A CLIENT-CENTRED CARE CURRICULUM FOR CASE MANAGERS

By

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Abstract

The purpose of this project is to improve case managers' personal effectiveness with clients, and to foster client-centred care. The project describes the plan for the development, implementation, and evaluation of a client-centred care curriculum for community case managers at the Hamilton-Wentworth Community Care Access Centre (CCAC). Client-centred care is really about how we treat one another, and is supported in the literature. For this project, client-centred care means: honoring personhood, communicating therapeutically, being reflective, setting goals with clients, and therapeutic use of self. The concept of therapeutic use of self is about how one uses oneself to help clients (Whall, 1988). The project describes implementation and evaluation of a therapeutic use of self workshop which is one component of the entire curriculum. The curriculum is guided by principles of adult learning, including self-directed learning, and transformative learning. The guiding theoretical frameworks for this project include: Miller and Seller's (1990) transaction and transformation education positions, the Leithwood-Innovations Profile For Implementation (as cited in Miller & Seller, 1990), and Patton's (1997) Utilization-Focused Evaluation.

Although this project has the potential to make a significant impact on case managers and clients, the curriculum has yet to be tested. Recommendations for use of the curriculum within the CCAC are provided.

Acknowledgments

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Finally, I would like to dedicate this project in loving memory of Betty Cardno, a special friend and mentor, who personified client-centred care.

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Chapter One

My Introductory Perspectives

1.1 Introduction To The Problem

This project is about a person-centred approach to client care. Historically, health care practice has been and still is guided by the biomedical model of care, which is sometimes perceived to ignore the person with the disease (Stewart, Belle Brown, Weston, McWhinney, McWilliam, & Freeman, 1995). I have long been troubled by what I believe are paternalistic approaches to care, that is, the tendency by health care providers to believe (and to act) as if they are the ones best able to make decisions for clients (Cappell, 1994). In reality, there is evidence that professionals often know very little about the complex aspects of their clients' lives (Gage, 1994).

The health care system is undergoing rapid social change, and this involves changing health care practices and services (Weisel & Joshi, 1995). Past practices steeped in tradition may fail to meet the needs of clients in the nineties. Practitioners need to integrate emotional, physical, social, and spiritual dimensions of life into practice (Miller & Seller, 1990). This paradigm shift involves learning, growing, and changing. Education is required to prepare health care professionals for the system shifting.

This project describes one such educational endeavour, the plan for curriculum development, implementation, and evaluation of a humanistic approach to care, often referred to as client-centred care. The focus of the project concerns educating health care professionals, who function in the case management role at the Hamilton-Wentworth Community Care Access Centre (CCAC), about client-centred care.

1.2 Client-Centred Care

Client-centred care is really about breaking the mold and keeping clients in charge of their lives (Weisel & Joshi, 1995). Client-centred care is a philosophical approach that acknowledges basic principles of humanity: clients have the right to be autonomous, to be actively involved in their care, and to be supported as the experts of their own lived experience (Parse, 1981). This approach to care enables clients, builds on strengths and capacities, helps clients to mobilize their personal resources for every day living, and is health promoting (Browne, Roberts, Byrne, Weir, Majumdar, Gafni, Watt, William, & Siuji, 1995; McWilliam, Stewart, Brown, McNair, Desai, Patterson, DelMaestro, & Pittman, 1997; McWilliam, 1998). In client-centred care, interdependent partnerships are developed, and there is a change in power so clients have more say in their care (Law, Baptiste, & Mills, 1995).

I believe being client-centred also means honouring personhood, enhancing client-centred qualities, setting goals with clients, and

therapeutic use of self. Personhood is about an individual's values, spirituality, history, strengths, and life experiences (Buzzell & Gibbon, 1991). For this project, the two client-centred qualities are: communicating therapeutically, and being reflective. Communicating therapeutically is a skill that helps people learn how to relate effectively to others, and being reflective heightens self-awareness and self-understanding (Northouse & Northouse, 1998; Witmer, 1997). Goal-setting with clients provides an end that clients strive to achieve. The assessment and intervention should reflect the visions and values of clients while goal-setting is designed to focus on client-based outcomes (Law et al, 1995). How one uses one's self to help clients is central to the concept of therapeutic use of self (Whall, 1988).

1.3 Rationale For The Topic

The need for a change to more client-centred approaches to care, and the concomitant need for case manager education, stems from many changes in society in general, and the health care system in particular. The following provides the rationale for client-centred care.

1.3.1 Medicalization

Historically the helping professions have been obsessed with pathology, deficits, problems, abnormalities, and disorders (Rapp, 1998). Although the initial impairment of clients may be "fixed", quality of life issues which

determine health are often not addressed (Browne et al, 1995). People need to be understood beyond the pathology and disorder.

1.3.2 Living Longer

Although the life expectancy has increased by four to six years in the past 25 years, the number of disability free years has only increased by one and a half years (Premier's Council On Health, Well-Being and Social Justice, 1993). This means that seniors will increase in numbers, and they will likely be living longer with chronic illnesses and/or disabilities. Studies have shown client-centred approaches to care can equal or improve well-being outcomes of clients who are chronically ill compared to reactive approaches to care (Browne et al, 1995; McWilliam et al, 1997).

1.3.3 Consumers

The consumer movement of the sixties has resulted in more educated consumers who want more say in their care (Weisel & Joshi, 1995; McWilliam et al, 1997). Today's consumers use their rights to ensure their needs are met, and they are not content to sit passively by as many of their elders did in the past. Being client-centred is congruent with their desire for active participation in their plan of care.

1.3.4 Assumptions

Assumptions have been made that all health care professionals subscribe to being client-centred (Wilkins & Evans, 1997). Similarly,

many health and social service organizations and educational

programmes may include a focus on client-centred care, and then make

the assumption that the practitioners are client-centred. Unfortunately,

assumptions do not always translate into actual practice and one does not

have to go far to hear testimonials about non client-centred practice from

clients.

1.3.5 Cut Backs

The current health and social service system is faced with cut

backs, and cost constraints (Browne et al, 1995). As the population ages,

the cost of institutionalizing seniors creates pressure on health care

providers to develop better approaches to care in the home (McWilliam et

al, 1997). In fact, seniors themselves prefer community tenure, and often

consider being institutionalized as a last resort, and an undesirable option.

Research findings indicate that providing respectful and supportive

services, an aspect of client-centred care, leads to improved client

satisfaction (Law et al, 1995).

