | 50.0 |
| 4 | 3 | 8.8 | 3 | 8.8 | 4 | 11.8 | 4 | 11.8 |
| 5 | 0 | 0 | 1 | 2.9 | 0 | 0 | 0 | 0 |
| Mean | 2.41 | | 2.68 | | 2.79 | | 2.71 | |
| S.D. | 0.86 | | 0.81 | | 0.64 | | 0.72 | |
| Missing values: 4 | | | | | | | | |

Value:
1= significant impact
3= some impact
5= no impact

**2) Self managed care**

Table 4.20: The case manager's perception of their impact on SMC clients

| Value | Sense of control | | Good they feel | | Feel healthy | | Feel happy | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| 1 | 17 | 48.6 | 8 | 22.9 | 0 | 0 | 7 | 20.6 |
| 2 | 11 | 31.4 | 12 | 34.3 | 16 | 47.1 | 12 | 35.3 |
| 3 | 7 | 20.0 | 12 | 34.3 | 14 | 41.2 | 14 | 41.2 |
| 4 | 0 | 0 | 3 | 8.6 | 4 | 11.8 | 1 | 2.9 |
| 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mean | 1.71 | | 2.29 | | 2.65 | | 2.26 | |
| S.D. | 0.79 | | 0.93 | | 0.69 | | 0.83 | |
| Missing values: 3 | | | | | 4 | | | |

Value:
1= significant impact
3= some impact
5= no impact

Table 4.21: Wilcoxon test comparing the case manager's perception of their impact on DCM and SMC clients.

| SMC-DCM | Ranks | N | Mean Rank | Sum of Ranks |
|---|---|---|---|---|
| SMCA<DCMA | Negative Ranks | 19 | 10.58 | 201.00 |
| SMCA>DCMA | Positive Ranks | 1 | 9.00 | 9.00 |
| SMCA=DCMA | Ties | 13 | | |
| | Total | 33 | | |
| SMCB<DCMB | Negative Ranks | 13 | 9.62 | 125.00 |
| SMCB>DCMB | Positive Ranks | 4 | 7.00 | 28.00 |
| SMCB=DCMB | Ties | 16 | | |
| | Total | 33 | | |
| SMCC<DCMC | Negative Ranks | 9 | 7.44 | 67.00 |
| SMCC>DCMC | Positive Ranks | 4 | 6.00 | 24.00 |
| SMCC=DCMC | Ties | 19 | | |
| | Total | 32 | | |
| SMCD<DCMD | Negative Ranks | 16 | 9.56 | 153.00 |
| SMCD>DCMD | Positive Ranks | 2 | 9.00 | 18.00 |
| SMCD=DCMD | Ties | 14 | | |
| | Total | 32 | | |

Legend: A= client's sense of control
B= How good the client feels
C= How healthy the client feels
D= How happy the client feels

Wilcoxon Signed Ranks Test (all based on positive ranks)

| | SMCA-DCMA | SMCB-DCMB | SMCC-DCMC | SMCD-DCMD |
|---|---|---|---|---|
| Z | - 3.870 | - 2.427 | - 1.615 | - 3.273 |
| Asymp. Sig. | 0.00 ∞ * | 0.015* | 0.106NS | 0.001* |

Legend: * = $\alpha < 0.05$
NS = not significant

There was a significant difference in the impact the case managers feel they have on their SMC and DCM clients' sense of control, how good they feel and how happy they feel. The case managers felt they had more of an impact on their SMC clients on all three of these factors. The Z score and significance show that the case managers impact on the sense of control was the highest, followed by how happy the clients felt and then how good the clients felt. The impact the case manager felt they had on how healthy their DCM and SMC clients felt was equal.

**The following section will report the open-ended responses for the advantages and disadvantages of DCM and SMC for the client and the case manager. A more detailed account of the responses to the open ended questions is available in Appendix 6.**

Table 4.22: Summary of the of the advantages and disadvantages of DCM and SMC for clients

| | DCM | SMC |
|---|---|---|
| Advantages for client | One person to rely on(14): main resource for problem solving(7), familiar person(6), one person coordinating (7) | More client control over services (28) |
| | Consistency and relationship building (11) | More service for the money (4) |
| | Less responsibility for client (10) | Client more responsible (3) |
| | Client centered care (9) | Consistency of services (8) |
| | CM expertise and objectivity (4) | Flexibility (10) |
| | | More variety of services (2) |
| Disadvantages for client | Case manager as gatekeeper to services and resources (11) | Managing finances (8) |
| | Less control of services (13) | Staffing (18) |
| | Foster dependence upon CM (4) | Paper work (6) |
| | Some time poor relationship due to poor fit between client and CM (6) | Poor relationship between client and hired worker (5) |
| | No disadvantage (1) | Isolation of client from CM support (5) |
| | | Client has more responsibility (9) |

Advantages and disadvantages of the client : For the client, a theme that spans DCM and SMC was the influence of control on the advantages and disadvantages that were cited. Specifically, the fact that control of services was in the hands of the case manager in DCM and in the hands of the client in SMC. In DCM, the case manager felt that advantages to the client were: having one person to rely upon (14) who could be the

main resource (7) and the guide through the medical system (6). The case manager provided a "humanization of a large, confusing bureaucracy". This theme of one person continues with the case manager being identified as the "one main person [who] is looking after setting up all services, therefore streamlines the number of contact people the client has" (7). Having the case manager as the hub of the client's care provided consistency and relationship building (11) which provided the client with an expert who cared (4) and less responsibility for the client (10). The case management activities allowed for client centered care that gave the clients a sense of value (9).

The disadvantages of DCM were identified as the decrease in the control the client had over their services (13) and the consequences of being a part of a large caseload that may have hindered the timeliness, quality or quantity of the services (11). The loss of control and responsibility fostered dependency upon the case manager (4). Considering that the client relied so heavily upon the case manager to make decisions on their behalf, the relationship that needed to be formed was difficult to create because of differing opinions on the decisions made or difficult to maintain because of the disregard of boundaries (6). One case manager felt that there were no disadvantages for the client in DCM.

In SMC, the advantages arose from the increased amount of control the client had over their care (28). With the control in the client's hands the case manager felt that more services could be provided for the money (4), more services that could not be provided for them on DCM were available (2), more consistency of care was evident since the client "could have one individual providing services and often for years" and more flexibility in the care provided (10). The disadvantages came from having more control and responsibility (9) such as managing finances (8), staffing (18) and paper work (6). The transfer of control to the client could lead to their isolation from the supports that the EHCP provided to their DCM clients. "Some [clients] do not have a good back up plan and expect Home Care to provide personal care and we don't". This distance between the client and the case manager resulted in some boundary issues between the client and their paid care staff (5).

Table 4.23: Summary of advantages and disadvantages of DCM and SMC for case managers

| | DCM | SMC |
|---|---|---|
| Advantages for the case manager | More control (5) | Frees up time (7) |
| | Consistency (2) | Less work (10) |
| | Develop relationship with client (13) | Less responsibility (10) |
| | Job satisfaction (11) | Observe positive change in client (6) |
| | | Advantage depends on suitability of client to SMC (10) |
| Disadvantages for the case manager | Difficult clients (3) | Lack contact with client (13) so unable to monitor health, services or possible abuse of finances (5) |
| | Dependent clients (7) | |
| | Time consuming (11) | Set up is time consuming (8) |
| | High level of responsibility and demand (6) | Less control (7) |
| | Become a generalist (2) | None (2) |
| | Increased paper work (3) | |

Advantages and Disadvantages of DCM and SMC for the Case manager

For the case manager, the majority of the advantages and disadvantages of DCM and SMC also centered around whether the case manager had control over the care. The advantages of DCM for the case manager were the ability to have "more control of money and services delivery, more control in the client's outcomes" (5). As well, the case manager had the ability to ensure that all the client's needs were met and to address problems as they arose (7). The close monitoring allowed for consistency (2) and the development of a relationship with the client (13). The ability to meet the client' needs provided the case managers with the "feeling of accomplishment and/or ability to affect change and see outcome." (11).

The disadvantage of having control was the development of dependent clients (7). One case manager commented that he/she was "being looked at as a baby sitter in some cases". The reliance upon the case manager resulted in more responsibility and demand

being placed upon the case manager (6) and work that required a lot of time (11) and paper work (3). This increased amount of case management work restricted the use of profession-specific skills which resulted in the case manager becoming a generalist (2).

In SMC, the advantages first depended upon whether the client was suitable for SMC. If they were not, all the possible advantages were never realized (10). If the client was suitable, the case manager was able to see a decrease in their work load (10) (both in time (7) and responsibility (10)). The job satisfaction (16) the case manager received was from the positive changes that occurred with the client as they assumed their increased control

The disadvantages of case managing SMC arose from the distance created between the case manager and the client when the client coordinated their own personal care (13). More time had to be spent on ensuring the client could manage SMC. After the client was set up on SMC, the case manager was not able to monitor services and there was a decrease in the contact with the client. Along with this was a feeling of less control (7), more worry about the client's health and any possible abuse of finances (5) by the client (5). Despite all of these disadvantages, some respondents said there were no disadvantages to the case manager when case managing SMC (2).

When the advantages and disadvantages of DCM and SMC to the client and case manager were analyzed by a peer to ascertain content analysis reliability the following themes were identified:

Advantages of DCM to the client: client-case manager relationship (8),
Client knows where to call (4)
Client gets help accessing service
Gives to client- participation, flexibility, sense of control, consistency, autonomy, case manager expertise, personalized service
Takes away from client- responsibility, work, anxiety, dealing with problems, many people to contact.

Disadvantages of DCM to the client: client feels lack of control (12)
Client dependence on case manager
Potential for conflict (3)
Service depends on judgement of only one person (case manager)

Advantages of DCM to the case manager: close relationship with client (8)
Better idea of what is going on with the client (12) and thus able to be more responsive (7)
Job satisfaction (5)
Autonomy for case manager (4)

Disadvantages of DCM to the case manager: difficult clients (4)
Time consuming (5)
Too much paperwork (4)
Problems respecting boundaries (3)
Job stress- too much to do
Dissatisfaction if can't practice discipline specific skills (2)

Advantages of SMC to the client: more control for the client (27)
More flexibility (6)
More consistency in care giver (5)
More hours for the money (4)

Disadvantages of SMC to the client: more work and/or responsibility for clients (17)
Client have to manage complex task of being an employer including a) personnel matters (hire/fire/schedule/manager) (25) and b) administrative matters (financial/accounting/paper work) (15)
Clients have to see that their needs are met without being taken advantage of (6)
Arrangements for backup care can be difficult (8)

Advantages of SMC to the case manager: decreases case manager time and/or work (20)
Increase client responsibility/independence and/or empowerment (9)
Less client contact (5)

Disadvantages of SMC to the case manager: Problems monitoring (12) (abuse of system (5), changes in client's needs (3))
Time consuming to set up (7)
Less control for case manager (3)
Less contact with client (3)

Overall the external analysis of this qualitative data resulted in very similar themes to the themes identified by the writer. The only difference worth noting were in : a) advantages of DCM to client- the external reviewer categorized many of the writer's themes under the general themes of "gives to the client" and "takes away from the client". b) advantages of SMC to the client- the reviewer included more client responsibility with more client control and more variety of services with flexibility.

c) advantages of SMC to the case manager, the writer identified the condition of client suitability, the reviewer did not and d) the reviewer did not identify "no disadvantages" of SMC to the case manager nor of DCM to the client. The number of comments for each theme were roughly similar.

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**Objective 3: Comparison of general qualities of DCM and SMC**

Table 4.24: Comparison of general factors of SMC and DCM

| Program | Most CM time | | Most CM satisfaction | | Most CM stress | | Most prepared to case manage | | Most empowered clients | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| DCM | 36 | 94.7 | 14 | 37.8 | 22 | 59.5 | 11 | 29.7 | 1 | 2.8 |
| SMC | 0 | 0 | 4 | 10.8 | 1 | 2.7 | 1 | 2.7 | 31 | 86.1 |
| Equal | 1 | 2.6 | 19 | 51.4 | 14 | 37.8 | 25 | 67.6 | 4 | 11.1 |
| missing | 1 | | 1 | | 1 | | 1 | | 2 | |

The direct case management program was perceived to have required the most case management time. This can either be due to the fact that direct case managed clients are the bulk of any case manager's caseload or due to the highly intensive amount of time the case managers need to dedicate to the DCM clients/program.

Both the most satisfaction and the most stressed factors showed similar response patterns. The DCM clients/program gave the case managers more satisfaction (30%) than the SMC clients/program (11%), but there was a large number (51%) who rated both DCM and SMC as equally satisfying. The DCM client/program (60%) was chosen by the case manager as the most stressful and the number of responses that rated SMC and DCM equally as stressful was relatively low (38%).

When the sample was asked to decide which program they felt most prepared to case manage, they felt equally prepared for both the programs. The second most common choice was the DCM program and only one case manager felt that he/she was most prepared for the SMC program. This corresponds with the data from the questions asked earlier in the survey that related to the training levels of the case managers.

The response to the question of which group of clients were the most empowered,

the overwhelming response was the SMC client group.

**Objective 4: Overlap of DCM and SMC**

Do you believe that there are some direct case management clients who could be on SMC?

Yes: N= 20, %= 55.6
No: N= 16, %= 44.4
Missing: 2

**What are the barriers that are preventing the DCM clients from becoming SMC clients?**

1) Inability or not willing to take responsibility (18) [mentioning the needed support or willingness to do the added tasks]
*"not willing or able to be their own boss"*

2) Difficulty with caregivers (5) [hiring, maintaining appropriate relationship, lack of contingency plans]
*"having to worry about how they will receive care if a worker doesn't show up or quits."*
*"[no] ability to maintain good boundaries with caregivers"*

3) Does not have qualifications needed for SMC (6) [mentioning the inability to meet the criteria to be on SMC]
*"medically unstable"*
*"very low cost of care"*

4) Lack of knowledge of SMC(CM or client) (4) [misconception of SMC or the lack of information for the case manager]
*"clients sometimes think SMC is an option to get caregivers to do tasks that Home Care would not allow"*
*"lack of information and encouragement (this statement made by case managers who are not familiar with the program)*

The theme of matching the client to the program begun in the case management steps is seen to continue here. All of these reasons relate to the client not able to fulfil the responsibilities that SMC would place upon them. They also are similar to the disadvantages of SMC to the client and the case manager.

Do you case manage the potential SMC clients differently from the other DCM clients?

Yes: N=15, %=62.5
No: N=9, %= 37.5

What is done differently for this group of clients?

1) SMC client is responsible for his/her care (6) [mention more responsibility in the client's hands]
-*" Most SMC clients(or families) appear to be more independent in problem solving."*

2) Less involvement with the SMC clients (3) [mention a decrease in the contact with the client]
-*"I expect them to be more involved with their care. I don't follow them as closely as they are expected to call case manager if there is a need"*

3) CM is the facilitator for SMC clients (3) [assisting, guiding rather than doing for the client]
-*" guide them to making appropriate choices but client is able to use SMC dollars as they wish as long as money and time paid to worker is accounted for."*

4) The amount of time needed for the services is different (3) [ mention a difference in the time used in each service]
- *"more involved in day to day crisis [for DCM client]*

*"the distinction you are making does not seem valid. Direct case management is the process of getting clients hooked up with services. SMC is simply a different service option. Both require case management." (1)*

The responses showed a possible misinterpretation of the question. The responses distinguished between what was done in SMC and DCM. They were similar to the themes from the advantages and disadvantages. For example, less work load for the case manager due to the SMC client taking more responsibility, the case manager not as involved and the small amount of time spent with the client. The role of the case manager as a facilitator was mentioned.

