Canadian Forces Seek Out Civilian Nurses For Case Managers

Bérubé, D.
Carefoote, R.

Abstract

This article describes a novel case management program implemented by the Canadian Forces Health Services to care for its ill and injured members. A brief overview of the military environment is followed by the reasons why the military looked to the civilian sector and selected case management as a strategy for its continuity of care issues. Principles guiding the design and operations of the program are highlighted along with a description of the core case management activities. Staff roles are outlined including the reasoning behind hiring baccalaureate prepared civilian nurses as Case Managers. The article ends with a description of its current status and notes that preliminary member satisfaction findings demonstrate that nurses are making a positive difference in lives of soldiers that are ill or injured.

The Canadian Forces – they serve Canada and the world but to whom do they turn when their ill need coordinated care? Whom do they call when they want to facilitate or coordinate care so that an injured member can return to duty early and safely? Whom do they trust to smoothly transition a released and incapacitated member to the civilian health care system? They turn to baccalaureate prepared civilian nurses to carry out these activities as Case Managers.

The Impetus

In the late nineties, a number of reports emerged that dealt with the care of ill and injured military members and their families. (Department of National Defence, 1997, 1997, 1999, 2000; Standing Committee on National Defence and Veterans Affairs, 1998). Media accounts of member frustration and humiliating experiences, poor morale, a sense of abandonment, a lack of continuity of care, and significant administrative issues are but a few of the findings that surfaced. Of notable concern was the issue of continuity of care.

For individual members, morale was negatively impacted to the point where they believed their recovery was delayed or they experienced new ailments as a result of poor continuity of care. For military leaders, continuity of care issues meant that soldiers were not quickly returned to duty and they were faced with working without a replacement, reassigning tasks and constantly modifying task plans.

The military introduced a number of initiatives to improve continuity of care but despite these efforts, fragmented care persisted and the military looked to the literature and civilian sector for other remedies. Case management emerged as a possible solution given its effectiveness in improving continuity of care (Smith, 1998).

The Military Health Care System

The Canadian Forces (CF) is legislated to provide for the health care needs of approximately 57,000 regular and 28,000 reserve members. This mandate has its roots in The Canada Health Act of 1984 where military members are exempt from the list of "insured persons" for whom health services are provided under the provincial health care insurance plans. The Canadian Forces Health Services is responsible "to provide the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios" (Chief of the Defence Staff Task Force – Health Care Support to the Canadian Forces, 2000).

Since the nineties, the military has gradually decreased the range of services provided in CF medical facilities. For the most part, military facilities now deliver only ambulatory care services while other acute services are provided via the civilian sector. Shortages of primary care physicians and specialists as well as the diversity in civilian community and provincial resources greatly affect the amount and type of health care that military personnel can receive in their location. Further, more reliance on civilian resources at a time when such resources are constrained has exacerbated the variance in health care services accessible across the country.

The Canadian Force Member

Individuals in the military range from 18 to 55 years of age with close to 90% being men. They must be both employable (fit to do his/her specific job) and deployable (able to function as a universal solider capable of performing all the tasks deemed generic in the military). If an individual is medically unable to carry out his/her military role (and cannot be accommodated), they are released from the military. For many, this means the loss of a career and new financial and emotional stress.

Individuals in the military are exposed to continuous physical and emotional dangers. Many work with heavy pieces of equipment and munitions, often for long hours and under harsh conditions. Some are subjected to atrocities for which they are not prepared and develop life-long psychological problems. Also, frequent mobility

means being 'posted' near family for any length of time is rare thus preventing the development of effective support networks.

More than three-quarters of those in need of case management have multiple medical issues (Carefoote, 2000). Orthopedic conditions are the most common with 'back' pain being the most prominent orthopedic complaint. Close to one-third have mental health issues such as Post Traumatic Stress Disorder (PTSD). Cardiovascular, endocrine, respiratory and eye, ear, nose, and throat conditions account for much of the remaining conditions. Less than ten percent have cancer or neurological conditions.

Over 500 individuals are released from the military each year for medical reasons and another 400 individuals annually are medically incapacitated. It has also been estimated that up to five percent of the total military population (about 4500 members) are in need of case management support at any time. These are individuals that have a medical condition that requires care coordination and temporarily or permanently affects their ability to carry out their military role. Exhibit 1 highlights a hypothetical but not atypical situation of one CF member in need of case management.

Why Case Management?