1.4 The CCAC

The CCAC is a new agency, established on October 1, 1997. This

agency combines the former Home Care Program (HCP) and Placement

Coordination Services (PCS), and is funded 100% by the Ontario

government's Ministry Of Health. The current Hamilton-Wentworth CCAC

budget is forty five million dollars. The CCAC provides simplified access,

information and referral, and coordination of health and support services to eligible residents of all age groups, who reside in the Hamilton-Wentworth region. Every day, up to 8,000 clients receive service from the CCAC.

The CCAC pays for services from service provider agencies in the Hamilton-Wentworth community. Following assessment by a case manager, services may be provided to clients. Available services are: nursing (on a visitation or shift basis), physiotherapy, occupational therapy, speech language pathology, nutrition, and social work (all therapies are provided on a visitation basis). Depending on need, clients may also receive homemaking, drugs, medical supplies and sick room equipment. The present government is committed to ensuring that service provision is separated from the coordinating agency (the CCAC), and has introduced a tendering process (Request For Proposal or RFP) whereby providers compete for provision of services paid by the CCAC.

1.5 The Participants: Case Managers

The primary stakeholders for this project are community case managers at the Hamilton-Wentworth CCAC. According to Cowger (1994), "the role of case manager is to nourish, encourage, assist, enable, support, stimulate, and unleash the strengths within people" (Joshi, 1998, p.1). The case managers are primarily Registered Nurses but some also have health care backgrounds in occupational therapy,

physiotherapy, social work, or nutrition. The CCAC employs

approximately 76 full time equivalent case managers, and 52 of these are

assigned to community teams.

The role of community case managers is to assess clients'

eligibility for CCAC services, and to offer alternatives to ineligible clients.

Other responsibilities include: developing, planning, implementing, and

coordinating CCAC services; managing resources; monitoring and

reassessing clients, and facilitating community relations with clients,

families, community groups, and other health/social service providers.

Case managers have considerable experience and expertise in

navigating the health care system, and are able to assist clients through

the maze.

1.6 Rationale For Targeting CCAC Case Managers

Case managers are the core component of the CCAC. As front line

workers, they are often the first contact with clients and families. They

are targeted in this project because their practice is the focus for a need

to change, and as a case management supervisor, I have first hand

knowledge of their role, how they function within the role, and believe in

the CCAC's notion of continuous quality improvement. Some are client-

centred; others are not; many are in process; most acknowledge being

client-centred is a journey, not a destination. Therefore, as front line

workers, and health care professionals, it is important for case managers

to participate in continuous quality improvement, such as client-centred

care.

1.6.1 Current Situation

The CCAC's motto is service first and the quality management plan

consists of a consumer focus, and improving key processes and systems

to respond to consumers (Hamilton- Wentworth CCAC Agency Service

Plan, 1998-99). Currently, the CCAC is working through its mission,

values, and vision statements. Therefore, the views expressed in this

project are my own, and do not reflect the CCAC's understanding of

client-centred care because it has not yet been determined.

The CCAC has identified trends that add to the complexity and

stress inherent in the case management role. Over the past year, the

CCAC caseload has remained fairly stable (approximately 1,000

admissions per month). Discharges have decreased, and people are

staying on the program longer (length of stay has risen to 165 days from

156 days last year). Sixty percent of clients are over 65, and an

increasing number have aging caregivers and are of advanced age (85

plus). Client acuity has increased, and families are stretched to the limit in

trying to care for their relatives. The demand for service often exceeds the

available resources. The paradox for case managers is to fulfil the

mandate of the CCAC effectively and economically, while meeting the

quality of care requirements clients and families have come to expect.

Client-centred care offers a solution to meet the challenge.

1.7 Models for curriculum development and implementation

According to Miller & Seller (1990), curriculum should be congruent

with the educator's world view. My personal world view concerns the

practice of holistic health care where one gets to know the person beyond

the medical diagnosis. In this project, curriculum is defined as, " an

explicitly and implicitly intentional set of interactions designed to facilitate

learning and development and to improve meaning and experience"

(Miller & Seller, 1990, p.3). The Miller-Seller Model has been selected for

curriculum development, and the Innovation Profiles Model has been

selected for implementation (Miller & Seller, 1990).

1.7.1 The Miller-Seller Model

The Miller-Seller Model (Appendix A) has been selected for this

project because it serves to inspire dialogue and interactions that

facilitate learning (Miller & Seller, 1990). This project's curriculum is

designed to provide experiential education in client-centred care.

Three curriculum education positions are described by Miller &

Seller (1990): transformation, transaction, and transmission. The goals of

the transformation education position involve self-actualization, self-

transcendence, and social involvement. The learning experiences focus

on the integration of the physical, cognitive, affective, and spiritual

domains. Individuals are allowed to exercise personal autonomy, and it provides a holistic curriculum perspective. Personal and social change are required for client-centred care (transformation position). The CCAC is undergoing transformational change; case managers are having to think differently; change what they believe, and how they act. If case managers are to survive and thrive in today's chaotic work environment, they are bound to undergo personal change. Transformational change in the workplace provides the foundation for personal and social change required for client-centred care. The transaction position is associated with the scientific method of problem solving, and is an approach that can lead to the development of new skill sets (Miller & Seller, 1990). In the process of self-development, case managers are required to enhance their skills in building relationships, and interacting with clients. The transmission position involves rote learning, and teaching in this position is mechanistic (Miller & Seller, 1990). This position is not relevant to client-centred care because it is less humanistic than the other positions.

1.7.2 The Innovation Profiles Model

The Innovation Profiles Model by Leithwood & Montgomery (1980) (Appendix B) has been selected for implementation because the Miller-Seller Model (1990) lacks specific "how to" implement guidelines (Miller & Seller, 1990). In the Innovation Profiles Model, implementation is defined as the "process of reducing the gap between images and outcomes"

(Miller & Seller, 1990, p. 255). This means the model provides a method of reducing the gap between where we are now in client-centred care and where we want to be after implementation. The primary reason for implementing a client-centred care curriculum is to close the gap between current and future case management practice. This model is also useful because it provides teaching strategies to overcome implementation barriers. There are many barriers that impede being client-centred, and any model that can help to overcome some of these can be very useful to a novice curriculum worker, and the stakeholders.