**What do you do in DCM that is the same as what you do in SMC?**

1) Assessment and reassessment (22) [mentions assessment and what is done during the assessment]
This involves: - determining the levels of supports
- planning/setting goals
- discussing the needs of the client with client and family
- yearly reassessment
- determining the type of service needed

2) Planning (12) [the activities done as a result of the assessment to meet the needs]
This involves- care plan based on needs, service provision based on needs

- *"priorizing client issues"*

3) Monitoring (5)[identified the work monitoring]

4) Client relationship with case manager (7) [describe what the case manager provides the client and the role the case manager plays]
this involves- including clients in decision making, acting as a resource
- *"work with client as a part of the team."*
- *" client choice of treatment or services"*
- *"act as a resource for the client"*
- *"provide direction and information on health related issues."*

5) Availability of professional services (6) [professional services are mentioned]

6) All the steps are the same (2) [mentions all steps of case management]
- *"the process of assessing , planning, service authorization, service delivery and monitoring the clients situation is similar."*

The similarities identified here helps validate the description of the steps of case management. Two unique points were mentioned, the first was the building of relationships with the client, this was not mentioned anywhere for the SMC program. The second point was that all the steps were the same. This contradicts the description of case management steps. Service authorization and service delivery for SMC excluded personal care, but included professional care. It may be with some qualifications that all steps are the same in DCM and SMC.

**What do you do in DCM that is different from SMC?**

1) The amount of involvement (8) [mentions varying levels of involvement or contact]
- *"more involvement with DCM than with SMC"*
- *"DCM requires much more interaction between case manager and client re: services and programs available."*

2) Who does the problem-solving (6) [mentions who does the problem solving or conflict management]
- DCM: Case manager does more of the problem solving
- SMC: Expect the client to problem solve on their own
*"[the case manager for DCM]deals with difficult agencies and PCAs that refuse to provide services"*

3) Role of case manager regarding the services the client receives (23)
- SMC: there is no agency (1)

- SMC: the client or family organizes support services(4)
*"do not set up services or monitor if the hired caregiver is doing a good job"*

- DCM: case manager responsible for arranging, deciding and monitoring care services (13) [set-up, arranging services, obtaining, monitoring, implementing, coordinating]
- *"obtaining services especially respite. More coordination of services involved in direct case management"*
- *"service delivery, more regular involvement, input into daily lives and services in their homes"*
- *" deal with vendor agencies to negotiate what services go in for how long"*

- DCM: case manager is a bridge between the agency and the client (7) [case manager dealing with difficulties and communicating preferences]
- *"deal with staff and agency contracted to do care by Home Care"*
- *" spend a lot of time on the phone with clients/agencies trying to iron out difficulties"*

4) The role of the CM
- *"the role with SMC is more likely to be one of monitoring and support clients/families to manage their own affairs."*
- *" Case management restricts client choice by CM directing the client in certain directions and setting up services for them."*
- *"[the role in DCM includes]service delivery, more regular involvement, input into daily lives and services in their homes."*

5) Agency as a part of the service delivery team (2) [mentioning that the agency helps the case manager with their job]
- *"ask for feedback from PCA about client care, functioning, etc."*
- *"I know what I can expect from staff from agencies"*

6) Paper work (3) [mentions a difference in the paperwork done in the two programs]
- *"contracts. Deal with actual amounts of money provision according to need"*

The responses reiterated many themes from the steps of case management and the advantages and disadvantages of case management. They emphasized the independence that the SMC client has in problem solving, organizing services and determining the direction of care. The DCM situation has the agency as an additional participant in providing care and monitoring the client. The contrast of the roles of the case manager in SMC and DCM was interesting. In SMC, the case manager "support the client to manage

their own affairs", but in DCM the case manager "restricts client choice" which then determines the direction the client takes. Therefore, it is not surprising that matching of client to case manager is important as seen in the disadvantages of DCM results.

**Objective 5: Program preference**

Which program do you prefer to case manage?

1) No preference (19)
- doesn't matter (8)

*" no real preference. SMC can be handled with little to no coordination or they can be extremely difficult."*

- like both (11)

*" I enjoy working with both. The difference would be 1) due to client contact, I would feel more "attached, involved" with direct service clients. With direct service case manager is more likely to be involved with other family members 2) SMC clients provide me with a sense of assisting client to have more control in their lives."*

2) Can't make valid comparison due to lack of experience (1)

3) DCM preferred (6)

a) able to better monitor client *"more involvement with clients, more satisfying as regularly involved and get a good sense of client's functioning and needs."*

b) difficulty with the structure of SMC (lack of training and consistency in program implementation*)* *" Home Care expects CM to be able to provide service with SMC in a consistent, fair manner between clients, almost impossible."*

4) SMC preferred (8)
- Type of client who predominate SMC(independent, proactive, happier, more in touch with needs.). *"I haven't had many SMC clients but I enjoyed working with this client population because they understood their needs and their limitations re: budgetary constraints. Clients on SMC prioritized their needs and were more empowered than DCM clients."*
- less work for CM re: services. Better service for clients
- With reservations- *"In general I prefer younger, proactive independent clients. These clients tend to be more likely on SMC. However, SMC client who do not manage their care well are very difficult to case manage and it would be easier (preferable) if they were on direct service."*

Both programs are equally preferred. When DCM was preferred, one of the reasons was due to the difficulty of the SMC program. The other reason related to both the quality of work life and the quality of services delivered to the clients. When SMC was preferred it was not due to the quality of the services provided to the client but whether the program

fit the client, and in turn the client was rewarding to case manage.

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**Objective 6: The perceptions of work related empowerment by case managers**

In the following section, the responses regarding the Laschinger's elements of work related empowerment will be described.

**1) Opportunity**

The questions asked in this section were: How much each kind of opportunity do you have in your present job? 1) challenging job, 2) the chance to gain new skills and knowledge on the job, 3) access to training programs for learning new things, 4) the chance to learn how the Home care program works, 5) tasks that use all of your own skills and knowledge, 6) the chance to advance to better jobs, and 7) the chance to assume different roles not related to current job.

Table 4.25: Amount of access to opportunity structures in the EHCP

| Ques # and program | Values | | | | | | | | | | Mean value | Missing values |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 (None) | | 2 | | 3(Some) | | 4 | | 5(A lot) | | | |
| | R | % | R | % | R | % | R | % | R | % | | |
| 1) DCM | 0 | 0 | 1 | 2.7 | 7 | 18.9 | 10 | 27.0 | 19 | 51.4 | 4.27 | 1 |
| SMC | 1 | 2.7 | 4 | 10.8 | 14 | 37.8 | 12 | 32.4 | 6 | 16.2 | 3.49 | |
| 2) DCM | 1 | 2.7 | 3 | 8.1 | 9 | 24.3 | 15 | 40.5 | 9 | 24.3 | 3.76 | 1 |
| SMC | 1 | 2.7 | 11 | 29.7 | 12 | 32.4 | 12 | 32.4 | 1 | 2.7 | 3.03 | |
| 3) DCM | 1 | 2.7 | 11 | 29.7 | 17 | 45.9 | 6 | 16.2 | 2 | 5.4 | 2.92 | 1 |
| SMC | 8 | 21.6 | 18 | 48.6 | 9 | 24.3 | 2 | 5.4 | 0 | 0 | 2.14 | |
| 4) DCM | 0 | 0 | 0 | 0 | 14 | 37.8 | 15 | 40.5 | 8 | 21.6 | 3.84 | 1 |
| SMC | 2 | 5.4 | 7 | 18.9 | 19 | 51.4 | 7 | 18.9 | 2 | 5.4 | 3.00 | |
| 5) DCM | 0 | 0 | 4 | 10.8 | 12 | 32.4 | 12 | 32.4 | 9 | 24.3 | 3.70 | 1 |
| SMC | 2 | 5.4 | 11 | 29.7 | 10 | 27.0 | 7 | 18.9 | 7 | 18.9 | 3.16 | |
| 6) DCM | 5 | 13.5 | 16 | 43.2 | 13 | 35.1 | 3 | 8.1 | 0 | 0 | 2.37 | 1 |
| SMC | 12 | 31.6 | 15 | 39.5 | 10 | 26.3 | 0 | 0 | 0 | 0 | 1.95 | |
| 7) DCM | 5 | 13.5 | 9 | 24.3 | 15 | 40.5 | 7 | 18.9 | 1 | 2.7 | 2.73 | 1 |
| SMC | 10 | 27 | 14 | 37.8 | 11 | 29.7 | 2 | 5.4 | 0 | 0 | 2.14 | |

Mean of the scores of the DCM opportunity questions (1-7) = 3.37, S.D.= 0.58
Mean of the scores of the SMC opportunity questions (1-7) = 2.70, S.D.= 0.64
t-score = 5.450 (df=36), 2 tailed sig. = 0.00 $\infty$ ($\alpha$<0.05)

There was a significant difference between the responses regarding work-related opportunities in DCM and SMC when case managing. The DCM program provided more opportunities to the case managers than the SMC program.

**2) Information**

The questions asked in this section were: How much access to information do you have in your present job? 1) the current state of the Home care program, 2) how other people in positions like your do their work, 3) the values of top management, 4) the goals of top management, and 5) how salary decisions are made for people in positions like yours.

Table 4.26: Amount of access to information power structures in the EHCP

| Ques # and program | Values | | | | | | | | | | Mean values | Missing values |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 (None) | | 2 | | 3 (Some) | | 4 | | 5 (A lot) | | | |
| 1) DCM | 0 | 0 | 6 | 16.2 | 18 | 48.6 | 11 | 29.7 | 2 | 5.4 | 3.24 | 1 |
| SMC | 1 | 2.7 | 8 | 21.6 | 22 | 59.5 | 3 | 8.1 | 3 | 8.1 | 2.97 | |
| 2) DCM | 0 | 0 | 4 | 10.8 | 18 | 48.6 | 13 | 35.1 | 2 | 5.4 | 3.35 | 1 |
| SMC | 1 | 2.7 | 14 | 37.1 | 13 | 35.1 | 7 | 18.9 | 2 | 5.4 | 2.86 | |
| 3) DCM | 3 | 8.1 | 11 | 29.7 | 17 | 45.9 | 4 | 10.8 | 2 | 5.4 | 2.76 | 1 |
| SMC | 4 | 10.8 | 16 | 43.2 | 14 | 37.8 | 2 | 5.4 | 1 | 2.7 | 2.46 | |
| 4) DCM | 4 | 10.8 | 12 | 32.4 | 14 | 37.8 | 5 | 13.5 | 2 | 5.4 | 2.70 | 1 |
| SMC | 5 | 13.5 | 16 | 43.2 | 13 | 35.1 | 2 | 5.4 | 1 | 2.7 | 2.41 | |
| 5) DCM | 4 | 10.8 | 14 | 37.8 | 9 | 24.3 | 6 | 16.2 | 4 | 10.8 | 2.78 | 1 |
| SMC | 8 | 21.6 | 14 | 37.8 | 10 | 27.0 | 2 | 5.4 | 3 | 8.1 | 2.41 | |

Mean of the scores of the DCM information questions (1-5) = 2.97, S.D. = 0.70
Mean of the scores of the SMC information questions (1-5) = 2.62, S.D. = 0.74
t-score= 4.663 (df=36), 2-tailed sig. = 0.00 $\infty$ ($\alpha$<0.05)

There was a significant difference between DCM and SMC when it came to access to information. The DCM program provides more access to certain organizational information that influence work related empowerment. The response to note is to the question of how much access to information do you have regarding how other people in positions like yours do their work? There is a large difference in the number of 2s (between no and some knowledge) that are chosen regarding the SMC program compared to the DCM program. The reverse is found for the number of 4s (between some and a lot of knowledge) where more were chosen regarding the DCM program than the SMC program. This supports responses from other parts of the survey. For example when

asked about the concerns of the quality of work life in the SMC program combined with the type of training the case managers receive, the SMC program relies more heavily upon peers for training but the case managers identify the lack of sharing experiences.

**3) Support**

The questions asked in this section were: How much access to support do you have in your present job? 1) specific information about things you do well, 2) specific information about things you could improve, 3) helpful hints or problem solving advice, 4) information or problem solving advice, 5) discussion of further training or education, 6) help when there is a work crisis, 7) help in gaining access to people who can get the job done, 8) help in getting materials and supplies needed to get the job done, and 9) rewards and recognition for a job well done.

Table 4.27: Amount of access to support power structures in the EHCP

| Ques # and program | Values | | | | | | | | | | Mean Values | Missing values |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 (None) | | 2 | | 3(Some) | | 4 | | 5(A lot) | | | |
| | N | % | N | % | N | % | N | % | N | % | | |
| 1) DCM | 2 | 5.4 | 9 | 24.3 | 20 | 54.1 | 5 | 13.5 | 1 | 2.7 | 2.84 | 1 |
| SMC | 6 | 16.2 | 9 | 24.3 | 17 | 45.9 | 4 | 10.8 | 1 | 2.7 | 2.59 | |
| 2) DCM | 2 | 5.4 | 12 | 32.4 | 20 | 54.1 | 2 | 5.4 | 1 | 2.7 | 2.68 | 1 |
| SMC | 5 | 13.5 | 12 | 32.4 | 17 | 45.9 | 2 | 5.4 | 1 | 2.7 | 2.51 | |
| 3) DCM | 1 | 2.8 | 3 | 8.3 | 12 | 33.3 | 16 | 44.4 | 4 | 11.1 | 3.53 | 2 |
| SMC | 2 | 5.6 | 6 | 16.7 | 15 | 41.7 | 12 | 33.3 | 1 | 2.8 | 3.11 | |
| 4) DCM | 7 | 18.9 | 15 | 40.5 | 13 | 35.1 | 1 | 2.7 | 1 | 2.7 | 2.30 | 1 |
| SMC | 10 | 27.0 | 20 | 54.1 | 6 | 16.2 | 0 | 0 | 1 | 2.7 | 1.97 | |
| 5) DCM | 10 | 27.8 | 15 | 41.7 | 9 | 25.0 | 2 | 5.6 | 0 | 0 | 2.03 | 1 |
| SMC | 8 | 22.2 | 19 | 52.8 | 7 | 19.4 | 2 | 5.6 | 0 | 0 | 2.03 | |
| 6) DCM | 0 | 0 | 7 | 18.9 | 14 | 37.8 | 13 | 35.1 | 3 | 8.1 | 3.32 | 1 |
| SMC | 3 | 8.1 | 8 | 21.6 | 12 | 32.4 | 11 | 29.7 | 3 | 8.1 | 3.08 | |
| 7) DCM | 0 | 0 | 9 | 24.3 | 12 | 32.4 | 15 | 40.5 | 1 | 2.7 | 3.22 | 1 |
| SMC | 2 | 5.4 | 10 | 27.0 | 13 | 35.1 | 9 | 24.3 | 3 | 8.1 | 3.03 | |
| 8) DCM | 0 | 0 | 11 | 29.7 | 11 | 29.7 | 13 | 35.1 | 2 | 5.4 | 3.16 | 1 |
| SMC | 3 | 8.1 | 15 | 40.5 | 9 | 24.3 | 9 | 24.3 | 1 | 2.7 | 2.73 | |
| 9) DCM | 3 | 8.1 | 16 | 43.2 | 8 | 21.6 | 9 | 24.3 | 1 | 2.7 | 2.70 | 1 |
| SMC | 5 | 13.5 | 16 | 43.2 | 10 | 27.0 | 5 | 13.5 | 1 | 2.7 | 2.49 | |

Mean of the DCM support questions (1-9) = 2.87, S.D.= 0.56
Mean of the SMC support questions (1-9) = 2.62, S.D. = 0.69
t-score = 3.232 (df =36), 2-tailed sig.= 0.003 ($\alpha$<0.05)

There was a significant difference between the responses regarding perceived access to support in the work environment. Overall the SMC program provided less access to support than the DCM program. The most scores of 5 (a lot) in this set of questions were recorded for the DCM program when the case managers were asked about accessing helpful hints or problem solving advice. The scores for both programs were low in questions 4, 5 and 9.