Case management has proven effective in improving continuity of care, reducing health care costs, enhancing clinical conditions, preventing costly complications, reducing duplication and gaps in services, strengthening informal support networks, and improving an individual's satisfaction with health care. (Alexander & Mackey, 1999; Coben, 1991; Challis, 1993; Ethridge & Lamb, 1989; Kretz & Pantos, 1996; Presler, 1998; Quick, 1994; Smith, 1998).

The literature is clear that there are a variety of case management models and no one model fits all organizations. Beatrice (1981) states that "Case management is therefore neither inherently nor definitively defined. It derives its definition in large part from the nature and needs of a system whose component parts it will be co-ordinating and integrating...it must be a creature of its environment, tuned to the specific characteristics and needs of its host system, if it is to be effective". The Ontario Case Managers' Association's (2000) definition of case management resonated with military health leaders:

> *Case management is a collaborative service consisting of interrelated processes to support clients in their efforts to achieve optimal health and independence in a complex health, social, and fiscal environment.*

The military chose case management as the primary mechanism for managing cases across the continuum of care, thereby providing a seamless, integrated care process. And, it was selected as the primary method for co-ordinating multiple services for an individual. Case management was the logical choice to address the continuity of care concerns of members and health leaders and was deemed the priority strategy for responding to the needs of members suffering from long-term and complex health care issues. The strategy is expected to impact positively on the overall health of individuals as well as the operational capability of the military.

The Military Case Management Program

The program is designed to provide intensive, one-to-one, in-person case management services for eligible members - those who are temporarily unable to perform their duties or those who are being released for medical reasons, and those who have complex health conditions requiring significant care co-ordination. Several principles guide program operations.

- *Partnership.* Case Managers "partner" with the member, the health care team and the Chain of Command to help the member return to duty and achieve/sustain optimal health.
- *Health Focus.* The primary focus of the Case Manager is on health where health is broadly defined to include health determinants such as income and social status, education, social and family supports, employment and working conditions, health services, personal practices and coping skills, and physical environment. Case Managers work within the military system and reach out to civilian and community resources where necessary to achieve the member's optimal health status.
- *Responsive and Caring.* Case Managers allow time to understand the member as an individual and establish a relationship that is responsive to the member's needs and demonstrates a caring approach.
- *Proactive.* The Case Managers are trained to quickly identify real and potential health care issues and actively work to prevent or address such issues so that restricted duty is prevented or minimized.
- *Least Intrusive Approach.* CF members are ultimately responsible for their health and are not expected to abdicate this responsibility to the Case Managers or others.

Exhibit 1 – Case Example

> Corporal Bloggins is 27 years of age and has eight years of service in the Army. He is married to a woman who works part-time at the local bank. They have two school-aged children and his wife has just given birth to their third child. The unplanned pregnancy placed an emotional and financial strain on the marriage, exacerbated by the fact that his wife's medical condition required bed rest and she was unable to assume any childcare responsibilities. They live 500 miles away from their hometown.

Corporal Bloggins injured his knee and sustained a concussion in a training exercise one-month prior to the birth of his new son. He is scheduled for knee surgery and has persistent headaches that are also under investigation. At this time his disability is well below the minimum level required for his military occupation and he will most likely be released on medical grounds.

Corporal Bloggins, as the primary caregiver for his growing family, and at a time when he is physically and emotionally challenged is at a loss as to where to begin. He has unanswered questions in a variety of areas including:

- Disability pensions – does he qualify? When can he apply? How quickly will money be forthcoming? Who does he need to see? What information does he need to gather/ present?

- Childcare support – is there anyone that can help him with his immediate child care responsibilities?

- Family support – is there any help that he and his wife can access to support them in this situation?

- Medical release – what does it mean? When will it occur? What happens if he wants to move back to his hometown?

- Employment – what kind of work can he do? Is he eligible for job retraining?

- Health care – what is his diagnosis/prognosis? Who will help him recover at home after surgery? What will be his medical condition upon release? Will he need to find a civilian doctor? How will he get his military medical file? Does he qualify for provincial health care in another province?

- Administration – who does he need to report to, for what reason, and how frequently? How does he address the information or administrative gaps in his situation?

The case management program is designed to help Corporal Bloggins address his concerns in a timely fashion.

- *Data/Outcome Orientation.* Program policy and operational decisions are based on evidence rather than perception.

- *Advocacy.* Case Managers educate CF members in the art of self-advocacy and where appropriate support and protect the member's civilian and military rights.

- *Data Efficiency.* An automated assessment tool with national reporting capabilities provides program staff with basic but relevant information about the population served by the Program.