1.8 Curriculum Content

In my survey of case managers, to determine their client-centred learning needs, there was general agreement that the curriculum content was relevant to their day to day practice. Evidence for selecting the curriculum content was also supported in the literature (McWilliam et al, 1997; Buzzell & Gibbon, 1991; Weisel & Joshi, 1995). The content is organized into the following modules:

1. Honouring personhood
2. Enhancing client-centred qualities:
   a) communicating therapeutically
   b) being reflective
3. Setting goals with clients
4. Therapeutic use of self

If personhood is not honoured, clients feel depersonalized (Buzzell & Gibbon, 1991). Communicating therapeutically, a client-centred disposition, means actively listening, and being present with clients using prompts, reflection, and conveying understanding (McWilliam, 1997). Goal-setting with clients is designed to focus on client-based outcomes (Law et al, 1995).

The modules are interdependent, and integrate the cognitive, and affective domains of learning. Mastery of the content is expected to lead to case managers who embody the knowledge, skills and attitudes to practice client-centred care, and to enhance their therapeutic use of self in client encounters.

1.9 Model For Program Evaluation

"There is no best way to conduct an evaluation" (Patton, 1997, p. 126). Utilization-focused evaluation is a process to meet the information needs of stakeholders while focusing on their intended uses of evaluation. "The process of engaging in evaluation can have as much or more impact than the findings generated" (Patton, 1997, p.99). In this project, the intent is to foster client-centred care, and to increase the personal effectiveness of case managers.

As in client-centred care, utilization-focused evaluation is participatory and collaborative. It is anticipated that the evaluation

process will emerge and evolve as it is determined and developed by the stakeholders.

1.10 Overview Of Project

Chapter 2 includes a review of the current literature related to client-centred care, and a description of the curriculum content: honoring personhood, communicating therapeutically, setting goals with clients, and therapeutic use of self. Chapter three reviews the literature relevant to adult learning, and describes the adult learner, self-directed learning, and transformative learning. The focus of Chapter 4 is curriculum development and includes the Miller-Seller Model (1990) For Curriculum Development. Chapter 5 is about the plan for implementation and evaluation, utilizing the following guiding frameworks: The Innovation Profiles Model For Implementation (1980), and Patton's Utilization-Focused Evaluation (1997). Chapter 5 outlines the plan for implementation and evaluation of the curriculum, and moves from theory to practice by discussing implementation and evaluation of an educational session for case managers. Finally, Chapter 6, provides conclusions, limitations, practical implications, research implications, recommendations, and the significance of this project to case managers and clients. A bibliography and appendices will complete the project.
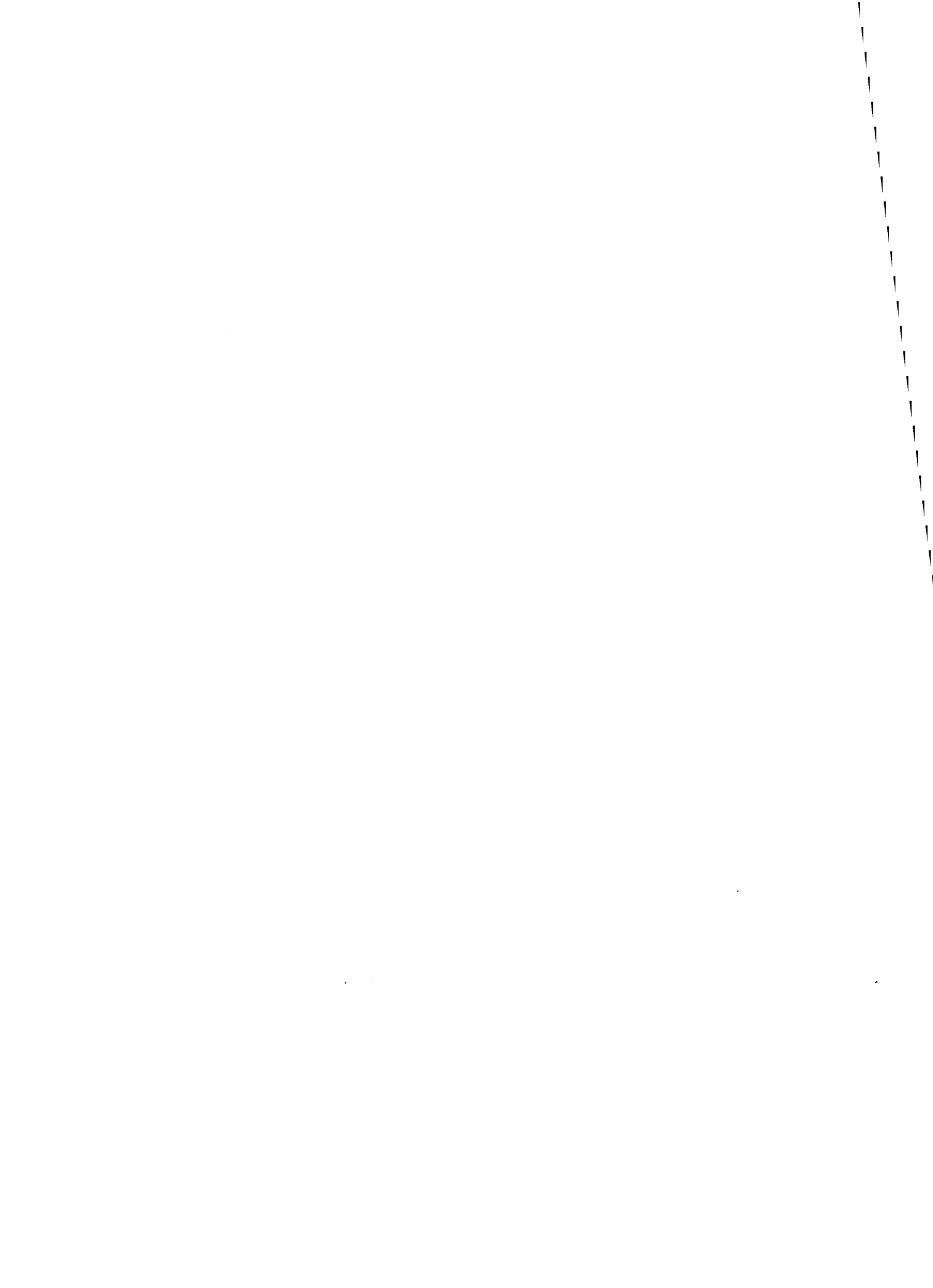
Chapter Two

Current Perspectives - A review of the literature

2.1 Introduction

A review of the current literature relevant to client-centred care is provided in this chapter. The client-centred care literature includes definitions and terminologies, its' benefits, controversies, and obstacles, and also provides the rationale for the content areas (Appendix E) selected for the curriculum. The content areas are: honoring personhood, communicating therapeutically, being reflective, setting goals with clients, and therapeutic use of self. Improvements in client well-being outcomes, with a corresponding reduction in service utilization and cost, will be described as evidence for client-centred care. Finally, client-centred curriculum is discussed.