**4) Resources**

The questions asked in this section were: How much access to resources do you have in your present job? 1) having supplies necessary for the job, 2) time available to do necessary paperwork, 3) time available to accomplish job requirements, 4) acquiring temporary help when needed, 5) influencing decisions about obtaining human resources for your office, 6) influencing decisions about obtaining supplies for your office, 7) influencing decisions about obtaining equipment for your office.

Table 4.28: Amount of access to resource power structures in the EHCP

| Ques # and program | Values | | | | | | | | | | Mean Values | Missing values |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 (None) | | 2 | | 3(Some) | | 4 | | 5(A lot) | | | |
| | N | % | N | % | N | % | N | % | N | % | | |
| 1)DCM | 0 | 0 | 3 | 8.1 | 12 | 32.4 | 20 | 54.1 | 2 | 5.4 | 3.57 | 1 |
| SMC | 0 | 0 | 8 | 22.2 | 12 | 33.3 | 14 | 38.9 | 2 | 5.6 | 3.28 | 2 |
| 2)DCM | 1 | 2.7 | 9 | 24.3 | 20 | 54.1 | 6 | 16.2 | 1 | 2.7 | 2.92 | 1 |
| SMC | 1 | 2.8 | 8 | 22.2 | 16 | 44.4 | 11 | 30.6 | 0 | 0 | 3.03 | 2 |
| 3) DCM | 0 | 0 | 12 | 32.4 | 16 | 43.2 | 8 | 21.6 | 1 | 2.7 | 2.95 | 1 |
| SMC | 0 | 0 | 8 | 22.2 | 20 | 55.6 | 8 | 22.2 | 0 | 0 | 2.92 | 1 |
| 4) DCM | 4 | 10.8 | 15 | 40.5 | 9 | 24.3 | 7 | 18.9 | 2 | 5.4 | 2.68 | 1 |
| SMC | 5 | 13.9 | 14 | 38.9 | 11 | 30.6 | 6 | 16.7 | 0 | 0 | 2.43 | 1 |
| 5) DCM | 17 | 47.2 | 13 | 36.1 | 3 | 8.3 | 3 | 8.3 | 0 | 0 | 1.78 | 2 |
| SMC | 12 | 34.3 | 17 | 48.6 | 6 | 17.1 | 0 | 0 | 0 | 0 | 1.83 | 3 |
| 6) DCM | 4 | 10.8 | 11 | 29.7 | 16 | 43.2 | 5 | 13.5 | 1 | 2.7 | 2.68 | 1 |
| SMC | 5 | 13.9 | 17 | 47.2 | 11 | 30.6 | 2 | 5.6 | 1 | 2.8 | 2.36 | 2 |
| 7) DCM | 7 | 18.9 | 16 | 43.2 | 11 | 29.7 | 1 | 2.7 | 2 | 5.4 | 2.32 | 1 |
| SMC | 8 | 22.2 | 16 | 44.4 | 10 | 27.8 | 1 | 2.8 | 1 | 2.8 | 2.19 | 2 |

Mean of the DCM resources questions (1-7) = 2.71, S.D.= 0.53
Mean of the SMC resources questions (1-7) = 2.61, S.D. = 0.53
t-score = 2.225 (df=35), 2-tailed sig. = 0.033 ($\alpha$<0.05)

There was a significant difference in the perceived access DCM and SMC had to resources. Again the overall scores for the DCM program are higher than the SMC program, but the difference in the mean scores was less than in any other group of questions. Question 2 that asks whether there is time available to do necessary paperwork resulted in the first incidence where the mean score for the SMC program was more than the DCM program. There is also very little difference in the scores of question 3 which asks about the time available to accomplish job requirements. This corroborates the response to the advantages of the SMC program and disadvantages of the DCM program for the case manager; less paperwork/workload and high workload respectively. The answers for questions 4,5,6 and 7 for both programs all tend towards the lower scores. The answers to question 5 in particular were very low.

**5) Global Empowerment**

The questions asked in this section were: 1) overall, my current work environment empowers me to accomplish my work in an effective manner, and 2) overall, I consider my workplace to be an empowering experience.

Table 4.29: The global empowerment score

| Ques # and program | Values | | | | | | | | | | Mean Value | Missing values |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 (None) | | 2 | | 3(Some) | | 4 | | 5(A lot) | | | |
| | N | % | N | % | N | % | N | % | N | % | | |
| 1) DCM | 0 | 0 | 7 | 18.9 | 20 | 54.1 | 10 | 27 | 0 | 0 | 3.08 | 1 |
| SMC | 1 | 2.9 | 7 | 20 | 17 | 48.6 | 10 | 28.6 | 0 | 0 | 3.03 | 3 |
| 2) DCM | 3 | 8.1 | 5 | 13.5 | 18 | 48.6 | 9 | 24.3 | 2 | 5.4 | 3.05 | 1 |
| SMC | 2 | 5.7 | 8 | 22.9 | 15 | 42.9 | 8 | 22.9 | 2 | 5.7 | 3.00 | 3 |

Mean of the DCM global empowerment questions (1-2) = 3.07, S.D.=0.73
Mean of the SMC global empowerment questions (1-2) = 3.01, S.D. = 0.81
t-score = 0.557 (df=34), 2-tailed sig = 0.581 ($\alpha$<0.05)

These results for DCM and SMC were the most similar of this section of the survey and were not significantly different. The similarity may be attributed to the fact that all of the case managers have at most 10% of their case load made up of SMC clients. When these questions ask for the overall opinion, it may have been difficult for the case managers to differentiate between SMC and DCM program clients.

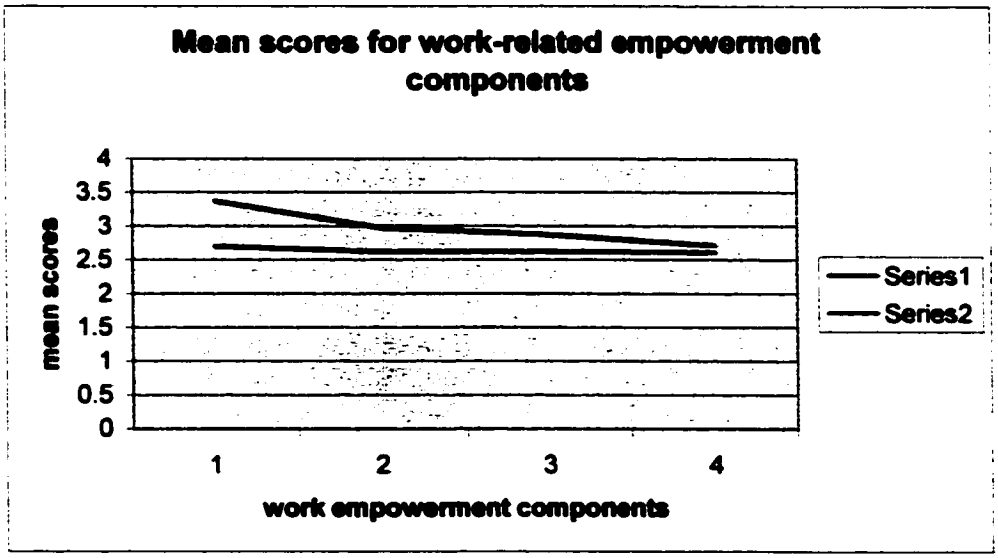
Mean of the sum of all DCM questions = 11.92, S.D.= 1.63
Mean of the sum of all SMC questions = 10.46, S.D. = 2.19

Table 4.30: Wilcoxon test comparing the sum of SMC and DCM empowerment scores

| SMCsum- DCM sum | Ranks | N | Mean Rank | Sum of Ranks |
|---|---|---|---|---|
| SMCsum<DCMsum | Negative Ranks | 29 | 20.00 | 580.00 |
| SMCsum>DCMsum | Positive Ranks | 5 | 3.00 | 15.00 |
| SMCsum=DCMsum | Ties | 0 | | |
| | Total | 34 | | |

Wilcoxon Signed ranks test
SMCsum-DCMsum (based on positive ranks)
Z= -4.830
Asymp. Sig. (2-tailed) = 0.00 ∞ ($\alpha$<0.05)

Figure 4.10: Mean scores of opportunity, information, support and resource access in DCM and SMC




**Legend:** Series 1 = DCM mean scores
Series 2 = SMC mean scores

1= Opportunity
2= Information
3= Support
4= Resources

**Case managers' concerns of the quality of work life in DCM**

1) Lack of feedback and support from management (support) (5) [ comments regarding input in the form of feedback or support from management]

- *"very little positive support from management, their comments are to "waitlist". Worked as a case manager for 6 years and have had only 1 performance appraisal. I have no idea how I am doing."*

2) Lack of training (opportunity) (2) [ identify needs to increase knowledge]

3) Lack of influence on decisions that are made (information) (1)

*- I'm frustrated with the lack of front-line input on strategic planning. Planners and decision makers are very far removed from front-line, operational knowledge. They would make better decisions if they relied on their knowledge. Data is not knowledge."*

4) Lack of access to needed man power (resources) (8) [lack of staff to do work, ability to communicate with staff and inability to manage caseloads/workload]

- *"lack of other disciplines to assist in providing over all services ie. Occupational and physical therapists. Waiting for services from same and delaying with clients and families frustration of waiting for assessing and obtaining equipment."*
- *"feel that you have no idea what is going on in client's home. Never have the opportunity to speak directly to PCAs. When we had PCAs that were employed by Home Care, it seemed client were getting better follow up."*

5) Physical environment (2) [issue regarding physical work place conditions]

- *"lack of say to go or not when it is an unsafe environment and lack of safety equipment"*
- *"lack of space, privacy, high noise level"*

6) Lack of time/heavy workload (resources) (10) [comments regarding workload and amount of time available to do job]

- *"lack of time to do a comprehensive and adequate job. Mostly I feel I am dealing with one crisis after another. I do not have time to do preventative work or treatment"*
- *"inability to complete the work I have now while new intake keep coming"*

7) Difficult to manage changing character of clients (5) [the characteristics of the client and the other health care organizations]

- *"increased frustration in being able to access outside resources. Much higher complexity of cases and the expectation that home care should be able to deal with them."*

The concerns case managers had regarding the quality of work life when providing DCM were related to Kanter's access to resource, support, opportunity and information organizational structures. The lack of access to resources such as time to manage a heavy workload and staff were the predominant concern. The lack of resources was said to lead to the inability to "do a comprehensive and adequate job" and waiting for professional services. Support and feedback or the lack thereof was the next most common of Kanter's organizational structures identified as a concern. One respondent stated she had "no idea how [she] was doing." The lack of training and control over decisions made by management, which corresponded with Kanter's opportunity and information structures respectively were only identified as a concern by three people in total. Two concerns were not captured by any of Kanter's organizational structure components. These concerns were difficulty with managing the changing characteristics of clients, with five responses, and the unhealthy and/or un safe physical work environment, with two responses.

**Case managers' concerns of the quality of work life in SMC**

1) Lack of connection to the client (4) [comments regarding a disconnection from the client. An inability to make a large impact upon a client's service]

- *"They don't get visits as often as the DCM client so do not have as strong a working relationship with them. Not always able to identify problems that crop up."*
- *"My client has been given permission to hire family (appropriateness?). I have no impact into this as it is a higher than high decision but I am expected to remain case manager without any role"*

Lack of training (opportunity) (3) [comments regarding need for training and knowledge]

- *"little training on how to set up a program. You fly by the seat of your pants"*

Lack of sharing experiences (information) (2) [inability to learn from peers]

- *" quite an isolated job experience, most colleagues are not interested in discussing SMC as they find it intimidating and want to avoid it. SMC, in my opinion should have some component of asset testing."*

Lack of assistance from management (3) [comments regarding a need for more management involvement and support]

- *"would like more direction regarding working with Home Care accounting to monitor compliance with SMC agreements and follow up re: identified concerns."*

Ethical dilemmas (3) [comments regarding incidences for program abuse by the client or inappropriate clients on the program]

- *"lack of consistency within offices and the region. I realize it is not realistic to expect complete consistency, however, it can improve greatly from where it is now. As case managers we are making decisions bout giving client thousands of dollars and the money is being misused, mismanaged and in some cases client are breaking the law by not paying revenue Canada. As a professional within the Home care organization I struggle in my work with these clients as it is not that easy to take away the funds from the client once we have given them."*

The concerns case managers had regarding case managing SMC corresponded with only three of Kanter's organizational structure components; opportunity, support and information. The lack of training was said by one respondent to result in "fly[ing] by the seat of your pants". The case managers also felt that management did not provide them with enough support, whether it was with difficult clients, or in the monitoring of finances. The lack of information sharing among peers was also identified as a concern, and acutely felt in SMC where "most colleagues are not interested in discussing SMC". The concerns with SMC also included two categories of responses that did not conform to Kanter's four structural components. These categories were the lack of connection to the client and ethical dilemmas. The lack of connection to the client was identified most often (4) of all the concerns case managers had with SMC. This category included concerns of the lack of strong working relationships with the clients and the inability to affect the personal care choices the client makes. Ethical dilemmas were identified three times. These dilemmas included incidences of program abuse by the client that the case manager could not control, inappropriate clients on SMC and the "lack of consistency [in program guidelines] within offices and the region".

Comparison of the concerns case managers had with the quality of work life in DCM to the concerns regarding SMC quality of work life reveals some similarities and differences. The similarities were the lack of training and the lack of support

from the management. The differences were: a) the emphasis of lack of resources in DCM, b) the lack of connection to the client in SMC, but not in DCM, c) the lack of influence on decisions made by management and difficulty in managing the changing characteristics of clients were identified in DCM, but not in SMC, d) the physical environment was just identified in the concerns regarding DCM, but it should be noted that this concern would effect the work life when providing SMC since the office and the case manager are the same in both DCM and SMC.

# Chapter 5: Discussion

## Introduction

The two main purposes of this study were a) to describe and compare what case managers did in each step of case management when providing Direct Case Management (DCM) and Self-Managed Care (SMC), and b) to describe and compare the quality of work life of case managers when doing DCM or SMC. A better understanding of DCM and SMC through the eyes of the case manager should provide the basis for purposeful and evidence-based changes or enhancements which in the end will improve the quality of services in the Edmonton Home Care Program (EHCP).

In this chapter, highlights of the results will be discussed in the context of the home care, human resources and case management literature. These highlights will then be used to derive implications and recommendations for the Edmonton Home Care Program and its case managers. The final sections of this chapter will discuss the strengths and limitations of this study and suggest further research directions.

## Demographics of Case Managers

The demographic data was found to be representative of the general population of case managers in the EHCP who had a mixed caseload of direct case management and self managed care clients. Similarities were also seen when some of the demographic measures were compared to provincial, national and American trends. The majority of the case managers in the sample fell between the ages of 41 and 50. This reflected the general trend of the national health work force for which the average age was increasing (39.1 y.o. in 1994 and 40.8 y.o. in 2000) ( CIHI, 2001). The combination of an aging work force with the national trend of earlier retirement from the health care sector, suggests an imminent loss of experienced employees from the EHCP and from national health organizations. Other similarities between the national trends and the study sample were the amount of case manager experience ( national: 5 years or more, sample: 3 or more years), and the dominance of nurses in the work force but with significant numbers of other health professionals.