The Program is envisioned as a system with specific inputs and outputs operating within the existing military and civilian health care systems. It is built on the functional model developed by the Ontario Case Managers' Association and the Ontario Community Support Association (2000). Figure 1 graphically depicts the case management system and highlights the core functions and key activities of the case management process - engaging, assessing, informing and referring, planning, monitoring and coordinating, evaluating and disengaging.

The attending physician frequently refers the member who requires co-ordination assistance. The Case Manager contacts the eligible member, describes the program, and establishes a suitable date/time for the assessment. The Case Manager also notifies the Commanding Officer of the member's involvement through the attending physician.

During the assessment, the Case Manager begins to understand the member as a person with unique strengths, capabilities and needs. They establish a responsive and caring relationship while validating relevant medical history, organizing treatment plans and determining the need for assistance. Such assistance can include help with disability pension applications as well as information about military and civilian resources. A key component of the assessment is to determine the appropriate level (0-3) of case management support.

Based on the needs of the member and the assessment findings, the Case Manager identifies information and service needs and helps the member acquire the knowledge and/or access the service. For example, the member might be referred to the Base Personnel Selection Officer for retraining options, the Military Information Guide to better understand the spectrum of health care benefits and services, or the Canadian Cancer Society for access to civilian support groups.

The Case Manager works with the member to identify goals and outline the activities that will be undertaken to achieve these goals within the desired timeframe. In keeping with the partnership principle, an "agreement" is developed and signed by the Case Manager and the member to indicate their understanding of and commitment to the plan. Part of the plan includes keeping the Chain of Command informed of the member's progress and when he/she is expected to return to full, active duty. The Case Manager monitors and co-ordinates planned activities and formally evaluates the accuracy and effectiveness of care plan in collaboration with the member every other month (or sooner if needed). A formal reassessment form guides the evaluation process and member satisfaction is included. Any changes to the goals or activities are noted on the care plan and signed by the member.

The member disengages from the Program when he/she returns to full active duty or has been successfully transitioned to other agencies and the civilian health care system. The Case Manager works with the Chain of Command and the attending physician to identify the criteria by which an individual member will disengage from the Program.

Program Staff

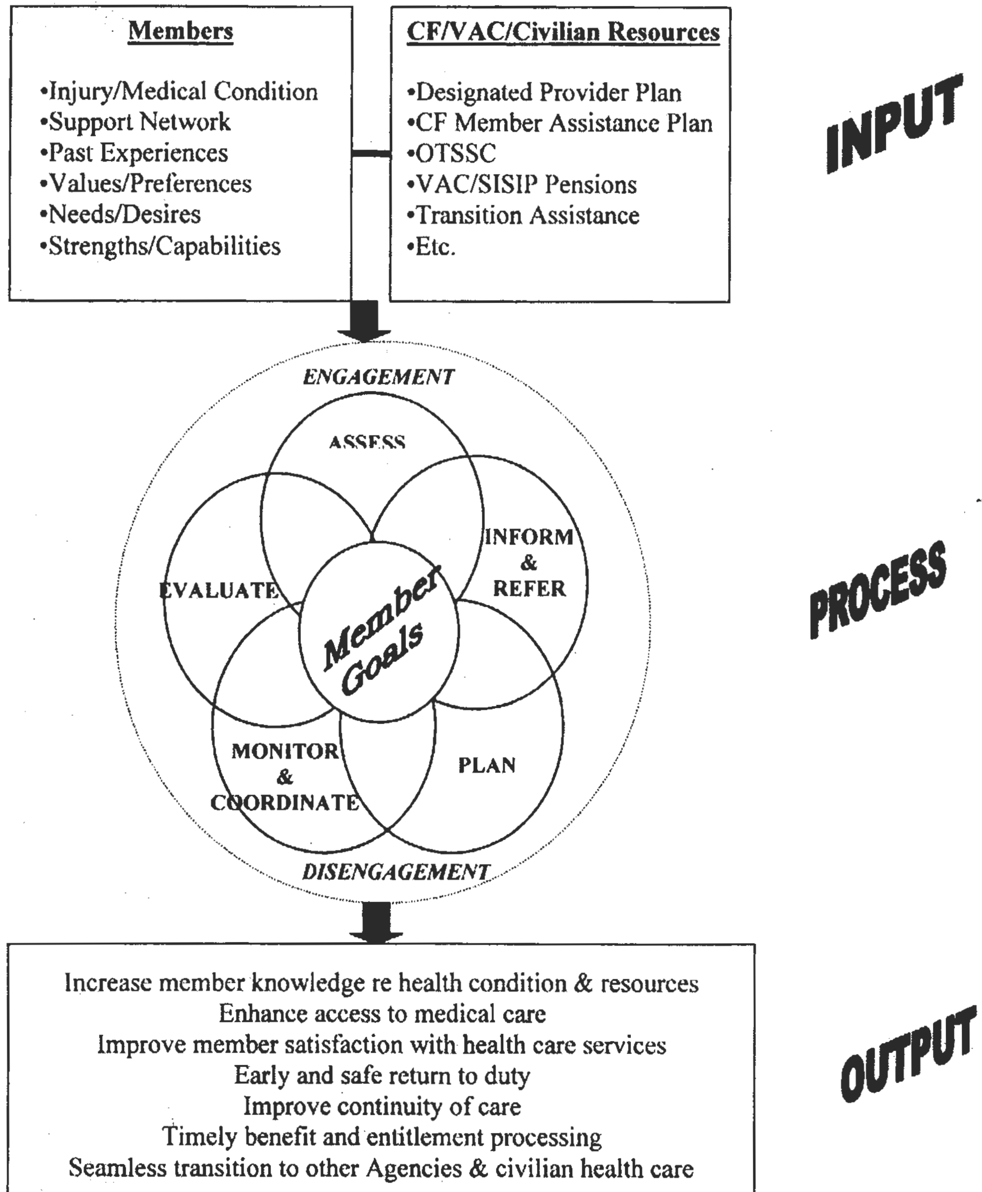
There are three key staffing roles in the Program: National Co-ordinators, Case Managers, and Support Clerks. The National Co-ordinators assume primary responsibility for planning, supporting and evaluating the program. They provide functional direction and specialist advice on case management services to military sites and headquarters.