2.2 Client-centred care defined

There are a variety of definitions and terminologies used to describe client-centred care in the literature (Wilkins & Evans, 1997). Common words are used by many health care professionals to describe the values that underlie their client-centred practice, such as autonomy and empowerment. Client-centred care means valuing the client's perspective, and respecting their autonomy and self-determination (Gerteis, Edgman-Levitan, Daley & Debanco, 1993; McWilliam, Belle Brown, Carmichael, & Lehman, 1994). The client-centred care literature

refers to abilities one needs to practice in a client centred manner. The curriculum content areas in this project consist of these abilities: honoring personhood, enhancing client-centred qualities: communicating therapeutically, and being reflective, setting goals with clients, and therapeutic use of self. (Buzzell & Gibbon, 1991; McWilliam, 1998; Rapp, 1998; Northouse & Northouse, 1998). In client-centred care, case managers give prime consideration to the client's perspective.

2.2.1 Subjective experiences

Literature that examines what is meaningful to clients is relevant to client-centred care. One such study is from The Picker/Commonwealth Program for Patient-Centred Care, established in 1981 in Boston's Harvard University (Gerteis et al, 1993). The goal of their program was to focus on patients' needs and concerns, as they defined them. Over 6,400 hospital patients were randomly selected from sixty two hospitals throughout the United States, along with 2,000 friends and family members of the patients. In order to determine their needs, all respondents received a survey questionnaire to complete. As a result of the survey, seven dimensions of patient-centred care in the hospital setting were defined. The seven dimensions are: respect for patients' values, preference and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of

family and friends; and transition and continuity. The subjective

experiences of patients in the study are very relevant to patient care in

the community, and help to narrow the gap in knowledge that reflects the

historical assumption that health care professionals are the experts and

know what is best.

2.2.2 Communicating and interacting

Clients value meaningful communication (Stewart et al, 1995;

Northouse & Northouse, 1998). Evidence suggests that problems in

communication are quite common (Stewart et al, 1995). For example,

54% of patient complaints are not elicited by doctors; and on fifty percent

of visits to a physician, the patient and doctor do not agree on the nature

of the primary presenting problem (Stewart et al, 1995). According to

Frankel & Beckman (1989), one reason for this discrepancy may be the

fact that doctors interrupt patients eighteen seconds, on average, into the

patient's description of the problem (Stewart et al, 1995). From the

patient's perspective, positive communication involves the physician

showing support and empathy; completely involving the patient and the

patient's perception that a full discussion of the problem has taken place.

Butler, Rollnick & Stott (1996) describe a patient-centred clinical

method. In the past, physicians dominant style of interacting was rooted in

a disease based model. Patients' resistance to change is viewed partly

from the way doctors communicate and talk to their patients, and not

rooted entirely in the patient. What really matters to patients is how physicians interact and talk to them (Butler et al, 1996). Telling patients what to do is often ineffective, and physicians need to pay more attention to issues that patients value. Physicians also need to be aware of patients' readiness to change and to encourage patients to make their own assessment of problems and solutions (Butler et al, 1996). When patients participate in their own assessment their intrinsic motivation is enhanced, and it is far more effective than giving advice. In a patient-centred approach, the patient becomes a therapeutic ally where mutually acceptable plans for the patient's well being are negotiated. The patient is the experiential expert and the physician is the clarification expert. This motivational interviewing method is a strategy from the addictions field, and an alternative to direct persuasion for promoting change in behaviour. In a client-centred interviewing style, physicians facilitate patients to make their own decisions. These owned decisions are more likely to result in lasting positive changes and to improve patient outcomes. This interviewing style also lends itself to respecting the autonomy of clients.

2.2.3 Respecting and preserving autonomy

In a client-centred approach to care, autonomy is respected and preserved. Health care professionals who are inclined to use a paternalistic approach to care, undermine older persons' autonomy. McWilliam et al, 1994 explored factors other than medical conditions

which contributed to experiences of patients after they were discharged from hospital. The purposely selected sample consisted of: 21 elderly patients, 22 informal caregivers, and 117 professionals from the hospital and/or the home setting. The interpretive research methodology included observation, in-depth interviews of all key participants and document review. The findings indicated when seniors with chronic illnesses had negative mindsets and professionals used biomedical and paternalistic approaches to care, clients experienced disempowerment and greater dependence on others for care. The more paternalistic the professional, the greater the patient perceived he was misunderstood. In turn, the patient's self-worth and self-confidence were further undermined. In some cases, the patient's anger and frustration increased, mindset became more negative, and the potential for autonomy was threatened further.

Although interpretive research does not achieve generalizable results, the findings of this study enhance understanding of seniors' experience of autonomy and contribute to the dynamic interaction between the patient and the professional (McWilliam et al, 1994). Empowerment needs to be part of a client-centred approach that includes an understanding of the client's mindset, goals and sense of purpose within a larger life context. Positive mind set and a sense of purpose may be critical intrinsic factors that shape client empowerment and autonomy despite continued health requirements (McWilliam et al, 1994).

2.2.4 Summary

In summary, the literature reinforces the importance of case managers finding out what is meaningful to clients, including how to and how not to talk and interact with them. The studies also provide the rationale and support for the content areas of the curriculum.

2.3 Benefits of client-centred care

Clearly, client-centred care has benefits for clients. Their values, preferences, expressed needs, and autonomy are respected and preserved (Gerteis et al, 1993; Mcwilliam et al, 1994). Their self-worth and self-confidence is preserved (Gerteis et al, 1993). They also feel emotionally supported, and their fear and anxiety is alleviated (Gereis et al, 1993). Finally, clients' mindset, goals and sense of purpose are understood, and client empowerment is shaped. (McWilliam et al, 1994).

2.4 Well-being outcomes

Four studies provide evidence that client-centred care can equal or improve well-being outcomes of clients who are chronically ill (Browne et al, 1995; Roberts et al, 1995; Mcwilliam et al, 1997; McWilliam, 1998). In the first study, 293 chronically ill subjects, with fair to poor levels of psychosocial adjustment to their physical illness, who attended a specialty out-patient clinic, were randomly allocated to one of three groups (Browne et al, 1995; Roberts et al, 1995). One group received conventional medical care, another problem-solving counselling and medical care, and

the third medical care and telephone support. The results showed that the client-centred or proactive problem-solving intervention and phone call support were associated with improvement in purpose-in-life, and less psychological distress for clients with specific characteristics and social supports.