Two exceptions to the provincial and national trends were the educational preparation of the case managers and the work patterns. Compared to provincial home care statistics, more case managers in the sample had undergraduate degrees than diploma level preparation. The Alberta home care sample in Alcock, Gallagher, Diem, Angus & Medves' (2000) study had relatively equal numbers of undergraduate and diploma level respondents. The other exception is the distribution of part time to full time case managers. The sample had more full time than part time respondents. According to the CIHI (2001) there is an increasing number of health care providers who work part time. If this trend becomes apparent in the EHCP, the ability to consistently rely on peers for problem solving assistance will be restricted. The effects will especially be felt in the SMC area because of the heavy reliance upon peers for SMC knowledge. Also the ability of the client to rely upon one person as their resource and single point of reference for the health care system may also be jeopardized.

The case load of each case manager in the sample (mode=55) was more than the case load from an American study (mode= 16-30) (American Health Consultants, 2001). Although this comparison cannot be done without remembering the differences in the two country's health systems one can apply the general conclusion made by the American study. "Caseloads vary by organization depending upon such factors as how the organization defines case management, the types of interactions case managers have with clients and providers, the professional experience of case managers, the acuity of the organization's patient population, the organization's case management goals and the resources case managers have available to help them in the performance of their daily work load." (p. 2).

The final demographic result to note is the low proportion (less than 10%) of SMC clients to DCM clients on any given case manager's case load. Considering governmental and consumer petition for more individualized and consumer driven health care, it seems the caseload mix is not reflecting the increased public demand for SMC. Many factors could be contributing to this low number. Factors such as those seen in the disadvantages of SMC results: the lack of skills in the client to manage the responsibilities of SMC; the case manager's inability to commit the time necessary to set up a client on SMC; or the lack of case manager training in SMC. The low number of

SMC clients could also be due to factors considered advantages of DCM, such as the lack of client responsibility and the need for or security in, the case manager being able to monitor a client frequently.

**Training for Case Management**

The inadequacy and low amount of formal case management training received for SMC could be attributed to the lack of peers who have experience in providing SMC. It is difficult to determine from the design of the questions in this area whether peers were identified as a major source of SMC training because there is a scarcity of formal training or because peers are the preferred method of gaining knowledge about SMC. The literature suggests that peers play a role other than as sources of training in the literature. Fletcher et al (1991) and, Stewart & Arklie (1994) identified the supportive relationship with peers as a positive aspect of working in health care. Considering that in the area of SMC the case managers felt inadequately trained, and in the area of DCM (which has a lot of formal training) the training was adequate, the conclusion is that formal training is needed in the area of SMC. The lack of SMC training seems to be a national problem for case managers (Martin, 1999; Parent & Anderson, 2001). The CIHI (2001) report stated that only 35% of health care providers in non-hospital settings such as the EHCP received on-the-job training as opposed to 95% of hospital staff. In this study's results, one of the contributing factors to the low empowerment measures for SMC was limited training. Powell (2000) discussed the negative effect the lack of training had on the case manager's work life.

**Comparison of the Case management Steps in Direct Case Management and Self-Managed Care**

Conclusions can be made from two different perspectives when comparing the descriptions of the case management steps in this study. The first perspective is to approach the differences and similarities from the point of view of activities done in each case management step (assessment to monitoring). The second perspective is to consider the case management steps as creating a case management experience, where the client becomes an insider-expert (Lamb and Stempel, 1994).

The activities performed in each case management step will be the beginning of this comparison of case management steps in DCM and SMC. When the case

management steps (assessment, planning, obtaining services, delivery and coordination of services and monitoring) of DCM and SMC were compared there were no significant differences in the first two steps (assessment and planning). This similarity may be because initially in the assessment and planning steps, the available resources and the client's needs are being determined for everyone admitted to the EHCP. It is only after SMC is chosen as the best method to meet the client's needs that another assessment is done to determine the appropriateness of the client for SMC. When this second assessment for the SMC candidates is compared to the first universal assessment, differences are seen. As indicated in the results, in DCM, the services were matched to fit the client's needs, whereas in SMC, the client was assessed to determine if they would fit the service. Two possible reasons for this difference in the assessment of DCM and SMC are: a) the need for certain qualities and skills in order to manage your own personal care in SMC as opposed to the fact that a client receiving DCM does not have to have any specific characteristic other than a need for services and b) the lack of time or confidence on the part of the case manager to educate or support the development of the skills and qualities needed by the client for SMC. The advantages and disadvantages of DCM and SMC identified in the study suggested that both of these reasons for the differences in SMC and DCM assessment, were possibly true. The disadvantages of SMC case management included the necessity for a large amount of time to help prepare the clients for SMC. In fact, until the client was settled into the program, SMC was just as time intensive as DCM indicating that the settling process in SMC may be changing some of the client's characteristics to fit SMC. Moreover, the lack of training and support provided by the employer was identified more often as a disadvantage for SMC than for DCM.

The ranking patterns of the steps according to difficulty and time required were worth noting for the differences in the variety of patterns in DCM and SMC. There were fewer ranking patterns in SMC (12 and 18 relatively) than in DCM (22 and 20 relatively) for both difficulty and required time. The fewer patterns in SMC may be due to the more uniform characteristics of the clients in SMC and the fewer number, and thus variety of clients in SMC. Scala, et al, (1996) did find that clients identified to be appropriate for SMC-type programs had similar characteristics.

Alcock (1998) stated that the role of the case manager was to coordinate the team in order to achieve a seamless level of care. In both the services, there were indications of the case manager fulfilling this role. They were also providing what Alcock identified as direct and indirect care. Direct care included activities such as teaching, authorizing, problem solving, offering encouragement, empowering and building rapport. There was a difference in the type of direct care provided to the DCM and SMC clients. For example, problem solving with the DCM clients implied that the problems were identified together (case manager and client) whereas with the SMC clients, the problems were primarily identified by the clients. Teaching was not mentioned as often in DCM as it was in SMC. The case managers ensured the provision of, and monitored the satisfaction with services more in DCM, but in SMC the case managers provided more teaching and support. Alcock's (1998) indirect care included activities such as placing phone calls, paperwork, and the coordination of supplies and equipment. All of the activities included in indirect care were performed in both DCM and SMC, but the case managers did more indirect care activities in DCM than in SMC. The results identified that in DCM more paper work and coordination of supplies and equipment are done, than in SMC.

In both SMC and DCM, peers were consulted in the planning and obtaining services steps of case management. The role of the peer in the planning and obtaining services steps was important to note because although the literature acknowledged the importance of peers in the work life of case managers, no studies identified when they were consulted. The peer consultations identified in this study's results were in the form of team meetings (as identified in the literature) or individually. In the planning and obtaining services case management steps, resources were sought and/or allocated, so peer consultation may be particularly valuable when making decisions about resources.

Lamb (1995) stated that "clients identified listening, counseling, problem solving and teaching as central nursing case management interventions." (p. 128). If by "central" the clients were meaning "most important" to them, then in both DCM and SMC, the case managers were performing what the clients would perceive as important functions.

From the point of view of the activities done in each case management step of DCM and SMC one can see that the differences between the two case management

services are: a) in the assessment step the client is fit to SMC, whereas DCM is fit to the client's needs, b) in SMC, less indirect care activities are done and c) the direct care activities are performed in different ways in DCM and SMC. The similarities of the activities done in the case management steps are: a) the case managers are doing what the clients think is important, b) peers are consulted at the planning and obtaining services steps, and c) the same indirect care activities done by the case managers in DCM and SMC.

If the comparison of the case management steps in DCM and SMC are done from the point of view of Lamb and Stempel's (1994) case management process, there seems to be a fundamental difference in the SMC and DCM experience of the case management. Lamb & Stempel (1994) called the process of case management the "process of individuals becoming their own insider-experts." (p. 9). This process started with the case manager as the expert who monitored health and taught health maintenance skills. Then as the relationship continued, bonding occurred where the "client begins to feel "known and cared for as an individual"(p.9). Gradually the client became more able to manage their care and could take more responsibility for that care. In the steps of case management identified in this study's results and in the advantages and disadvantages of DCM and SMC identified in this study, there were indications that the insider- expert process was occurring, but the order in which the steps of the insider-expert process occurred differed. The different renditions of the insider-expert process in DCM and SMC contributed to the perceived opinion client and case managers held for the services, for example, in the delivery and coordination of services step in DCM, one case manager stated that he/she made him/herself "accessible to them (client), maintain regular contact, empower client by giving them responsibility of making some of the contacts". These activities would suggest the case manager was attempting to support the development of the client as an expert by contacting them regularly and staying accessible which would demonstrate that the case manager cared for the client. In SMC, the case manager did not seem to do as much of the bonding activities as in DCM. The case manager jumped from giving the client and family information about the SMC service to assuming or determining the client could undertake the role of insider-expert. This premature advance to the insider expert role led to many of the case manager and client disadvantages

identified in the results of this study, for example, case manager's worry whether the finances were abused, the lack of opportunity for the case manager to monitor the client for the development of problems, and clients have difficulty with paper work, finances, increased responsibility and hiring of staff.

The advantages of DCM to the client relative to Lamb and Stempel's (1994) process was the support provided by the professional who coordinated and was familiar with care services. "[the case manager provides]humanization of a large, confusing bureaucracy". The result was that the client had less responsibility. "The client does not have to address another concern when they are faced with so many obstacles in their life." The client also experienced the relationship building that was a part of bonding stage of Lamb and Stempel's process. "Relationship develops and trust established therefore decrease in anxiety and increased sense of control". The disadvantage to the case manager was that the client experienced less control and dependency was fostered. Therefore, the last step of the Lamb and Stempel process was not achieved, since the clients were not perceived by the case managers to assume more control and independence expected of an insider-expert. The case manager found relationship building possible with their DCM clients, but dependency of the clients and the high level of control remaining in the case manager's hands indicated that the transfer of responsibility to the client was not occurring. In SMC, the advantages and disadvantages for the client and case manager arose from the fact that the first two steps of Lamb and Stempel's (1994) process were not completed and that the last step was the major focus. There was no or little opportunity for the case manager to provide services as an expert and subsequently build the bonds of a relationship with the client in SMC. The superficial progression through the relationship building and bonding activities to transferring responsibility to the client may be part of the reason why clients needed to fit SMC, there was no indication of case management activities that try to fit SMC to the client's needs. The client is expected to have most, if not all of the skills necessary for SMC.

Using the insider-expert process as the case management benchmark for DCM and SMC in the study, it would seem case managers only provided case management, to a certain extent, to their DCM clients. A derivation of Lamb and Stempel's (1994) process could be brought forward for consideration when trying to understand the process

of case management in SMC. The SMC clients and case managers may be progressing through the insider-expert case management process steps in reverse order. The SMC process started with the assumption that the client was an expert already, then through time and relationship building, the case manager came to trust the client's abilities to care for him/herself, and the case manager was able to determine /provide what was needed by the client from a case manager.

Alternatively, SMC could be considered the end point of the case management process. The case management process, as Lamb and Stempel (1994) describes it, could be regarded as a process of empowerment and thus DCM was the process of empowerment and SMC was the achievement of empowerment for the client.

**Differences and Similarities in the Case Managers' Activities in DCM and SMC**

The differences in DCM and SMC found in this study were in the role expectations of the case manager and client, and who performed the tasks. Many of the activities performed by case managers in DCM are the client's responsibility in SMC. The interactions between the case manager and the client differs in DCM and SMC. This study found that the case manager played more of a facilitative role in SMC and more of a controlling role in DCM. All of the above mentioned differences were expected considering the SMC and independent living literature. However, some of the consequences of transferring responsibility, and activities such as decreased workload with the associated decrease in case manager's stress (Micco et al, 1995) were not realized. The similarities identified in the results of this study suggest that the difference in the amount of workload in DCM and SMC may not be that great, especially when it is offset by the increased worry or concern in SMC over the client's services and medical condition (as indicated in the disadvantages to case managers section of the results).

The assessment, planning and monitoring case management steps were identified in the results as similar, and two respondents stated that all the steps were said to be similar. The relationship between the case manager and client was also considered the same. This appears to contradict the differing premise of DCM and SMC as well as the fact that a similar point was identified in the differences section of the results. One possible explanation for the identification of the roles of case managers as similar and

different in DCM and SMC could be that the similar roles of the case managers in SMC and DCM (for example, "act as a resource", "provide direction and information" and "work with client as a part of the team") can be enacted in degrees according to the general characteristics of clients that are in SMC and DCM. Clients who were candidates for SMC had "a lower number of impairments, lower number of services received, had strong support systems, and an ability to advocate on their own behalf" (Scala et al, 1996, p. 9). The EHCP requires that SMC candidates are medically stable for at least a year (Alberta Health, 1993). If the opposite is true for DCM clients then it is not surprising that the case manager would take more control and limit the client's involvement in service provision. The case manager in DCM would most likely engage the client as much as possible, knowing the limits of someone with a high number of impairments and services, weak support systems and difficulty in advocating for themselves. The case manager is placed in a position where they need to be more regularly involved and more in control of the direction of care, due to the fact that decisions about care for a more medically unstable client is often required sooner than consultation with the client would allow. Another possibility may be that there was no difference in the role case managers play in SMC and DCM. This could explain why the case manager identified the lack of control and contact with the client as a disadvantage in SMC. In SMC the client has the ability to search for resources other than the case manager. Since the client is in more control, the case manager is not as able to influence direction of care.

**Perceived advantages and disadvantages of DCM and SMC to the client and case managers**

The advantages to the clients in the DCM program were similar to the positive experiences clients had in Nelson &Arnold-Powers' (2001) study of community case management. Rapport development, feeling cared for, and help negotiating the system were common positive experiences for the client. In SMC, none of the advantages to the clients were similar to the positive experiences of Nelson & Arnold-Powers'(2001) clients. However, Nelson & Arnold- Powers' clients and the SMC group of clients did find that some of the case manager activities increased their sense of control through facilitation or assuming less control, respectively.

Alcock, Edwards & Morris (1998) identified the difficulties and rewards of case management in Canada. The difficulties were very similar to the disadvantages identified for DCM and SMC; namely, work life, tough decisions, difficulties with clients, management and resources. The advantage identified in this study that was similar to the rewards identified by Alcock et al (1998) was personal satisfaction. The other rewards in Alcock et al's study were enthusiasm, working independently and fully using professional competencies, but these were not mentioned as advantages in the results of this study. In fact the lack of opportunity to use profession-specific skills and becoming a generalist was identified as a disadvantage of DCM.

The increased stress from case managing client directed care in Scala et al's (1996) study was due to the case manager's loss of control and worrying. The same pairing of factors were identified as disadvantages of SMC to the case manager in this study. The responses ranged from the loss of control affecting the case manager's ability, to monitor and ensure services, to the inability to control the hiring choices the client made. The worrying stemmed from the possible bad choices in the personal support workers hired and the possibility of the client misusing funds. Micco et al's (1995) found that the case manager had decreased interactions, and did less problem solving for the client and had decreased work loads; results which were confirmed in this study. However the workload for the EHCP's case managers only decreased if the client was well suited for SMC.