The Case Manager is a full-time civilian registered nurse prepared at the baccalaureate level. The Case Manager reports to the local Health Care Co-ordinator (who is the lead physician on the military base) and works as an integral part of the health services team. The Case Manager is responsible for providing case management services, establishing relationships with external agencies, and for supervising case management support staff employed in their area.

Civilian nurses rather than military nurses are employed in the case manager position. Military nurses are skilled in military operations and must meet specific training requirements and participate in deployments. These career demands take the military nurse away from the case manager role and prevent them from effectively establishing a relationship with the member or providing continuity in case management. For these reasons, it was decided that civilian nurses, who could provide continuity in the role, are more appropriate.

Full-time Case Managers will be on all military bases where there are 1,800 or more CF members. Some sites are scheduled to have more than one Case Manager given the nature of the military activities at that location, for example, training bases. Each Case Manager will manage an active caseload of approximately 50 cases.

Figure 1 – CF Case Management System



Two distinct types of Case Managers exist. The first carries a general caseload and works in the military clinic to provide general case management services. The second has additional mental health expertise and works with a specialized team to provide case management services to members suffering from chronic or complex mental health conditions such as PTSD.

A Support Clerk provides administrative support to the Case Manager and assists in the preparation of documents for disability benefit applications. Generally there is one full time support clerk for every two full-time Case Managers.

Why Nurse Case Managers?

Murer and Brick (1997) note a variety of opinions as to who makes the best case manager and report that nurses have historically had a strong claim on case management. In most health care settings, nurses are called upon to coordinate client's care, drawing on other specialty providers as needed. The role of coordinator is integral to nursing practice and it is a role that nurses continue to cultivate and expand (Bower, 1992). The American Nurses Association now considers Nursing Case Management a specialty within the practice of nursing and credentials these professionals accordingly.

Through their education, baccalaureate nurses acquire the knowledge and skills to address diverse and complex health issues. Their knowledge base, qualifications, experience and scope of practice extends across all components of the health care system and positions them well to address multifaceted and complex client needs. They are skilled in addressing the dynamic and intense situations found in the military. Further, the essence of professional nursing is the therapeutic relationship with the client (CNO, 1999). Nurses understand the needs of clients as well as the role and contribution of other health care providers who comprise the multi-disciplinary health care team.

Physicians, social workers and other regulated health care professionals also serve as Case Managers in the civilian sector however cost and availability often play a significant part in the decision to hire nurses rather than the other professional groups. Registered nurses comprise one of the largest regulated health care professional groups and are generally available in all sectors of health care and geographic areas. Given the medical needs of the military members and the disparate locations of the military sites, registered nurses are the logical choice for the Program.