Problem-solving counselling was most effective for those clients who lived alone and did not use problem-solving strategies on a frequent basis to help them cope (Browne et al, 1995; Roberts et al, 1995). Alternatively, telephone support was most effective for clients who lived with others and frequently used problem-solving strategies.

In the second study, 152 disabled clients living in the community were referred to a Community Health Services Centre (CHSC) for a rehabilitation day program (Browne et al, 1995). The client-centred or proactive approach at the day program aimed to build on strengths and capabilities of clients, empowering them to minimize the impact of the risks associated with their chronic illness. The discharged clients improved in their activities of daily functioning when they were compared to those who lived in an institution and were not enroled in the program. Perceived burden of care was lowest in those caregivers whose family member had completed the CHSC rehabilitation day program.

The third study consisted of another client-centred approach: a health promotion partnership intervention   (Appendix C) (McWilliam et

al, 1997). A randomized controlled trial tested the impact of the health

promotion partnership intervention on 203 chronically ill seniors.

Individuals who received the health promotion partnership had

significantly greater independence, perceived ability to manage their own

health, and quality of life when compared to those who did not receive the

intervention.

The fourth randomized controlled trial was designed to explore

whether compassionate care, by improving patient satisfaction, can alter

the number of times homeless adults visit emergency rooms (Redelmeier,

Molin & Tibshirani, 1995). In Toronto, Ontario homeless adults visit

emergency rooms frequently and often leave dissatisfied. One hundred

and thirty three homeless patients were randomly allocated to one of two

groups. One group received conventional medical care, and the second

had contact with a volunteer along with the conventional medical care.

The volunteer provided compassionate care by spending time listening to

the patient's concerns, and often discussed their living situation.

After one year of follow up, the results showed the provision of

compassionate care to selected homeless adults improved patient

satisfaction, and decreased the number of repeat visits to the emergency

room (Redelmeir et al, 1995). The findings showed the demand for

emergency services by homeless adults decreased if they perceived the

quality of care improved. By providing client-centred care, client satisfaction improved and expense to the system decreased.

2.5 Lower expenditures

The fact that client-centred care has been shown to reduce health care utilization and expenditures provides further evidence of its benefits. For example, in the first study, expenses for those who lived alone, infrequently used problem-solving coping methods and received conventional medical care, were 10 times those who received the problem-solving counselling (Browne et al, 1995).

In the second study, disabled clients who completed the rehabilitation program at a Community Health Services Centre consumed fewer health care services (Browne et al, 1995). This group consumed $1792-$2219 per person per year compared with those not enroled and receiving in-home services where costs were $16,607 per person per year. In relation to the caregivers' perceived burden of care, the greater the perceived burden, the more health and support services were utilized.

Individuals who received the health promotion partnership intervention, in study three, had, on average, 15 hours fewer in-home services (McWilliam et al, 1997). The cost of the health promotion intervention was approximately 10 hours of additional care at $34 per hour.

2.5.1 Summary

In summary, these studies provide clear evidence of the benefits of client-centred care in improving clients' well-being outcomes, their satisfaction, and reducing utilization, and lowering expenses. These findings have implications for CCACs and case managers (Appendix D). CCAC forms that case managers use could be refined to include space to document information about clients' psychosocial adjustment to illness, their capacities and strengths (Roberts et al, 1995). Similarly, CCAC services that are directed toward improving clients' coping capacity, social support, functional abilities and personal health practices may enhance clients' psychosocial adjustment to illness (Brown et al, 1995). Finally, CCAC case managers may benefit from being aware of the perceived needs of clients by listening to their stories (McWilliam et al, 1997; Redelmeier et al, 1995).

2.6 Controversies and obstacles surrounding client-centred care

The argument for client-centred care is not without controversies and obstacles. Some case managers complain that being client-centred is more time consuming than the more traditional models of health care practice. Faced with very real workload issues, getting to know clients and listening to their stories takes longer than only focusing on problems and services to address the problems. In CCACs, large caseloads and heavy

workloads are a reality, and are consistent with the notion of working quicker and smarter.

Although a workplace's philosophical approach to case management may be client-centred, the actual practice may not be supported. Research provides an example. In a qualitative study, researchers wanted to determine the extent to which case managers' statements of client-centred theory are reflected in their self-reported practice (Clemens, Wetle, Feltes, Crabtree & Dubitzky, 1994). Although the sample consisted of only 7 case managers, the findings were interesting: 1. client autonomy decreased as system constraints (eligibility, cost-containment, policies) increased. 2. as the role conflict between client advocacy and resource management increased, the differences between theory and practice become more obvious. 3. as client safety issues increased, case managers devoted less attention to client autonomy. In general, the research showed that the client-centred philosophical approach of case managers was inconsistent with the realities of daily practice.

Further obstacles that impede being client-centred may arise from either the client or the case manager (Law et al, 1995). For example, some clients may choose to let someone else assume responsibility for their care, and to make decisions on their behalf. Similarly, some case managers may be hesitant to give more control to clients because they

perceive themselves to be the experts. In other situations, case managers

may not have a clear understanding of how some of the values that

underlie client-centred care can be applied in their daily practice (Joshi,

1998).

2.6.1 Summary

In summary, although there is evidence to support the benefits of

client-centred care, it is not without its controversies and obstacles. The

challenge for workplaces is to move beyond the client-centred

philosophical approach and support case management in client-centred

practice. Content areas follow next.

2.7 Content areas

The literature indicates there are abilities and attitudes required to

practice client-centred care. These are reflected in the content areas:

having the ability to honor the personhood of clients; to communicate in a

therapeutic manner; to reflect on one's practice; to set goals that are

meaningful to clients; and to use one's self to help clients, commonly

called therapeutic use of self (Buzzell & Gibbon, 1991; Northouse &

Northouse, 1998; Whall, 1988; Witmer, 1997). Descriptions follow.

2.7.1 Honoring personhood

Honoring personhood is referred to in the literature about client-centred

care (Buzzell & Gibbon, 1991). When personhood is not honored

individuals feel depersonalized. Personhood is really about human to

human relationships (Buzzell, Meredith, Monna, Ritchie & Sergeant,

1993). Knowing the persons we care for, their past interests and abilities,

"helps others to use the attributes, build on them, and maintain them for

as long as possible (Buzzell et al, 1993, p. 6). In order to know

personhood, client care needs to be individualized and customized

(Evans, 1996). Personhood is really about being with patients in a way

that acknowledges shared humanity, and case management needs to be

designed so case managers can know their clients (Tanner, Benner,

Chesla, & Gordon, 1993). The responsive use of self preserves

personhood and embodies the fact that connectedness is critical to

meeting basic human needs (Smith Battle, Drake, & Diekemper, 1997).