**Program preferences of case managers in the EHCP**

The variation in preferences and the reason for the preferences mirror some of the conclusions made from other parts of the data. Three points were reinforced. 1) An important aspect of SMC to the case manager was the decrease in the work load it provided, contrary to the predictions of the case managers in British Columbia (Micco et al, 1995) in which any expected decrease in work load was offset by the predicted increase in worry and assistance the client needed to manage finances. Some of the results of this study did identify these increases, but it seems that the workload decreased enough to prefer SMC. 2) Case management was different in DCM and SMC, at least from the point of view of the advantages it provided to the case manager. Case managers

are required to reframe the rewards they receive from the interactions they have with the client. DCM allowed the case manager to feel more "attached and involved" with their clients, and that they are making more of an impact on the client's care. On the other hand, the SMC clients were able to be more involved with their care so the case manager could work with them collaboratively which was considered a rewarding relationship. The increased client independence challenged the case manager to provide support that was beyond the services associated with DCM. The client knew their needs, therefore more of the case manager's time could be spent on meeting those needs. As well, the case manager may have accepted that the client has a right to live at risk, which is one of the key principles of SMC (Martin, 1999). 3) The boundaries of SMC are not well defined. It is expected that with more client control, there would be more variance in the services provided and in the relationship the case manager had with the client, but if many of the SMC clients' characteristics are similar, the case managers can expect some consistency in the program and what is expected of them. Therefore, training of the case managers should be provided to reframe their expectations of this program, such that the clients as well as the case managers can benefit from the SMC opportunity to the fullest.

**Case managers' Perceptions of Job- Related Empowerment**

Many studies have been done featuring nurses and their managers to confirm Kanter's theory of power in organizations. Some have studied the Canadian experience, but none have focused upon a variety of professionals, the home care setting, or the task of case management. Since the basis of Kanter's theory is that the structure has more of an impact upon employee attitudes, behavior and performance than the individual characteristics of the employee, the unique structural characteristics of the EHCP work setting and the service models of SMC and DCM may have influenced the case managers' experiences of empowerment.

A brief comparison of nurses in acute care hospitals, public health units and assisted living and conventional long term care, SMC and DCM empowerment scores was done (Table 5.1). The SMC total empowerment score was the lowest of all the work settings. The DCM empowerment score was the second highest score, behind the assisted living long term care nurses' score.

Table 5.1 Comparison of study empowerment scores with scores in the literature

| Score | DCM | SMC | Assisted living *** | Public health units ** | Acute care * | Conventional Long term care *** |
|---|---|---|---|---|---|---|
| Total empowerment | 11.92 | 10.46 | 12.57 | 11.77 | 11.20 | 11.58 |
| opportunity | 3.37 | 2.70 | 3.38 | 3.19 | 2.92 | 3.42 |
| information | 2.97 | 2.62 | 2.95 | 2.90 | 2.81 | 2.91 |
| support | 2.87 | 2.62 | 3.26 | 2.95 | 2.76 | 2.84 |
| resources | 2.71 | 2.61 | 2.98 | 2.75 | 2.81 | 2.42 |

Legend: * Sabiston & Laschinger, 1995

** Haugh & Laschinger, 1996

*** Turnbull, 2001

The two most relevant work settings to consider for comparison with this study are the public health units and the assisted living long term care centers because of their community setting and similar relationship with the client, respectively. Haugh and Laschinger (1996) indicated that the nurse managers in the public health setting had provided some support to the staff nurses, but had to improve in sharing knowledge about corporate decisions in order to increase work effectiveness. The DCM score (11.92) would indicate that while providing DCM, the EHCP managers are sharing more information about corporate decisions with the case managers regarding DCM than SMC, and more information than the nurse managers are in a public health unit. The feedback and assistance managers provide to their front line staff is important in facilitating job effectiveness (Brown & Kanter, 1982). Haugh and Laschinger (1996) also found that the more power managers were perceived to have, the more power the nurses felt they had in the work environment. The empowerment score in DCM (11.92) may be an indication of the high level of power the case managers feel their managers have compared to the level of managerial power perceived in SMC or the public health setting. The managers in the EHCP have the ability to decide most of the resource questions and requests that the case managers present regarding DCM, but regarding SMC, the managers are limited due to the control given to the client that cannot be influenced by the manager.

When the DCM empowerment component scores are compared to the scores of the assisted living long term care center, DCM has lower support and resource scores which result in the lower DMC total empowerment score. The different settings for assisted living and DCM, institution versus community respectively, may be a factor in the differences in the resource and support scores. In home care often the resources available to do case management are based on community and governmental initiatives that establish programs or resources to address the physical, mental and social needs of the client. In facilities, the resources to meet needs are known and controlled by the staff. In the community, the case manager has to wait or search for resources that have been created by organizations or persons outside the home care organization. In a facility, other staff are always at hand and the ability for managers and peers to recognize performance is easier. Since case managers practice in the home, it is often difficult to access peers for problem solving or recognition of good performance. A facility also has a finite amount number of residents, so the workload of the nurses is more predictable than in the community. As well, because assisted living facilities are using relatively new models of long term care, the staff are more likely to be provided with training to perform their job. On the other hand, the case manager role and home care in general have existed for a long time, therefore the predicted need for training is not as great as for a new service delivery model. Further more, the difficulties the EHCP is experiencing in retaining and recruiting staff and the increased complexity and referrals to home care has increased the workload for the case managers. In addition, work load demands in home care are not "capped" in the conventional way, therefore the case managers are required to manage a large and/or varying number of clients.

The SMC scores for all of the empowerment structures including the total empowerment score were the lowest of all the health care settings. A higher SMC score would have been expected due to the empowering nature of the independent living principles that are the basis of the SMC service model which, according to Kanter, should be empowering the case manager as it empowers the client. Upon reviewing the issues that were perceived as advantages and disadvantages in the steps of case management, it appears that there were differing view points as to the role and activities that were expected of the case manager when providing SMC, by the client, organization and case

manager. The case manager's job was not well defined as seen in the need for more training and the manner in which it did not fit into Lamb and Stempel's insider-expert process (1995). The difficulty in defining case management in SMC would have had an affect upon the ability of case managers and their managers to identify opportunity, resource, support, and information needs and opportunities. The case manager also may perceive decreased flexibility in what they can do as a case manager in SMC than in DCM due to the transfer of control to the client and the expectations on the client to assume more responsibility for his/her care. The case manager only has control of the professional services, which reduces the scope of influence he/she has when planning a client's care. The decreased number of care responsibilities under the case manager's control may limit opportunities for the case manager to use all of their skills. On the other hand there is a perception of too much flexibility in SMC because the interpretation of SMC varies from case manager to case manager. The perceived inconsistency may affect the ability of management to provide training, support or to even know what resources are needed.

The majority of the case managers in this study had caseloads that comprised of only 10% SMC clients. The small proportion of SMC clients may make it difficult to enhance the visibility of the case manager in the SMC case manager role which affects the access to all of the empowerment structures. As well, the low numbers of SMC clients may have contributed to the similarity in the global empowerment scores for SMC and DCM. When the particular characteristics of work life were explored (opportunity, support, resources and information), the case managers likely to be more able to differentiate between SMC and DCM. However, when the case managers were asked for an overall opinion, it may have been difficult for the case managers to differentiate between SMC and DCM programs.

The informal power element of peers was mentioned repeatedly in the SMC data. Although peers were an important training source, the program does not have an organized method to share experiences and learn from peers. As well, the total number of peers who have the ability to discuss SMC is small. One case manager pointed out that SMC is "quite an isolated job experience, most colleagues are not interested in discussing

SMC as they find it intimidating and want to avoid it." This isolated job experience subsequently restricts access to training opportunities, information and support.

A final contributing factor to the case managers in SMC low scores in all organizational power structure areas, was the possible influence of the case managers' differing perceptions of their managers power over the SMC and DCM work environments. Specifically, the case managers may have perceived their managers to have less influence over the SMC work environment than the DCM work environment. This lack of perceived managerial power may be due to the fact that the managers do not have any more power than the case managers to affect the day to day activities of SMC clients or services. Some of the information needed by case managers comes from the accounting department, not the managers.

From the concerns the respondents had about the quality of work life, it became apparent that in home care, the work environment extends beyond the walls of the organization. The work environment includes the community. When the home or neighborhood is unsafe, the case manager is not able to do their job and resources and support need to be accessible so that work can continue. The characteristics of the EHCP's clients are changing. They are more demanding of quality and more complex. These clients need an increasing number and variety of community resources, but they are currently limited or may not exist.

## Strengths and Limitations of the study

The main strength of the study was its focus on the role and work empowerment of case managers in a home care program. This component of the health system has received little attention by researchers in Canada and has the ability to impact the concept of quality of care. A related contribution of the study was its investigation of the differences in case manager roles in the direct care and self managed care models. In the study an important conceptual link was made between the measures of case manager activities and case manager empowerment experience. The open-ended responses helped develop the points mentioned in the close-ended responses, and provided many insightful and detailed quotations that assisted in developing a complete picture of the case managers' experiences. The understanding of case manager activities and their

perspectives on their experiences and the client, helped to develop an appreciation for the importance of the empowerment structures. As well, the empowerment scores had the backdrop of the day to day activities of the case manager to provide context and detail to the short- comings and benefits of the work environment. These scores also presented the data in a manner that could be better understood by an organization like the EHCP. From another pragmatic point of view, a strength of this study was its timeliness and focus on a sector of the health care system that is gaining national momentum and being considered for inclusion in the federally funded health system.

The limitations of this study were a) the survey's length, which resulted in a low response rate; b) a methodology that did not allow for the inclusion of all demographic areas in determining representativeness of the sample, and c) the experiential nature of qualitative data. Two written comments on the returned surveys indicated that the survey was too long. As well, some of the respondents reported that their co-workers were reluctant to complete the survey because of its length. One of the questions designed to determine if case managers recognized the SMC potential of some of their DCM clients was not clear. The methodology of the study could have been modified to include all case managers in the EHCP at least to complete the demographic portion in order to determine the representativeness of the sample in the areas of education level, experience with case management and length of time employed by the EHCP. The validity and better understanding of some of the responses could have been ascertained if a focus group had been held with the case managers to confirm the study results and the conclusions drawn from them. A final limitation to consider was the small number of SMC clients on any given case managers' caseload. The effect this small number had upon the global empowerment score and the response rate was apparent. On the other hand, the case managers provided responses in the specific empowerment areas that had significant differences between DCM and SMC.

**Implications of results**

The findings of this study were, a) the case management process proceeded as expected (Lamb & Stempel, 1994) when providing Direct Case Management (DCM) but when providing Self-Managed Care (SMC) the process proceeded in reverse; b)the case

management steps taken were similar and; c)when providing DCM, the case managers had greater access to the sources of empowerment and thus felt more empowered in the DCM work environment than in the SMC work environment. These results have implications for the Edmonton Home Care Program (EHCP), its case managers, managers, the DCM and SMC services it provides and the clients.

The Edmonton Home Care Program is under pressure to improve quality of services, reduce or maintain fiscal expenditure, provide services to a larger population, and retain and recruit health professionals. The key to helping release some of this pressure is to develop a better understanding of the health professional's perspective when providing case management. The case manager is not only the figurative canary in the coal mine but he or she can be the agent for improvement. An unhealthy work place cannot sustain high quality care (Eisenberg et al, 2001) and it has difficulty recruiting and retaining staff. A healthy work place requires case managers who are empowered. "Job redesign to increase access to work empowerment structures would create environment that support true professional practice because nurses who feel empowered are more likely to provide more effective and efficient care" (Laschinger & Havens, 1996. P.32). By creating a healthy, empowering work place, retention and recruitment of staff in the national environment of a shrinking health care work force will help to address the increasing work load of the EHCP.

The case managers and their managers will benefit from knowing the empowerment structures that are not presently being well accessed. The case managers will also be able to use the results as a learning opportunity and a source of information in order to standardize their practice in the EHCP. The standards can then be used by managers to provide more accurate and informed performance appraisals. The managers can also use the information to evaluate their own access to empowerment structures.

Self- Managed Care has been touted as the answer to address clients' requests for increased independence and individuality when receiving home care. The results of this study can be the beginning of a better understanding of the characteristics of SMC. By developing an understanding of SMC, case managers may become more proficient and encouraged to suggest SMC to their clients more often.

Sabatino & Litvak (1992) advocate "that consumer choice and control can become a reality only if the structure and process of delivery systems are built from the ground up". The implications of SMC proceeding in reverse to DCM with regards to the process of "becoming an insider-expert" necessitate the development of SMC programs with their own structure and processes based on principles of client control and choice. The results of this study revealed that the provision of SMC can improve by acknowledging the unique case management process and support case managers to feel empowered providing it.

## Recommendations for the Edmonton Home Care Program

The recommendations suggested in this section address the implications of the results on the organization, managers, case managers and clients of the Edmonton Home Care Program. These recommendations require the involvement of the organization, managers and case managers. Some recommendations are common to the delivery of DCM and SMC, but there are some that are unique to DCM and SMC. The dissemination of these recommendations and study results will be accomplished through presentations to the senior managers and case managers in the Edmonton Home Care Program and hopefully through publications in relevant journals

. From an organizational point of view Kanter's theory informs many of the recommendations. The lack of training was identified as a concern by the case managers in both DCM and SMC. The organization could regularly provide more opportunities for learning about case management and case management in SMC. Providing this training not only has the potential to increase the empowerment case managers perceive they have, it also is an opportunity to standardize practice. By establishing a standard of practice, case managers and managers have a bench mark that can be used to monitor case management practices and allow for some consistency of care.

The lack of information from the organizational level to the case manager was a concern because of its impact on the ability for case managers to influence pertinent decisions. The organization could provide more access to their goals and activities. This

communication and accessibility needs to occur during the decision making process as well as when decisions are made and need to be actualized.

The results suggested that the process of case management in SMC was different from DCM. In recognition of this difference and the impact it has upon the case manager, the quality of care and accessibility of SMC to the EHCP client, the organization should revisit their SMC policies and procedures. In 1991, when SMC started in the EHCP there was little research-based evidence to support the best method to deliver SMC in home care. However, there was a strong ethical basis for promoting independence that SMC afforded the clients. Now, 10 years later, it is time to consider the growing evidence in the literature and the results of this study to revisit the organizational premise of SMC. The appraisal of SMC policy and procedures would go hand in hand with the development of a standard of practice that accounts for the unique qualities of case managing SMC. One possible change to consider would be a procedure that transfers responsibility to the client incrementally. The ability to ease into SMC would address the present lack of relationship building between the client and case manager and the lack of opportunity to ensure that the client has the skills necessary for a successful SMC experience. Providing an SMC option that is graded in difficulty also provides an opportunity for DCM clients who could benefit from SMC, but lacked the skills to attain a level of independence that only the SMC option could provide them.

From the manager's point of view, the results places two recommendations within their control. The first recommendation is for the managers to provide feedback to the case managers more often and regularly. By providing more feedback to the case managers, the managers are able to provide support when needed. As well, the managers are able to ensure the consistency of care delivery and identify any third party training that maybe required by the case managers. The second recommendation is for the managers to become aware of and strengthen organizational factors that influence their power in the organization. Haugh and Laschinger (1996) demonstrated the importance of the perception of managerial power to the front line staff.

From the case manager's point of view, the recommendations require them to take initiative that can be enhanced by the managers and organization. The case managers could rely upon each other to provide feedback on performance in both SMC and DCM.

The case managers could also organize regular meetings to share SMC experiences. These meetings would provide a forum for learning and for developing an understanding of SMC that is common throughout the EHCP.

