Primary Care Perspective for Case Management Program

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Faculty/Presenter Disclosure

- Faculty: Annie Bouchard

- Relationships with commercial interests:
  - None.
OUTLINE

• Optimization of Primary Healthcare delivery
• Building on internal relationships
• Canadian Armed Forces Case Management Program
  • Historic background
  • How does it work
  • Roles and responsibilities
  • External relationships
• Future of Case Management in healthcare
Optimizing Primary Health Care Delivery

- What optimization means?
- How to achieve this objective?
- What can be the role of a case manager?
Different aspects of optimization

- Quality of care
  - Patient-centered
  - Continuity of care
  - Collaborative practice
  - Standardization
- Improve efficiency
  - Metrics are essential
- Nurture relationship with partners
CAF Case Management Program
The beginning…

- The CFHS National case Management Program has been implemented in early 2000 to fill gaps that were identified for transitioning CAF members.
- Since the beginning, registered nurses answered the call and it’s been more then ten years now that, as case managers, they have been helping thousands of people dealing with health challenges.
- “Caring for our own, across the continuum” theme is still of actuality even thirteen years + after the birth of the program.
CAF Case Management Program
Growing up…

• On a daily basis, the CAF 66 Case Managers help all ill and injured personnel to transition to civilian life.
• Navigation of the system
• Processes can be complex:
  – All CMs contribute to and are part of the solution
    • CMs have high level of SA wrt patient needs and level of satisfaction with health services
    • CMs play a key role in coordinating the member’s medical tx plan in concert with all medical and non-medical providers who support members and their families
    • CMs are instrumental in assessing member’s needs and facilitating services for those who need it most in collaboration with the medical team and partners.
CAF Case Management Program
Continuous improvement…

• Along assisting CF personnel on a daily basis, the CFHS Case Management Program has also been at the forefront of advocating for policy and process changes where they are needed. This is an instrumental step in influencing improvements to services and benefits available to CF personnel and their families.
Build on internal partnership

- Affiliation with primary care team includes:
  - Case reviews with PCN
  - Participation in Care Delivery Unit’s (CDU) interdisciplinary team meetings
  - Participation in mental health team case reviews for member’s receiving CM services
  - Education about the case management program and services for new clinic staff members
  - Facilitation clinic education about programs and services offered by IPSC & service partners
Build on external relationships

- Lots of partners, including the units (the company!)
- Regular meetings and discussion
- Alignment of processes (mostly with Veteran Affairs)
Affiliation/Integrations with the CDUs

- Include CDU mentoring activities as part of the orientation process for new staff
- Consider integrating CM to CDU
- Participate in regularly scheduled inter-disciplinary team meetings
- Develop a system with PCN for identification, referral and follow-up of members who require case management intervention.
**Average Caseload per Case Manager**

**What are we measuring?**
The workload of each nurse case manager to ensure equitable distribution of caseloads and number of nurse case managers. Target caseload is currently at 50 clients per nurse case manager which is deemed appropriate considering the complexity of the cases.

**Why is it important?**
It allows the nurse case managers to balance their workload in order to deliver efficient case management services.

**Average Caseload per Case Manager**

**Annual Summary**

**as of July 2013**

<table>
<thead>
<tr>
<th>Location</th>
<th>Average Caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver</td>
<td>50</td>
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<tr>
<td>Toronto</td>
<td>70</td>
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<tr>
<td>Calgary</td>
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<tr>
<td>Edmonton</td>
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<td>Edmonton</td>
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<tr>
<td>North Bay</td>
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<tr>
<td>Toronto</td>
<td>70</td>
</tr>
<tr>
<td>Montreal</td>
<td>57</td>
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</tbody>
</table>

**Target = Overall < 60 Cases per Case Manager**

**What does our performance tell us?**
The current data demonstrates that the average nurse case manager is carrying caseloads above the target. Note, in addition to Case Managers at some locations Team Leaders take cases as well on a 5-10 case max. These are located at Edmonton, Esquimalt, Gagetown, Halifax, Ottawa, Petawawa, Valcartier, Winnipeg and Borden.

**Action:**
National Office to work with Team Leaders and local clinics to ensure proper distribution of caseload and delegate tasks as appropriate. National Office will also monitor that all approved and funded case management positions are staffed.
How does it work?