2.7.2 Communicating therapeutically

Communicating therapeutically or therapeutic communication is "

the ongoing process of interaction in which meaning emerges " (Boyd,

1998, p. 251). Relationships, interactions, and the need to communicate

with clients in a therapeutic manner are referred to in the literature about

client-centred care (McWilliam et al, 1997; Northouse & Northouse,

1998). The Rogerian model is useful in explaining interactions that occur

between health care professionals and clients. Carl Rogers (1951)

focuses on how individuals in the helping professions can facilitate

learning and personal growth (Miller & Seller, 1990). Roger's model is

called client-centred because the focus of the interaction is on the client

(Northouse & Northouse, 1998). The role of the helper is to provide a climate of "facilitative psychological attitudes so individuals can tap their inner resources " (Miller & Seller, 1990). Facilitative attitudes are: genuiness, empathy and respect. Helpers are encouraged to communicate with " empathy, positive regard, and congruence " (Northouse & Northouse, 1998).

2.7.3 Being reflective

Being reflective is about transformative learning, and is referred to in the literature about client-centred care (Lauterbach & Becker, 1996; Witmer, 1997). When one reflects on oneself, one becomes more self-aware (Lauterbach & Becker, 1996). " Ultimately through self-understanding one is guided to becoming more aware and understanding of experiences of others " (Lauterbach & Becker, 1996, p. 57). It is through self-reflection, that the journey of self-inquiry and self-discovery begin. In the process of becoming more client-centred, case managers are required to undergo this self-growth journey where they view familiar situations differently.

2.7.4 Setting goals with clients

"A goal is a statement of a desired state or something that a person wants to achieve " (Cranton, 1992). In the client-centred care literature, goal-setting consists of the following assumptions: health is defined by clients; goals are determined through dialogue between health care

professionals and clients; clients strengths, interests, needs and values, in addition to obstacles and challenges, determine goals; and final decisions about goals reside with clients (Clark, 1995; Mold, 1995). Ultimately, it is most desirable for the client to be responsible for goal identification and achievement (Rapp, 1998). This is possible when the goal is the client's and not someone else's. For example, standardized goals that apply to all are less likely to provide clients with a sense of ownership when compared to individualized goals that are specific to their situation. Similarly, goals that are written in professional language have little meaning to clients.

2.7.5 Therapeutic Use Of Self

The literature shows that therapeutic use of self is an ability required in being client-centred (Clemens et al, 1994; Fast, Chapin & Rapp, 1997). Therapeutic use of self is "the ability to use one's person consciously and in full awareness in an attempt to establish relatedness (Jacono & Jacono, 1994, p.288). Therapeutic use of self refers to the ability of a nurse to "employ his/her person as a tool for promoting health and limiting disease" (Uys, 1980, p.175).

Improving one's personal effectiveness with clients and reaching out of self to others is a requirement of the case management role. In order to use one's self to help clients, a willingness to understand our own motives and needs is required (Whall, 1988). "Know thyself" is a basic

tenet of psychiatric nursing (Boyd & Nihart, 1998), and is applicable to case managers as well. "We cannot begin to know others until we know ourselves. We cannot grow and change until we have removed our shortcomings" Stewart et al, 1995, p. 82). Therapeutic use of self, when used effectively, can facilitate the health of clients (Whall, 1988).

Self-awareness enables nurses to make changes in how they interact with clients and families (Rushton, McEnhill, & Armstrong, 1996). The more "fully functioning" nurses are in the psycho-social aspect the better they will be able to help clients emotionally (Uys, 1980, p. 178).

2.7.6 Summary

The curriculum content areas were defined and described as they are referred to in the literature about client-centred care. In summary, the more willing case managers are to understand their own motives and needs, the better prepared they will be to practice client-centred care. The client-centred curriculum provides the foundation for educating case managers.

2.8 Client-centred care curriculum

Clearly, the evidence supports the usefulness of a client-centred approach to care. The School of Gerontology, at McMaster University in Hamilton, also supports this approach by conducting an annual, week long seminar devoted to client-centred case management. In addition, McMaster University includes the Canadian Occupational Therapy

Association's Guidelines For Client-Centred Practice in their occupational therapy programme curriculum.

Throughout the review of the literature, this writer was unable to find any references to a curriculum dedicated to client-centred care. Most health care curriculum, designed to educate professionals, remains discipline specific, and what seems to be missing is a client-centred care curriculum that could be integrated into other professional curricula.

2.9 Summary

In summary, the primary reason for implementation of a client-centred care curriculum for case managers is to close the gap between current and future case management practice. Just as health care is being restructured, it is my belief that there is also a need to restructure curricula in educating health care professionals. In this project the health care professionals are case managers and adult learners. The next chapter explores adult learning, and includes the adult learner, self-directed learning, and transformative learning.

Chapter Three

Adult Learning - A Review Of The Literature

3.1 Introduction

A review of the literature relevant to adult learning is provided in

chapter 3. This is an essential feature of this project because case

managers are adult learners. "Adult learning is viewed as transforming,

modifying, relearning, replacing knowledge, skills, strategies, and values

through experience" (Brundage & Mackeracher, 1980, p.5). The adult

learner, self-directed learning, and transformative learning, are explored

in this chapter. The relevance to case managers is also included.

3.2 The Adult Learner

Adult learners display a collection of individual characteristics that

can have a profound effect on learning (Cranton, 1992). Learner variables

include: experience, philosophy, values, and autonomy.

3.2.1 Experience

Experience as a resource for learning is a fundamental principle of

adult learning (Cranton, 1992). "An experience is seen as containing

behaviors, ideas, and feelings" (Cranton, 1992, p. 57). Reflection is a key

component of learning, and "includes returning to an experience, using

the positive ideas and feelings involved, examining and removing ideas or

feelings which are obstacles to learning, and reevaluating the experience"

(Cranton, 1992, p. 58). The outcome leads to a new perspective on the experience, a behavioral change, and an action plan.