## Recommendations for Further Research

This was a study that had a very broad scope. It explored two aspects of case managers' work life in the EHCP. The case management activities and the organizational power structures that affected the case managers' perceptions of empowerment. Although the ultimate goal of this study was to improve quality of care through increased awareness of case managers' perspectives many other factors were found to play a role in the quality of care and are worth exploring in future research.

Scala et al (1996) discovered that clients most likely to be considered eligible for the SMC program had certain qualities. A test of these client qualities could be done with the present population of SMC clients in the EHCP to determine if the qualities were applicable to the EHCP's SMC client population.

Haugh and Laschinger (1996) identified the need for empowerment to be felt by the service provider in order for the client to feel empowered. As well, the satisfaction of clients is closely linked to the satisfaction professionals derive from their jobs (CIHI, 2001). The correlation between clients' and case managers' feelings of empowerment and satisfaction should be tested.

The study results identified lack of resources as more of an issue to the case managers in DCM than in SMC. Further research should also be done to determine if the organizational power structures effect case manager's quality of work life and quality of care differently. An example would be to determine if SMC training makes a difference in the perception of empowerment and the activities the case managers perform.

Lamb and Stempel (1994) described the case management process from the client's point of view. The unique characteristics of the case management process in SMC suggest a reversal of Lamb and Stempel's "insider-expert" model. Further research should validate whether case management in SMC in the EHCP does proceed with the assumption that the client is an expert at the outset.

Kanter's model of power in an organization was based upon business practices and principles. There is another body of knowledge that approaches work wellness from a psychophysiological point of view. Karasek (in Schnall, 1998) developed a "job strain" model that related the job demands placed upon a worker and the ability/freedom of a worker to use their skills and make decisions. Karasek's model has been used to predict the physical and mental health of the workers, which includes feelings of autonomy and its translation into job performance. The future of work place wellness, especially in the stressful health care sector would benefit from combining these two models. Future research could measure health professionals' work –related empowerment and job strain and determine if there is a correlation of the results. Finally, this study should be replicated in other home care settings to determine if the results are generalizeable.

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## Appendix 1
## Information Letter for Participants

**Title of Project:** Case management in Home Care: Case managers' perspectives of work life when providing Self-Managed care and Direct case management

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Jane Yi is a student doing her Master of Science in Health Promotion at the University of Alberta. She would like your help to understand what the role of case managers is with long term care Home Care clients who are receiving direct case management and Self-Managed Care. As well she would like to know what support case managers need to perform the activities of a case manager in both the above programs. This research is being done for academic purposes only, although it is hoped the results will be informative, they are not meant to change the present practice of Capital Health Home Care. The results of this study may help improve the work life of case managers and the provision of case management. You can help by filling out and returning the attached questionnaire in the pre-stamped envelope by **June 22nd**.

The Case manager Role and Work life survey will ask you about your activities as a case manager as well as the support you receive and would like to receive in doing your work as a case manager. It will take approximately 45 minutes to complete. We would like you to fill you the questionnaire during a break or at home. Your employer has given permission for us to ask you to participate in the research study and participation in the study is completely voluntary. The results are only being used for the thesis project.

If you choose to complete the questionnaire please note:

1) The answers to the questionnaire are anonymous, therefore it is important that you do not make any identifying marks on the questionnaire. The anonymity of your survey answers will be ensured by returning the survey in the attached self-stamped and addressed envelope. Please do not put your return address on this envelope.

2) The results will be reported so that you and your office cannot be identified.

3) In return for your employer's agreement to allow this research to occur, a summary report will be prepared for the employer and feedback will be provided to the case managers.

4) You can decline to answer any particular question, or decide to stop participating at any time.

5) All the information collected will be kept in a locked cabinet at the University of Alberta and nobody, other than the research team will have access to this information.

6) This information will be held in a secure location for at least seven years after the study is completed as mandated by the University of Alberta.

7) By completing the following questionnaire you have indicated that you understand these conditions and that you have granted consent to participate in this study.

8) There are no known risks to you if you take part in this study.

9) We may publish or present the information and findings of this study at conferences, any material that may identify you will not be used.

10) The information gathered for this study may be looked at again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically.

If you have any questions about the survey, please feel free to contact Jane or her thesis supervisor, Dr. Douglas Wilson, using the information at the beginning of this letter. It is also possible to contact Dr. Helen Madill, Graduate programs coordinator at 492-4039. When completed, a summary of the findings will be made available at each office.

We hope that you will take the time to contribute to this research project. Thank you very much for being a part of this study!

Jane Yi

## Appendix 2
## Case Manager Task and Conditions of Work Survey

*For any of the long answer questions, please feel free to use the back of the page.*

**I. Demographics**

*Please circle the choice that is most appropriate.*

1. Your age

   20-30 31-40 41-50 51-60 61 +

2. Your gender

   Male Female

3. The highest level of education you have completed.

   Diploma undergraduate degree graduate degree other_____

4. Employment status

   Part time Full time Casual

5. Your profession

   RN SW OT PT RT

6. How long have you worked as a case manager with Home Care?

   Less than1 year 1 or <2 years 2 or <3 years 3 or more years

7. How long have you worked with Self managed care?

   Less than1 year 1 or <2 years 2 or <3 years 3 or more years

8. How many clients in total do you case manage? _____

9. How many of those clients are on SMC? _____

**II. Tasks of the Case manager**

*First I would like to know about what you do in **direct case management***

1. a. What type of training have you had with regards to direct case management?

School On the job Both other _____

b. If on the job, specify the source(s) of training. *Please circle all that apply*

formal workshops peers resources provided by the employer other_____

2. Would you say your training has prepared you for direct case management?

| Strongly disagree | | Neither disagree or agree | | Strongly agree |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

3. Please describe briefly what you would do in each step

Assessment

Planning

Obtaining services/resources

Delivery and coordination of services

Monitoring

4. Please rank the following activities according to the amount of time, per average client, you as a case manager spend doing them. (1- being the most time and 5- being the least amount of time)
   _____Assessment and problem identification
   _____Planning
   _____Obtaining services/resources
   _____Delivery and coordination of services
   _____Monitoring

5. Please rank the following activities, per average client, according to difficulty. (1- being the easiest and 5 being the hardest)
   _____Assessment and problem identification
   _____Planning
   _____Obtaining services/resources
   _____Delivery and coordination of services
   _____Monitoring

6. Generally since starting Home care what impact have *you as a case manager* had in the following areas of direct case managed clients' lives?

| | Significant impact | | some impact | | no impact |
|---|---|---|---|---|---|
| a. Their sense of control over their lives | 1 | 2 | 3 | 4 | 5 |
| b. How good they feel about themselves | 1 | 2 | 3 | 4 | 5 |
| c. How healthy they feel | 1 | 2 | 3 | 4 | 5 |
| d. How happy they feel | 1 | 2 | 3 | 4 | 5 |

7. What are the *advantages* of direct case management to the *client*?

8. What are the *disadvantages* of direct case management to the *client*?

9. What are the *advantages* of direct case management to you as a *case manager*?

10. What are the *disadvantages* of direct case management to you as a *case manager*?

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*Now I would like to know what you do in **Self-Managed care***

11. a. What type of training have you had with regards to self-managed care?

School On the job Both other _____

b. If <u>on the job,</u> specify the source(s) of training. *Please circle all that apply*

formal workshops peers resources provided by the employer other_____

12. Would you say your training has prepared you for self-managed care :

| Strongly disagree | | Neither disagree or agree | | Strongly agree |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

13. Please describe briefly what you would do in each step

Assessment

Planning

Obtaining services/resources

Delivery and coordination of services

Monitoring

14. With regards to your SMC clients, please rank the following according to the amount of time per average client you as a case manager spend doing them. (1-being the most time and 5- being the lease amount of time)
    _____Assessment and problem identification
    _____Planning
    _____Obtaining services/resources
    _____Delivery and coordination of services .
    _____Monitoring

15. With regards to being a case manager to a SMC client, please rank the following activities, per average client, according to difficulty. (1- being the easiest and 5 being the hardest)
    _____Assessment and problem identification
    _____Planning
    _____Obtaining services/resources
    _____Delivery and coordination of services
    _____Monitoring

16. Generally since starting on SMC what impact have *you as a case manager* had in the following areas of clients lives?

| | Significant impact | | some impact | | no impact |
|---|---|---|---|---|---|
| a. Their sense of control over their lives | 1 | 2 | 3 | 4 | 5 |
| b. How good they feel about themselves | 1 | 2 | 3 | 4 | 5 |
| c. How healthy they feel | 1 | 2 | 3 | 4 | 5 |
| d. How happy they feel | 1 | 2 | 3 | 4 | 5 |

19. What are the *advantages* of SMC for the *client*?

20. What are the *disadvantages* of SMC for the *client*?

21. What are the *advantages* of SMC for you as a *case manager*?

22. What are the *disadvantages* of SMC for you as a *case manager*?

**III. Comparison**

Please circle the option that best matches the statement

1. Requires the most of my case management time

   Direct case management  Self-managed care  Equal

2. Gives me the most satisfaction

   Direct case management  Self-managed care  Equal

3. Makes me feel the most stressed

   Direct case management  Self-managed care  Equal

4. I am most prepared to case manage

   Direct case management  Self-managed care  Equal

5. The client group that is most empowered

Direct case management Self-managed care Equal

## IV. Overlap of DCM and SMC

1. Do you believe that there are some direct case management clients who could be on SMC?

Yes No

If yes, please answer the following 3 questions. If no, please go to questions 5 and 6.

2. What are the barriers that are preventing them from moving to SMC?

3. Do you case manage this group of clients differently than the other direct case management clients?

Yes No

4. If yes, then in what way do you case manage them differently?

5. What do you do in direct case management that is the *same* as what you do in SMC?

6. What do you do in direct case management that is *different* from what you do in SMC?

## V. Program preference

7. Which group of clients (direct case management or SMC) do you prefer and why?

**VI. Conditions of work**

*Now I would like to know the conditions of your work. Note that the same questions will be asked about direct case management and self-managed care.*
*Please draw a circle around the one number that most closely and honestly indicates how you feel about each statement as a case manager providing direct case management.*

**A. Opportunity**

**How much of each kind of opportunity do you have in your present job?**

| | None | | Some | | A lot |
|---|---|---|---|---|---|
| 1. Challenging work | 1 | 2 | 3 | 4 | 5 |
| 2. The chance to gain new skills and knowledge on the job | 1 | 2 | 3 | 4 | 5 |
| 3. Access to training programs for learning new things | 1 | 2 | 3 | 4 | 5 |
| 4. The chance to learn how the Home care program works | 1 | 2 | 3 | 4 | 5 |
| 5. Tasks that use all of your own skills and knowledge | 1 | 2 | 3 | 4 | 5 |
| 6. the chance to advance to better jobs. | 1 | 2 | 3 | 4 | 5 |
| 7. The chance to assume different roles not related to current job. | 1 | 2 | 3 | 4 | 5 |

**B. Information**

**How much access to information do you have in your present job?**

| | No Knowledge | | Some knowledge | | Know A lot |
|---|---|---|---|---|---|
| 1. The current state of the Home care program | 1 | 2 | 3 | 4 | 5 |
| 2. How other people in positions like yours do their work | 1 | 2 | 3 | 4 | 5 |
| 3. The values of top management | 1 | 2 | 3 | 4 | 5 |
| 4. The goals of top management | 1 | 2 | 3 | 4 | 5 |
| 5. How salary decisions are made for people in positions like yours | 1 | 2 | 3 | 4 | 5 |

**C. Support**

**How much access to support do you have in your present job?**

| | None | | Some | | A lot |
|---|---|---|---|---|---|
| 1. Specific information about things you do well | 1 | 2 | 3 | 4 | 5 |
| 2. Specific information about things you could improve | 1 | 2 | 3 | 4 | 5 |
| 3. Helpful hints or problem solving advice | 1 | 2 | 3 | 4 | 5 |
| 4. Information or suggestions about job possibilities | 1 | 2 | 3 | 4 | 5 |
| 5. Discussion of further training or education | 1 | 2 | 3 | 4 | 5 |
| 6. Help when there is a work crisis | 1 | 2 | 3 | 4 | 5 |
| 7. Help in gaining access to people who can get the job done | 1 | 2 | 3 | 4 | 5 |
| 8. Help in getting materials and supplies needed to get the job done | 1 | 2 | 3 | 4 | 5 |
| 9. Rewards and recognition for a job well done | 1 | 2 | 3 | 4 | 5 |

D. **Resources**

**How much access to resources do you have in your present job?**

| | None | | Some | | A lot |
|---|---|---|---|---|---|
| 1. Having supplies necessary for the job | 1 | 2 | 3 | 4 | 5 |
| 2. Time available to do necessary paperwork | 1 | 2 | 3 | 4 | 5 |
| **3.** Time available to accomplish job requirements | 1 | 2 | 3 | 4 | 5 |
| 4. Acquiring temporary help when needed | 1 | 2 | 3 | 4 | 5 |
| 5. Influencing decisions about obtaining human resources (permanent) for your office | 1 | 2 | 3 | 4 | 5 |
| 2. Influencing decisions about obtaining supplies for your office | 1 | 2 | 3 | 4 | 5 |
| 3. Influencing decisions about obtaining equipment | 1 | 2 | 3 | 4 | 5 |

for your office

**E. Global empowerment**

| | Strongly Disagree | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1. Overall, my current work environment empowers me to accomplish my work in an effective manner | 1 | 2 | 3 | 4 | 5 |
| 2. Overall, I consider my workplace to be an empowering experience | 1 | 2 | 3 | 4 | 5 |

F. Please tell us about any concerns you have about the quality of your current work life as a case manager for direct case management.

*Please circle the number that most closely indicates how you feel about each statement as a case manager providing self-managed care.*

**A. Opportunity**

**How much of each kind of opportunity do you have in your present job?**

| | None | | Some | | A lot |
|---|---|---|---|---|---|
| 1. Challenging work | 1 | 2 | 3 | 4 | 5 |
| 2. The chance to gain new skills and knowledge on the job | 1 | 2 | 3 | 4 | 5 |
| 3. Access to training programs for learning new things | 1 | 2 | 3 | 4 | 5 |
| 4. The chance to learn how the Home care program works | 1 | 2 | 3 | 4 | 5 |
| 5. Tasks that use all of your own skills and knowledge | 1 | 2 | 3 | 4 | 5 |
| 6. The chance to advance to better jobs. | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 7. The chance to assume different roles not related to current job. | 1 | 2 | 3 | 4 | 5 |

**B. Information**

**How much access to information do you have in your present job?**

| | No Knowledge | | Some knowledge | | Know A lot |
|---|---|---|---|---|---|
| 1. The current state of the Home care program | 1 | 2 | 3 | 4 | 5 |
| 2. How other people in positions like yours do their work | 1 | 2 | 3 | 4 | 5 |
| 3. The values of top management | 1 | 2 | 3 | 4 | 5 |
| 4. The goals of top management | 1 | 2 | 3 | 4 | 5 |
| 5. How salary decisions are made for people in positions like yours | 1 | 2 | 3 | 4 | 5 |

**C. Support**

**How much access to support do you have in your present job?**

| | None | | Some | | A lot |
|---|---|---|---|---|---|
| 1. Specific information about things you do well | 1 | 2 | 3 | 4 | 5 |
| 2. Specific information about things you could improve | 1 | 2 | 3 | 4 | 5 |
| 3. Helpful hints or problem solving advice | 1 | 2 | 3 | 4 | 5 |
| 4. Information or suggestions about job possibilities | 1 | 2 | 3 | 4 | 5 |
| 5. Discussion of further training or education | 1 | 2 | 3 | 4 | 5 |
| 6. Help when there is a work crisis | 1 | 2 | 3 | 4 | 5 |
| 7. Help in gaining access to people who can get the job done | 1 | 2 | 3 | 4 | 5 |
| 8. Help in getting materials and supplies needed to get the job done | 1 | 2 | 3 | 4 | 5 |
| 9. Rewards and recognition for a job well done | 1 | 2 | 3 | 4 | 5 |

D. **Resources**

**How much access to resources do you have in your present job?**

| | None | | Some | | A lot |
|---|---|---|---|---|---|
| 4. Having supplies necessary for the job | 1 | 2 | 3 | 4 | 5 |
| 5. Time available to do necessary paperwork | 1 | 2 | 3 | 4 | 5 |
| **6.** Time available to accomplish job requirements | 1 | 2 | 3 | 4 | 5 |
| 4. Acquiring temporary help when needed | 1 | 2 | 3 | 4 | 5 |
| 5. Influencing decisions about obtaining human resources (permanent) for your office | 1 | 2 | 3 | 4 | 5 |
| 4. Influencing decisions about obtaining supplies for your office | 1 | 2 | 3 | 4 | 5 |
| 5. Influencing decisions about obtaining equipment for your office | 1 | 2 | 3 | 4 | 5 |

**E. Global empowerment**

| | Strongly Disagree | | | | Strongly Agree |
|---|---|---|---|---|---|
| 6. Overall, my current work environment empowers me to accomplish my work in an effective manner | 1 | 2 | 3 | 4 | 5 |
| 7. Overall, I consider my workplace to be an empowering experience | 1 | 2 | 3 | 4 | 5 |

F. Please tell us about any concerns you have about the quality of your current work life as a case manager for <u>self-managed care</u>.