- CAF Member has medical employment limitations likely to be incompatible with service
- Permanent medical category
- Referral to Case Management
- Evaluation (with intermed tool), complexity assessed
- Follow-up until release
- Referral to external stakeholders (benefits)
- Continuity with Veterans Affairs Canada Case Management
Intermed tool

• The INTERMED tool is a good tool for assessment because of 10 years of published research, an explicit outcome of complexity, and inclusion of biological, psychological, social and health system factors.
• The INTERMED is a matrix based on a standardized patient interview where the four domains mentioned above are each scored for history, current state and prognosis.
• Study is lacking as an outcome measurement in a primary care setting.
### Intermed tool 4 domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>History</th>
<th>Current State</th>
<th>Prognoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biologic</td>
<td>Chronicity</td>
<td>Severity of symptoms</td>
<td>Complications and life threat</td>
</tr>
<tr>
<td></td>
<td>Diagnostic dilemma</td>
<td>Diagnostic challenge</td>
<td></td>
</tr>
<tr>
<td>Psychologic</td>
<td>Restrictions in coping</td>
<td>Resistance to treatment</td>
<td>Mental health threat</td>
</tr>
<tr>
<td></td>
<td>Psychiatric dysfunctioning</td>
<td>Psychiatric symptoms</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Restrictions in integration</td>
<td>Residential instability</td>
<td>Social vulnerability</td>
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<tr>
<td></td>
<td>Social dysfunctioning</td>
<td>Restrictions of network</td>
<td></td>
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<tr>
<td>Health care</td>
<td>Intensity of treatment</td>
<td>Organization of care</td>
<td>Coordination</td>
</tr>
<tr>
<td></td>
<td>Treatment experience</td>
<td>Appropriateness of referral</td>
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</table>
Our experience with the Intermed tool

- Below 21: non-complex, normal transition
- 21-30: borderline, some complex needs
- 31 and up: complex needs, probable longer transition

- As of 2014: no borderline anymore.
  - 21 is the cut-off
  - More false-positive, but no false-negative. So if a member has complex needs regarding transition, he will have the potential for a longer transition with increased support (financially, vocational rehabilitation, healthcare needs addressed...)

Canadian Forces Health Services Group
Groupe des Services de santé des Forces canadiennes
Canadian Armed Forces member expecting medical release engages in **CFHS Case Management Process**

Case Manager conducts a **Needs and Complexity Assessment** and develops a **Case Plan**

- **Complex Intermed® Score**
  - Integrated Transition Plan Board
  - Develops transition plan for a 6-36 month transition period to civilian life

- **Non-Complex Intermed® Score**
  - Member receives support from CAF **Integrated Personnel Support Centre**

**LEGEND**
CAF = Canadian Armed Forces
CFHS = Canadian Forces Health Services
VAC = Veterans Affairs Canada
CM = Case Management
IPSC = Integrated Personnel Support Centre

**Start of Planning (Pre-Release)**
Six Months Prior to Release (Complex Intermed®)

Joint CFHS & VAC Pre-Release Case Management Planning

Referral to non-CFHS healthcare specialist(s)
Referral to non-CFHS family physician
CFHS medication verification with VAC
Case coordination until release date

VAC Client Needs Assessment in the Home & Complexity and Risk Assessment (RRIT-R)
Transition Interview
Completion of Case Plan

Joint CAF-VAC Release Transition Case Conferencing (one month before release)
Clinical: CFHS and VAC participate
Non-Clinical: CFHS, VAC and IPSC participate

Proceed to Release
Six Months Prior to Release (Non-Complex Intermed®)

Complementary Transition Planning

- Referral to non-CFHS healthcare specialist(s)
- Referral to non-CFHS family physician
- CFHS medication verification with VAC
- Case coordination until release date
- CFHS Discharge Summary to VAC

CFHS

Transition Interview, and Complexity and Risk Assessment (RRIT-R)

VAC

Low Risk
- Referral to VAC Case Management
- Re-Engage with CFHS Case Management

Moderate or High Risk
- Re-Engage with CFHS Case Management

Proceed to Release

VAC 6-Month Post Release Follow-up and RRIT-R
Post Medical Release

- Continuum of Case Management Services by VAC
- VAC Programs, Benefits, and Services
- SISIP Vocational Rehabilitation Program
- SISIP Financial Services
- IPSC Casualty Support Follow-Up
- Provincial/Territorial Health Care Plan
- OSI Clinic
- OSISS
- Community Support
- Public Service Health Care Plan
- Public Service Dental Plan

LEGEND
SISIP = Service Income Security Insurance Plan
OSI = Operational Stress Injury
OSISS = Operational Stress Injury Social Support
IPSC = Integrated Personnel Support Centre
VAC = Veterans Affairs Canada
Future of Case Management in the CAF

• A major stakeholder in our healthcare system:
  – Increased collaborative care is needed
  – Increased complexity of cases
  – More deployments to come

• Now working to better align VAC and DND processes
• Focus on complex needs’ members
QUESTIONS ?