Past educational experiences will influence the way learners approach current learning situations (Tarnow, 1979; Cranton, 1992; Knowles, 1980). If an adult has had an unpleasant learning experience in the past, new learning experiences may be avoided or approached with caution. If a past learning experience was rewarding, the learner will come to the new experience expecting to be successful.

"Adults are what they have done" (Knowles, 1980). Their self-identity is derived from their experience. If one asks adults who they are, they often identify themselves in terms of their unique experiences. When experiences are not used or their worth is minimized, adults may even feel rejected as individuals (Knowles, 1980).

3.2.2 Philosophy

An individual's philosophy is an important variable in the learning process (Cranton, 1992). Cranton (1992) defines philosophy as "a set of principles for the conduct of life" (p.59). Epistemic, sociocultural, and psychic influences affect how a person understands the world (Cranton, 1992). Epistemic (related to knowledge) influences are the manner in which the learner views knowledge. For example, an individual who believes it has always been that way and that's the way it is, sees the

world very differently than one who has a questioning approach to knowledge. In between these two extremes, most learners are found.

Sociocultural influences pertain to social relationships (Mezirow, 1991; Cranton, 1992). One's philosophy of life may be based on the acceptance of social norms. Beliefs that are based on race, gender, or culture are examples of sociocultural influences (Cranton, 1992). Psychic influences are childhood events that influence the ways adults conduct their lives, and also influence their philosophy of life. Childhood events may have been traumatic or positive, and can influence the perspective of learners.

3.2.3 Values

Values refers to "beliefs about what is desirable or good" (Kane & Degenholtz, 1997). "The adult learner needs to be aware of his own value system through which he evaluates both input and learning outcomes" (Brundage & Mackeracher, 1980, p.69). Although values are a learner characteristic, changed values are a possible outcome of a learning experience (Cranton, 1992). Having an

awareness and respect for learners' values are critical for working effectively with individuals. The role of the educator is to challenge the learner, to question his or her values, and to work toward changes in values (Cranton, 1992).

3.2.4 Autonomy

The term autonomy means self-rule, and denotes a state of independence (Candy, 1991; Cranton, 1992). Some people are more autonomous than others, and the same persons may be more or less autonomous in different circumstances (Candy, 1991). In general autonomy increases with age, and it is amenable to educational intervention. It is important to understand that adults are not passively sitting around waiting to be "made more autonomous" (Candy, 1991, p. 122).

If individuals are to be viewed as self-determining, they need to be treated with respect or "given reason" by educators (Candy, 1991, p.122). One of the responsibilities of educators is to challenge learners to become more autonomous (Cranton, 1992).

In summary, experience, philosophy, values, and autonomy are variables that can have a profound effect on adult learners such as case managers and influence their ability to be self-directed learners.

3.3 Self-directed learning

The actual definition of self-directed learning varies in the literature. Self-directed learning is where "the learner takes the initiative and responsibility for the learning process" (Weinberg & Griffith, 1992, p.392). The learner is described as being responsible for the content and the

outcomes as well as the processes of learning (Muscari, Aikin, Bailey, Fitzgerald, Mings, Mitchell & Rigby, 1993). According to Cooper (1988), the importance of student behaviours in the learning process is emphasized rather than the actions of the educator. Self-directed behaviour is an approach to learning in which the learner is responsible for: developing his or her learning abilities; learning with and through others and providing active input into decision-making associated with the learning task (Higgs, 1992).

Becoming increasingly self-directing is an essential aspect of maturing as an adult (Knowles, 1975;1980). The author believes every act of teaching should have some provision for helping the learner to become self-directing. Learning is defined as a lifelong process and the main purpose of education is to develop the skills of inquiry (Knowles, 1980).

In summary, the challenge for this writer is to develop curriculum that integrates the dimensions of self-directed learning as well as other teaching/learning methods that are in tune with case managers who may not be self-directed.

3.4 Relevance to case managers

Self-directed learning is relevant to CCAC case managers because it is one method many may be familiar with already, and others may ascribe to, given the opportunity. In order to be successful, individuals need to develop an understanding of self-directed learning and be aware of their

own readiness for this type of learning (Higgs, 1992). Self-directed learning is about successful learner control.

As a diverse group, case managers have a variety of educational needs, learning styles and, methods of practice. Self-directed learning may be a method for some to integrate client-centred care into their repertoire of practice. For case managers who are not self-directed, opportunities to become self-directed need to be provided, including orienting and preparing them before implementing a self-directed learning process. Examples of this process are programmed instruction, independent study modules, and self-learning packages (Weinberg & Stone-Griffith, 1992).

3.5 Becoming self-directed

Cranton (1992) acknowledges some learners will reject the concept of being self-directed either at the start or part way into the process. Individuals may vary in their ability, capacity and preferences to undertake intentional learning (Candy, 1991). Social and cultural factors can impede one's personal freedom to become a self-directed learner. Ultimately, within the self-learning process, one hopes case managers will gain an ability to understand themselves within the context of enhancing their client-centred practice through participation in the client-centred care curriculum.

Cranton (1992) describes stages learners go through in the

process of becoming self-directed: disconfirmation, disorientation,

identification of the problem, exploration, reflection, reorientation, sharing

the discovery and equilibrium. Although these stages provide a useful

framework, Cranton (1992) acknowledges there are probably other ways

that diverse learners may react. In the process of becoming self-directed,

the beliefs and values of learners change (Cranton, 1992).

3.5.1 Summary

Clearly, self-direction is not the automatic result of maturation into

adulthood. Although the process of becoming self-directed should be a

goal of education, there will be times when the learner will prefer the

educator as the expert (Cranton, 1992). The learners in this project are

case managers, and their learning experience needs to be meaningful

and relevant to their daily practice. Transformative learning may bring

meaning to their learning experience.

3.6 Transformative learning

Transformative learning is a "process of critical self-reflection, or a

process of questioning the assumptions and values that form the basis for

the way we see the world" (Cranton, 1992, p.146). Transformative

learning may involve correcting distorted assumptions from prior learning.

Meaning transformation is the central function of adult education

(Callin, 1996). Callin (1996) uses Mezirow's Theory Of Perspective

Transformation to explain the shift in the way nurses view themselves and their worlds. It is the change in perspective that enables Registered Nurses enroled in the Bachelor Of Science In Nursing Programme, at McMaster University in Hamilton, Ontario, to see familiar situations in different ways. One outcome of a successful post Registered Nurse program is when nurses demonstrate these changes in different approaches to client care.

In the transition from diploma to degree nurses, specific conditions are necessary so that they may reflect critically on their meaning perspectives (Callin, 1996). The conditions include: a safe climate for learning, peers who respect and challenge each other, and a process-driven curriculum which encourages flexibility, empowerment, and risk taking.