Program Status

The Case Management Program started in the fall of 2000 with five 'founding' staff in Edmonton, Ottawa, Petawawa, Gagetown and Valcartier. One year later in the fall of 2001 another fourteen Case Managers were added and a total of fourteen military sites had at least one full-time Case Manager on-site.

A formal program evaluation is planned for the summer of 2002 to address three specific issues —

- Program rationale (Does the program make sense?)
- Program impacts and effects (What has happened as a result of the program?)
- Program objectives achievement (Has the program achieved what was expected?)

Member satisfaction surveys, stakeholder focus groups, program statistics and case management chart audits will serve as the primary data collection methods. While it is too early to tell if the program is meeting its goals, initial member satisfaction survey results suggest that the program is definitely moving in the desired direction. On a scale of one to ten where one is the individual's worst program experience and ten is their best experience, members give the case management program an average score of eight. And, 98% of the members report that they would recommend the program to their colleagues.

Case management is proving to be an effective strategy and Nurse Case Managers are making a positive difference in the lives of military members who are ill or injured.

Acknowledgements

The authors wish to thank Violet Parker of Veterans Affairs Canada for her assistance in designing the Program and editing the article.

Authors

Commander Danielle Bérubé is a Senior Staff Officer with the Canadian Forces Health Services in Ottawa, Ontario.

Roberta Carefoote is a consultant specializing in case management programs with VVC Healthcare Consulting in Toronto, ON.

References

Ontario Case Managers' Association and Ontario Community Support Association. (2000) Provincial standards and guidelines for case management.

Alexander, J. W. & Mackey, M. C. (1999). Cost effectiveness of a high-risk pregnancy program. Journal of Case Management. 1(3), 170-174.

Applebaum, R. & Austin, C. (1990). Long-term care case management – design and evaluation. Springer Publishing Company: New York.

Beatrice, D.F. (1981). Case Management: A policy option for long-term care. In Callahan and Wallack (eds), Reforming the long-term care system. Lexington, MA: D.C. Health, Lexington Books.

Bower, K. A. (1992). Case management by nurses. Washington DC: American Nurses Publishing.

Carefoote, R. (2000). TMC snapshot study – on behalf of the Canadian Forces Medical Group. Ottawa, Ontario.

Challis, D. (1993). Case management in social and health care. Journal of Case Management. 2 (3), 79-89.

Coben, E. L. (1991) Nursing case management – Does it pay? Journal of Nursing Administration. 21(4), 20-25.

College of Nurses of Ontario (1999). Standard for the therapeutic nurse-client relationship. Toronto: Author.

Department of National Defence. (August, 1997). Personnel Policy Review. A study of the treatment of service members released from the Canadian Forces on medical grounds.

Department of National Defence. (1997). Care of injured personnel and their families review.

Department of National Defence. (October, 1999). Chief Review Services. Review of CF Medical Services.

Department of National Defence. (2000). Final Report – Board of Inquiry Croatia.

Department of National Defence, (2000). Chief of the Defence Staff Task Force – Health Care Support to the Canadian Forces - Putting the 'Care' back into 'Health Care'. Speech.

Etheridge, P. & Lamb, G. S. (1989) Professional nursing case management improves quality, access, and costs. Nursing Management. 20 (3), 30-35.

House of Commons, Canada, Standing Committee on National Defence and Veterans Affairs. (October, 1998). Moving forward – A strategic plan for quality of life improvements in the Canadian Forces.

Kretz, S. E. and Pantos, B. S. (1996). Cost savings and clinical improvement through disease management. Journal of Case Management. 6 (4), 173-181.

Murer, C. G. & Brick, L. L. (1997). The case management sourcebook – A guide to designing and implementing a centralized case management system. New York: Healthcare Financial Management Association.

Presler, B. (1998). Care coordination for children with special health care needs. Orthopaedic Nursing. March/ April Supplement: 45-51

Quick, B. (1994). Integrating case management and utilization management. Nursing Management. 25 (11), 52-56.

Smith, J.E. (1998). Case management: A literature review. Canadian Journal of Nursing Administration. 11(2), 93-109.

Correction to Charts
Patient Safety Article
by W. Nicklin & J.E. McVeety
Volume 15, Number 3
September/October 2002

Two of the charts accompanying the article "Canadian Nurses' Perceptions of Patient Safety" (Figures 4 and 5, pages 17-18) were incorrectly reproduced in the last Journal. The corrected charts have been reprinted on page 33. We apologize for any inconvenience this may have caused.