Thank you for your time.

## Appendix 3: Broadcast voice mail

Hello, this is Jane Yi, I am a graduate student in Health Promotion from the University of Alberta. I am doing my thesis research on the role of case managers who have a mixed caseload of direct case management and self-managed care clients. I am also trying to determine what is needed to support these managers in their work with these two programs. I am placing an information letter and questionnaire in your mailbox. If you have not received one by June 15th please contact me at the North East Home Care office at 496-1340 ext. 2225. I would appreciate if you took time to complete the survey.

Thank you.

## Appendix 4: Broadcast voice mail reminder

Hello, this is Jane Yi, I am a graduate student in Health Promotion from the University of Alberta. In the month of May and June, I distributed a questionnaire to the case managers who have self-managed care clients. This is a reminder to complete and return those questionnaires by June 22nd. If you did not receive a survey and have self-managed care clients, please call me at the North East Home Care office at 496-1340, ext. 2225. If you have already returned your questionnaire, thank you very much for your time.

## Appendix 5: Tables summarizing the data collection methods and analysis

### Summary of data collection methods

| Objective | Survey question |
|---|---|
| 1. Describe general demographics | Section 1. Demographics |
| a. age | 1. Your age |
| b. gender | 2. Your gender |
| c. highest level of education | 3. Highest level of education you have completed |
| d. employment status | 4. Employment status |
| e. profession | 5. Your profession |
| f. number of years with Home Care | 6. How long have you worked as a case manager in Home care? |
| g. number of years with SMC | 7. How long have you worked with SMC? |
| h. number of DCM and SMC clients | 8. How many clients in total do you case manage?<br>9. How many of those clients are on SMC? |
| | |
| 2. Describe and compare what case manager tasks case managers do in DCM and SMC | Section 2. Tasks of the case manager (DCM/SMC) |
| a. type of training and preparedness of case manager to case manage | 1a. What type of training have you had with regards to DCM?<br>b. If on the job, specify the source(s) of training<br>2. Would you say your training has prepared you for direct case management? |
| b. description of activities done in each step of case management | 3. Please describe briefly, what you would do in each step |
| c. relative status of the amount of time to complete, and difficulty of, each step of case management | 4. Please rank the following activities according to the amount of time, per average client you as a case manager spend doing them<br>5. Please rank the following activities, per average client, according to difficulty |
| d. what the case manager believes has been their impact on the client's happiness, sense of control, perception of health, and how good the client feels about him/herself | 6. Generally, since starting Home care what impact have you as a case manager had in the following areas of (DCM/SMC) clients' lives? |
| e. the advantages and disadvantages of the program for the client and the case manager | 6. What are the advantages of (DCM/SMC) to the client?<br>8. What are the disadvantages of (DCM/SMC) to the client?<br>9. What are the advantages of (DCM/SMC) to you as a case manager?<br>10. What are the disadvantages of (DCM/SMC) to you as a case manager? |
| | |
| 3. Compare the SMC and DCM programs in general terms | Section 3. Comparison |
| a. most case management time | 1. Requires the most of my case management time |
| b. provides the most satisfaction | 2. Gives me the most satisfaction |
| c. most stressful | 3. Makes me feel the most stressed |
| d. the most prepared to case manage | 4. I am most prepared to case manage |
| e. the client group that is most empowered | 5. The client group that is most empowered |
| | |

| Objective | Survey question |
|---|---|
| | |
| 4. Determine if SMC could be expanded to include more Home Care clients | Section 4. Overlap of DCM and SMC |
| a. Can some of the clients receiving DCM be in the SMC program?<br>b. What barriers prevent DCM clients from being in the SMC program? | 1. Do you believe that there are some direct case management clients who could be on SMC?<br>2. What are the barriers that are preventing them from moving to SMC? |
| c. Are there differences between this group of DCM clients and the other DCM clients? | 3.Do you case manage this group of clients differently than the other direct case management clients?<br>4. In what way? |
| d. What are the similarities and differences of each program? | 5. What do you do in direct case management that is the same as what you do in SMC?<br>6. What do you do in direct case management that is different than what you do in SMC? |
| | |
| 5. Determine case manager's program preference | Section 5. Program preference |
| | Which group of clients do you prefer and why? |
| | |
| 6. Describe and compare what support the work environment provides the case manager in DCM and SMC. | Section 6. Conditions of work (DCM/SMC) |
| a. Describe and compare the opportunities available | A. How much of each kind of opportunity do you have in your present job? |
| b. Describe and compare information accessibility | B. How much access to information do you have in your present job? |
| c. Describe and compare the support provided by the job | C. How much access to support do you have in your present job? |
| d. Describe and compare the access to resources | D. How much access to resources do you have in your present job? |
| e. Describe and compare the overall empowerment | E. Does the work environment empower the worker |
| f. Describe and compare concerns about the quality of work life | F. Please describe any concerns about the quality of the current work life as a case manager for DCM/SMC. |

**Summary of data analysis methods**

| Survey question | Data calculation | Data analysis |
|---|---|---|
| Section 1. Demographics | | |
| 1. Your age | % each category | descriptive |
| 2. Your gender | % each category | descriptive |
| 3. Highest level of education you have completed | % each category | descriptive |
| 4. Employment status | % each category | descriptive |
| 5. Your profession | % each category | descriptive |
| 6. How long have you worked as a case manager in Home care? | % each category | descriptive |
| 7. How long have you worked with SMC? | % each category | descriptive |
| 10. How many clients in total do you case manage?<br>11. How many of those clients are on SMC? | mean number of clients, % DCM and % SMC of total | Descriptive and comparison for representativeness |
| | | |
| Section 2. Tasks of the case manager (DCM/SMC) | | |
| 1a. What type of training have you had with regards to DCM?<br>c. If on the job, specify the source(s) of training<br>2. Would you say your training has prepared you for direct case management? | % each category<br>% each category<br>mean, % each category | <br><br>Wilcoxon |
| 3. Please describe briefly, what you would do in each step | Content analysis | |
| 7. Please rank the following activities according to the amount of time, per average client you as a case manager spend doing them<br>8. Please rank the following activities, per average client, according to difficulty | % of each level of time ie. 1,2,3,4,5 in each activity<br>% of each level of difficult ie. 1,2,3,4,5 in each activity | Wilcoxon and rank patterns<br>Wilcoxon and rank patterns |
| 6. Generally, since starting Home care what impact have you as a case manager had in the following areas of (DCM/SMC) clients' lives? | Mean of each item | Wilcoxon |
| 9. What are the advantages of (DCM/SMC) to the client?<br>11. What are the disadvantages of (DCM/SMC) to the client?<br>12. What are the advantages of (DCM/SMC) to you as a case manager?<br>13. What are the disadvantages of (DCM/SMC) to you as a case manager? | Content analysis<br>Content analysis<br>Content analysis<br>Content analysis | |

| Survey question | Data calculation | Data analysis |
|---|---|---|
| Section 3. Comparison | | |
| 1. Requires the most of my case management time | % in each category | |
| 2. Gives me the most satisfaction | % in each category | |
| 3. Makes me feel the most stressed | % in each category | |
| 4. I am most prepared to case manage | % in each category | |
| 5. The client group that is most empowered | % in each category | |
| | | |
| Section 4. Overlap of DCM and SMC | | |
| 3. Do you believe that there are some direct case management clients who could be on SMC?<br>2. What are the barriers that are preventing them from moving to SMC? | % yes, % no<br>Content analysis | |
| 3. Do you case manage this group of clients differently than the other direct case management clients? In what way? | % yes, % no<br>Content analysis | |
| 4. What do you do in direct case management that is the same as what you do in SMC?<br>5. What do you do in direct case management that is different than what you do in SMC? | Content analysis<br>Content analysis | |
| | | |
| Section 5. Program preference | | |
| Which group of clients do you prefer and why? | % prefer DCM and SMC<br>Content analysis | |
| | | |
| Section 6. Conditions of work (DCM/SMC) | | |
| A. How much of each kind of opportunity do you have in your present job? | Mean of each question<br>Sum of scores | Wilcoxon |
| B. How much access to information do you have in your present job? | Same as above | Same as above |
| C. How much access to support do you have in your present job? | Same as above | Same as above |
| D. How much access to resources do you have in your present job? | Same as above | Same as above |
| E. Global empowerment | Same as above | Same as above |
| F. concerns about the quality of current work life as a case manager for DCM/SMC | Content analysis | |

## Appendix 6: Responses regarding the case management steps and the advantages and disadvantages for DCM and SMC

**The following sections will report what is done in the case management steps for direct case management and self managed care.**

The number in brackets indicates how many responses were made in the category.
The phrases in the square brackets indicate what ideas fall within the category.
The phrases in italics are quotes from the responses given.
Some abbreviations used: AFAT= Adult Functional Assessment Tool- which is the data base that is completed upon admission.
RAPs = Residential Aide Placement services- an organization that assists in bookkeeping and recruitment of personal assistants for SMC clients. Funded by the Alberta government.

### Description of the case management steps when providing Direct Case Management (DCM)

1) Assessment

a) Information collected (34)
Information = medical history/condition (6), demographics (1), situation (environment) (3), support system (5), client needs (10), family needs (4), physical status (2), functional status (6), medical needs(11)
- *"Assess in home, client's and/or family's ability to manage in the community. Get a clear understanding of client's needs"*

b) Who information is collected from- client (17) , family(7), involved parties(1), significant others (1), community, which includes the Dr. (4) and hospital (2), referrals source (2), read information (past and current) (3), previous case manager (2)
- *"face to face, questioning, collateral contacts with doctors, family, medical, old chart, AFAT, referral."*

c) Paper work- AFAT(14), med sheet (5), other evaluations (mini mental, SW and OT database) (5), initial assessment package (3), care plan (3)

d) Establish a relationship- establish rapport (1), home visit (14), one to one/face to face interview(4)
- *"establish rapport with client, ask questions re: all aspects of client's daily life to determine the client's areas of need. Discuss with client and family to obtain their view on their own needs and what they're capable of doing/providing."*

e) Observation (3)

f) Match Home Care to client process
i) have a general discussion of their wants and needs (17)
*" ask where they feel they need help, what kind of help, how often."*

ii) assess client's and/or family's ability to manage in community (4)
*"discuss with client and family to obtain their view on their own needs and what they're capable of doing/providing"*

iii) discuss how home care can help and let client know what can be done and who will do it.(4)
*"negotiate with client care plan to meet those needs based on what they would like and what the health system can provide."*

2) Planning
Very often the case managers mention completing this step with the client and/or family (17).

Who is considered in the planning: client (21), family (8), agency (2)and/or other disciplines (7)

What is done:
a) Needs assessment (5)- *"Identify areas where client has specific needs which cannot be fulfilled by the family."*
b) Match what Home Care can provide and what client requests or needs (15) *"[determine] how best to provide client with the appropriate services within Home Care's scope and limitations"*
c) set down client's options (3)
d) Complete care plans (9) *"make decisions as to type of support and professional services are needed"*
e) priorize needs (4)
f) Paper work (2)- complete documentation and collateral contacts (placement)
g) Discuss with peers (3)- present in case review, consult with peers, discuss with RC
h) Obtain services- phone calls(1) and liason with agency(2)

3) Obtaining services/resources- *"identify who is the best service provider and refer"*

a) Paper work (4)- examples are: write letters for funding requests, applications, referral forms, care plans
b) Phone calls (8)
c) Make appropriate referrals (3)
d) Arrange services - with agencies (24)
e) Involve other disciplines- discussion (6)
- make referrals to (14)

f) Access or refer to other resources (7)- for example funding agencies, cost share with other agencies, resource manuals
community resources (8)- for example mental health, AADL, Short Term

Equipment Loan Pool, government agencies.
Family and client (6)- The family and client were given responsibility for some of the planning tasks such as finding resources.
*"get cooperation from client and family for resources/services that they are responsible for"*

g) determine required services/resources (4)

h) waitlist (4)

4) Delivery and coordination of services

Who is involved- other disciplines(13), service providers/agencies (25), family (8), peers (14)
-Use phone(3), fax (1), face to face(2) and home visit(3)

What is done:
a) Make referral to the necessary professional services or community(5)

b) Coordinate and confirm services and professional services (8)
- *"ensure professional services follow up and that each professional knows what the other is doing "*

c) Coordinate and confirm professional services (8)
- *"ensure professional services follow up and that each professional knows what the other is doing "*

d) Ensure and monitor- keep in contact with client, family, agencies (11)
  - make changes as required (3)
  - check suitability, appropriateness and receiving the services (6)
- *"make myself accessible to them, maintain regular contact, empower client by giving them responsibility of making some of the contacts."*

- *"liase between agencies/professional/family/client"*

d) Problem solving(3)- problem solving with client and agency
- *"on-site problem solving and plan generation with the client followed by telephone contact or site contact if appropriate"*

e) Paper work(3)
Process of paper work- wait list service on service authorization, start date for service, contact agency by phone coordinating coverage of hours between agencies.

5) Monitoring

When: a) Set time- yearly(5), 2 months (1), monthly (1), at beginning (1), more often at

the beginning, then becomes less frequent (3)
- *"one month after admission then [as needed] until year",*
- *" Usually shortly after initial assessment, until needs stabilize, then usually an annual assessment or as needs change and brought to attention by client/family/agency"*

b) For a purpose- As needed (10), when services need re-authorization (1), maintain contact (1)
c) Case management determined- Regularly (7), occasionally(1), ongoing (1), appropriate interval (1)
d) Depends on client (3)
- *"if client is competent and able, I encourage client to contact CM if issues arise."*
- *"timing and amount depends on client"*

What (Reason): a) Needs (7)- change in needs, ensure meeting needs, as issues arise
b) Changes (4)- in needs, modify care plan, return from hospital
c) Regarding services (6)- quality of services, appropriate services
d) client's progress (5)
e) issues arise (3)

Who contacts CM: a) client (10)
b) family, informal support (7)
c) agency (5)
d) hospital (1)

How monitoring is done: a) phone (14)
b) home visit (10)
c) case conference (1)
d) updates from other disciplines (1)

**Description of the case management steps when providing Self-Managed care (SMC)**

1) Assessment (13 same as DCM), 3 have never set up a SMC contract
a) Same as DCM assessment except (3)

- *"the main difference is deciding when client is stable enough and when client/family can handle the paper work involved and is this the best solution for the client"*
- *"to probe further regarding informal support and financial arrangements (guardian, enduring power of attorney)"*
- *"also assess clients ability to manage their own case ie. workers*

b) Collect information

Information = review of case (1), medical (2), identify needs (3), identify services (2), assess environment (1), support network (2), whether client is stable (1), assess how much care a client requires and the needs/problems they identify(2), functional needs (3), resources available (1)

- *" have client describe a typical day and outline what areas he/she is dependent/independent"*

Who provides information- client (5) and family (4), professionals (1).

What is done:

a) Paper work- AFAT (2), medication list (1)

b) Educate client (2)- explain to client the SMC concept
-provide client with written explanation

b) Match client to SMC (12) [assessing for indications that client would benefit or be able to manage the SMC program, appropriateness]

- *"assess how best to address needs (DMC or SMC)"*
- *"assess client's own autonomy/knowledge base"*
- *"Assess client's and/or family's ability to meet SMC requirements and contract agreement and ability to obtain private care"*

Client meets SMC requirements (6)

Skills needed to be on SMC
- manage finances (2), recruit care givers (2), ability to problem solve (1), meet deadlines (1), ability to communicate needs (1), to teach (1), direct care (3), willing to comply with conditions within contract (1).

2) <u>Planning (7 same as DCM)</u>

a) Overlap with DCM (9) [Match client needs with what is available in Home care and the community]

*" compare service gaps and client requests with actual client functioning."*

*"Prioritizing most urgent needs and looking at time available to put in for client. Make appropriate suggestions and referrals to other community services as needed."*

*" according to needs, funding is provided" (4)*

b) Overlap with assessment-

a) Match client to SMC (6)

- *"suitability of SMC as the choice for the client"*

- *"determine if SMC is desired by client and is the best option to meet their needs and at what level and budget"*

b) educate client (1) – *"Provide info on SMC"*

*"time intensive for coordination while discussing SMC options"*

Who is involved:
- client (14), family (6), peers (3), accounting department (1), payroll assisting agency (1), others (2)

What is done:
a) Paper work (5)- accounting does audit
- complete documentation, sign contracts, schedule A's , letters for funding requests, schedule for care, determine funding amounts (according to needs), timelines re: tasks to be completed
- write out service plan with input from client (how many hours they may need (3)

b) Prepare the client for SMC-
- define roles and time lines (2)

i) Financial (3)- *"Inform client/ family of need to have a separate bank account and options available"*

ii) General information (6)- the SMC process
- review SMC policies and procedures
- walk client through what he/she needs to do
- *"time intensive for coordination while discussing SMC options"*

iii) Hiring/finding staff (3)- provide information on finding caregivers
-ensure client knows how to find care givers

c) discuss with peers (4)- review with SMC team

3) Obtaining services/resources (5 same as DCM)
*"can be simple or complex depending on client's needs and resources and availability of community resources and/or informal care givers. May access services within home care, or in the community"*

a) client or SMC manager is responsible for hiring staff and outlining duties (10)
- may use community resources for assistance (RAPs) (4)

b) What CM does with the client

Educate- Connect family/client with resources (6) for services, possible care givers, possible respite care, for managing their account.
- provide client and family with information for where to get caregivers (recruit and advertise) (10)
- explain the SMC process (2)

Assist- if they are having difficulty (1)
- with payroll and employer/employee details (1)

c) What CM does without the client
- make referrals to professionals (3)
- make phone calls (1)
- review case with SMC team (1)
- very little to do for CM (4)

d) Paper work – forward documentation to finance (2)
- credit checks(2)
- complete and submit request for approval (4)
- set up contract (3)
- CM and client sign agreement (2)

4) Delivery and Coordination of services (3 same as DCM)

a) Responsibility of the client (11) [indicate that client, family or SMC manager is responsible for this step, the resultant minimal involvement of the case manager]
- Promote independence (1)
- Very little to do (2)
- Consult only (1)

*"rarely see these client, they are good advocates for themselves and contact CM if necessary."*

b) Paper work- sign schedule As and contracts (2)
- complete SMC documentation (1)
- provide funds (2)

*" no delivery of services however funds are automatically deposited to client's special SMC account"*

b) Action of CM
- provide and coordinate professional services (10) (ie. Vendors, pharmacies, agencies)

- act as a liason between client and: management if changes arise (1), RAPs to ensure client is getting services arranged (1)
- provide support and ongoing teaching (3)
  - phone calls (2) *"leave phone number for client to contact case manager"*
  - resolve problems (2) *"answer questions as they arise"*

- Monitor the match between SMC and the client (1)
  *"ensure family or client is able to do this and satisfied with SMC program"*

*"ensure client fully understands responsibilities as an employer and his/her budgetary constraints"*

5) Monitoring (3 same as DCM)

a) *"this is a lot less as client manages the care"* (4)

c) Who initiates-
i) client (6)
ii) case manager (15) for the yearly re-assessment
iii) accounting (4)

b) When-
i) Distinct time limit- Yearly reassessment (18)- includes AFAT updates, renewal of agreements, hours required
- 6 months (2)
- every 3-4 months (2)

ii) More often at beginning then less frequent (4)
*"Initially every 2 weeks for 6 weeks to establish that SMC is working and continue to be the best option for the client/family, then yearly."*

iii) Case manager determined (1)- routinely
iv) Continuous (6)
- *"continue to assess client's ability throughout "*

v) For a purpose
- when necessary (issues arise or services need review) (6)
- when there are changes (client condition or family situation) (4)
- contract renewal (5)

vi) Depends on client (3)
- *"some client still need contact every month or few months to address specific discipline needs or to link with other community services"*
- *"cases when client is having difficulties with workers that monitoring requires significant case management time"*

What is done- consultation and problem solving (3)
Audits by accounting (3)
Review items associated with yearly assessment (7)
Examples of the items: Services, client's condition, how care is being delivered and if care level/need remains appropriate, funding level still matches needs

**The following section will report the open-ended responses for the advantages and disadvantages of DCM and SMC for the client and the case manager.**

**Advantages of DCM for the client**

1) There is one person to rely upon (14) [case manager as the main contact]
This results in:

a) main resource for problem solving (7) [to know where to call for help with problems]

- *"one main individual for the client/family to call re: questions and concerns."*
- *" can refer to case manager to solve problems"*

b) familiar person to access health care (6) [linking of client to the health care system]

- *" Humanization of a large, confusing bureaucracy"*
- *" case manager able to locate and arrange resources with less red tape"*

2) one person coordinating services and resources (7) [ case manager looking after many service providers ]

- *" one main person is looking after setting up all services therefore streamlines the number of contact people the client has."*
- *" they have someone who can assist them to deal with multiple agencies, professionals and caregivers."*

3) consistency and relationship building (11) [personal connection between client and case manager]

- *" Relationship develops and trust established therefore decrease in anxiety and increased sense of control."*
- *" client services are managed by one person and this results in consistency"*

4) Less responsibility for the client (10) [deferment of activities to case manager]
*"client doesn't have to spend time doing case coordination, problem-solving, arranging services, completing paper work"*
*" client does not have to address another concern when they are faced with so many obstacles in their life"*

5) Client centered care (9) [client has input into their care and the results of this consulting on the client]
*" clients can maintain independence over themselves at home"*
*" clients have a sense of value"*

6) Case manager expertise and objectivity (4) [case manager's personal attributes and job responsibilities]
*"case manager's bring expertise and a more objective approach."*
*" relationship with someone who is supportive and non-judgemental"*
*" monitors health and provides socialization"*

**Disadvantages of DCM for the client**

1) Case manager as gatekeeper of services and resources (11) [variation in services provided, limited time and resources]

*" Case load demands may not allow case manager to deliver services in a timely manner." "*
*" quality and quantity is provided in some degree dependant on case manager"*

2) Client experiences less control over type, time and provider of services (13) [less, lack, no, etc control]
*" client's feel they don't have a lot of control ie. Who comes into their home and what type of services are provided."*

3) Foster dependence upon the case manager (4) [client becomes compliant or dependent]
*" can become compliant so can want case manager to solve their problems"*

4) Sometimes difficult to forge good working relationship with clients because of poor fit or lack of boundaries. (6) [poor match, conflict between client and CM]
*" respecting boundaries can be difficult for some people."*
*" conflictual relationship with case manager may arise if there is disagreement in assessment/planning or service delivery."*

5) No disadvantages (1)

**Advantages of DCM for the case manager**

1) More control (5) [more control, or independence for the CM]
*" More control of money and service delivery, more control in client outcomes, ability to ensure consistency in practices."*

2) Know what is done and not done so can have quicker reaction to problems, monitor progress and outcomes.(7) [awareness of the services and client's reaction to the services]
*" Able to see the results of the services and implement change as necessary"*
*" have a clear picture of client's situation and able to deal quicker with crisis situations"*

3) Consistency (2) [consistency]
*"ability to ensure consistency in practices"*

4) Able to develop a relationship with client (13) [develop relationship, understanding the client]
*" Ongoing rapport with client allowing greater understanding of the person in environment, facilitating accurate assessment of change needs."*
*" feeling I have a good handle on the clients' situations and influence in*

*regards to this. Once get to know client may notice signs otherwise would not, therefore possibly earlier intervention."*

5) Job satisfaction (11) [rewarding, challenge, satisfaction, like, variety, positive aspects of the job]

*" A feeling of accomplishment and/or ability to affect change and see outcome and be able to evaluate and develop plan with client and/or family and others."*

**Disadvantages of DCM for the case manager**

1) Difficult clients (3) [difficult clients, disagreement with client]
*" difficult clients can be time consuming, frustrating and energy draining."*
*" disagreement and conflict over what client wants and what case manager can or is willing to do"*

2) Dependent clients (7) [activities that should be done by the client is given to the case manager]
*" being looked at as a baby sitter in some cases"*
*" some clients tend not to make decisions and expect a lot from their case manager."*

3) time consuming (11) [a lot of time, time consuming]
*" a lot of case management time is spent on setting up and making arrangements for home support services and then communicating these plans to the client"*

4) High level of responsibility and demand (6) [ too much, more responsibility, demanding, expectations, and needing to act]

*" occassionally too much responsibility"*

5) Become a generalist (2) [unable to do discipline specific treatment]
*" difficult to know all the services available to offer. Have to be a generalist and don't always get to use my professional OT skills"*

6) Too much paper work (3)

**Advantages of SMC for the client**

1) More client control of service providers, frequency of services, treatment plan and health which results in empowerment, more flexible care and consistency.(28) [indicating control and choice is given to the client]
*" client has control over who provides care. They may hire based on who they like and who they may better get along with. Freedom to flex care hours based on unexpected circumstances/events."*

*" they get to hire the home support worker of their choice and allocate services that caters to their own needs/situation"*

2) More service for the money (4) [mentioning the financial impact of SMC]
*"more hours for the money"*
*"able to receive more care hours than care through agency"*

3) More variety of services (2) [indicating SMC clients get services not available to DCM clients]
*" the client can actually get services direct service does not provide"*

4) Consistency (8) [indicating less variance in care provider]
*"There is a greater opportunity for consistency re: workers, as they can have one individual providing services and often for years"*

5) Flexibility (10) [indicating client able to determine care giver, time of care, and type of care]
*"client able to arrange services to fit his/her needs"*
*"set own schedules"*

6) Client more responsible(3) [indicating client is responsible for certain aspects of care]
*"Allows client to set their own terms and conditions and makes them more responsible for the health dollars allocated to them"*
*"they are responsible for hiring/firing staff. The contract is between client and staff"*

**Disadvantages of SMC for the client**

1) Managing the finances (8) [indicating financial aspects of SMC are difficult ie. Book keeping, managing money]
*" accounts are difficult to manage"*
*"keeping the banks quarterly audits"*

2) Staffing (18 ) [finding, keeping, supervising, training and managing being an employer]
*" Clients may have difficulty choosing or finding appropriate caregivers."*
*"much work is involved in accounting and hiring, training and scheduling care givers."*
*"no experience running a business"*

3) paper work (6 ) [large amount, confusing types and inability to maintain]
*" managing forms and paper work"*
*" more work in terms of training, hiring personnel and bookkeeping"*
*"degree of paper work: reporting back to Home Care accounting, paying for pay roll services (if used)."*

4) relationship between client and hired worker (5) [mentions the relationship between the client and hired personnel, abuse in the relationship]
*"some times the relationship between worker and client can be difficult since*

*client is an employer, but is very dependent on employee, so difficulties can occur if employee abuses relationship"*
*"a lot of boundary issues"*

5) isolation of the client (5) [Home care not playing the usual (DCM) role, client required to be self-reliant]
*"some do not have a good back up plan and expect Home Care to provide personal care and we don't"*
*"on their own to make things work, have to organize advertising, interviewing, hiring, getting reference checks, starting business, doing books, payroll, mediating conflicts, doing scheduling."*

6) Client has more responsibility (9) [skills that must be developed by the client, the changing role of the case manager]
*"responsibilities re: accounting, recruiting care givers, etc. Less likely to have case manager in support role."*
*"responsibility for managing care is on the client or family. It does take knowledge and time."*

**Advantages of SMC for the case manager**

1) Frees up time (7) [reduction in the time needed to address client's needs]
*"less time consuming as clients are responsible for arranging for their care"*

2) Less work (10) [mentions a reduction in the number or types of activities done by the case manager]
*" less day to day up keep re: client"*
*"less paper work, less problems with other agencies re: coordinating services"*

3) Shift in responsibility from case manager to client (10 ) [mentioning more responsibility for client and/or less for case manager, more independence for the client]
*"shift of responsibility of finding/coordinating care to client and/or family"*
*"client takes ownership of care and makes the decision as opposed to the case manager"*

4) Changes quality of CM work life because of changes seen in client (6) [empowerment or increased independence of client, effect of this on the case manager]
*" able to see clients actively involved and feeling part of their care."*
*" empowering client and families is gratifying"*

5) the advantages dependent on the suitability of the client to the program or after a certain point in the SMC process (10) [if screened for suitability, after an activity is completed the advantage occurs]
*"reduced time for client, once contract set up"*
*"decreased management in some cases that work well"*
*"potential for less work if client has been screened for suitability and is complying with terms of SMC agreement"*

**Disadvantages of SMC for the case manager**

1) Lack of contact between client and CM (could risk health or cause client stress) (13) [mention of less contact, not being aware of the client's conditions, the once a year monitoring]
*"don't know what personal care is actually being provided and not aware of client changes until there are major problems"*
*"don't have anyone monitoring health"*

2) risk abuse of finances (5) [inappropriate use of funds, the client not receiving the care expected]
*"difficult to check if people are abusing the system ie. Getting too many hours or using it for other purposes"*
*"unable to determine if client is using SMC appropriately to receive care they need"*

3) Set up takes a lot of time (8) [mentioning the amount of work or time needed to set up the SMC process]
*"with the initial set up of a contract increased time is required to iron out the kinks"*

4)None (2)

5) Less control (7) [having no control over unsafe or inappropriate activities/decisions that effect the client, change in how case managers perceive themselves]
*"client may hire worker that is inappropriate"*
*"much difficulty discontinuing funding, taking people off program even if there is a long history of non-compliance"*