3.7 Relevance to case managers

Transformative learning is relevant to a curriculum for case managers because they require a change in perspective; to see familiar client situations in different ways. Not only is it desirable for them to view client situations differently but this also needs to be demonstrated in actual practice. The different approach in this project is client-centred care. By reflecting critically about their practice methods with clients, case managers may correct past assumptions and act differently in the future.

In the process, previously valued assumptions are replaced, and clients are expected to benefit.

3.7.1 Summary

Transformative learning causes us to rethink previous valued assumptions. By participating in a curriculum that uses a transformative learning approach, case managers may revise their interpretation of the meaning of situations, and in the process, replace previous assumptions and values with alternative perspectives. Clearly, educational strategies in this project need to foster case managers' meaning perspectives.

3.8 Analogous roles and relationships

In digesting the literature, it would appear that the roles and relationships between educators and students in education are analogous to the roles and relationships between case managers and clients in client-centred care. In education, teachers need to stop doing things for students and instead do things with them (Candy, 1991). Also, individuals may vary in their ability, capacity and preference to undertake self-directed learning. The educator has to be in tune with the emotional, intellectual and skill needs of learners (Cranton, 1992). In client-centred care, case managers need to stop doing things for clients and instead do things with them. Clients may also vary in their ability, capacity and preference to participate in client-centred care. Case managers also have

to be in tune with the emotional, intellectual and perceived needs of

clients.

3.9 Summary

In reviewing the similarities between educators and students with

case managers and clients, the stage is set for the project's guiding

frameworks: the theoretical models. In the next chapter, The Miller-Seller

Model (1990) For Curriculum Development is the guiding framework for

the plan for development of the curriculum in this project.

Chapter Four

Curriculum Development

4.1 Introduction

Chapter 4 describes the plan for developing the client-centred care

curriculum for case managers. The aims and objectives, developmental

goals, content, organization of the curriculum content, and teaching

strategies/learning experiences, as they relate to Miller and Seller's

(1990) transaction and transformation education positions will be

discussed.

4.2 Curriculum Components

Miller and Seller (1990) describe key components of curriculum

development: 1. aims and objectives; 2. developmental goals; 3. content;

4. organization of content; 5. teaching strategies/learning experiences;

and 5. evaluation. The first four components will be described as they

relate to the development of the client-centred care curriculum.

Implementation and evaluation of the curriculum will be discussed in the

next chapter.

4.2.1 Aims And Objectives

"Aims provide overall direction or guiding images for curriculum

development" (Miller & Seller, 1990, p. 175). Aims may also reflect more

than one major curriculum position. The aim of the curriculum in this

project is to foster client-centred care. More specifically stated, case

managers will learn what client-centred care is and how to implement it in the short term, and implement a client-centred approach in their daily practice, in the long term.

Within the transaction and transformation orientations, objectives are learner centred and are not in the form of behavioral objectives (Miller & Seller, 1990). Behavioral objectives are used within a transmission framework and not within a transaction or transformation orientation (Miller & Seller, 1990). "Complex problem-solving skills, personal growth skills, and social action strategies cannot be reduced to behavioral terms" (Miller & Seller, 1990, p. 184). The curriculum in this project is about personal and social growth.

4.2.2 Developmental Goals

After the aim of the curriculum has been established, developmental goals are identified (Miller & Seller, 1990). This is an intermediate step between aims and instructional objectives. "The breakdown of a general goal into more specific levels provides some conception of student growth that can be used as a framework for achieving that particular goal" (Miller & Seller, 1990, p. 179). Developmental goals can range from broad developmental sequences to those that are more specific. An example of a developmental goal for case manager's is to improve their effectiveness in interactions with clients.

4.2.3 Content

After developmental goals have been established, content needs
to be determined (Miller & Seller, 1990). In this project, honoring
personhood, communicating therapeutically, being reflective, setting
goals with clients, and therapeutic use of self (Appendix E) constitute the
content. Other terms used interchangeably with content are, "Subject
matter, knowledge, concepts and ideas" (Miller & Seller, 1990, p. 185).
The criteria for selecting content falls into the following areas: 1.
psychological criteria; 2. social/political criteria; 3. student interest criteria;
4. student readiness criteria; 5. utilitarian/practical criteria; and 6.
philosophical criteria.

The selection of content for the client-centred care curriculum was
influenced by four of these criteria. First, the philosophical criteria for
selection of the content in this project emphasizes epistemological issues
and basic value positions (Miller & Seller, 1990). For example, honouring
personhood and setting goals with clients indicates valuing the
uniqueness of individuals, and the active participation of clients in their
plan of care. The philosophical criteria can be easily integrated with the
cognitive and affective domains of learning, which helps case managers
to view knowledge in terms of relationships.

Secondly, the utilitarian/practical criteria focuses on criteria that
will be socially useful or required for employment (Miller & Seller, 1990).

As adult learners, case managers want to be able to acquire knowledge that is useful and relevant to their everyday practice. Being client-centred needs to extend beyond a philosophical approach into actual case management practice. An approach to care that improves the well-being of clients is socially useful.

Thirdly, student interest criteria for selecting content should be integrated with subject matter (Miller & Seller, 1990). This means that "subject matter should be related to the interests and maturity level of the learner" (Miller & Seller, 1990, p. 187).

For this project, a Client-Centred Care Curriculum Learning Needs Assessment was utilized to survey case managers (Appendix F). Thirty one case managers (59.6% response rate) completed the survey questionnaires. Although the response rate is over fifty percent, it is probably somewhat low considering the fact that the case managers work together and all know each other. Personhood was ranked as the first and second choice for an educational session by 24%; being reflective 41%; goal-setting 17%; and 55% ranked therapeutic use of self as their first and second choice for inservice education (Appendix G). Although most either strongly agreed or agreed that the content of the curriculum was important, 6% were undecided whether they understood the concept of communicating therapeutically, and 3% were undecided whether they use the concept in their practice. Regarding being reflective, 3% were

undecided whether they understand the concept, and whether they use the concept in their practice. Therapeutic use of self was selected as the topic for an educational session based on case management interest.

Finally, the social/political criteria refers to the fact that content should include value positions, such as the principle of individual dignity and specific client rights (Miller & Seller, 1990). The content in this project does take into account the dignity and rights of clients, and may be reviewed by reading pages 12, 27, 28, and 29. A Bill Of Rights for clients who receive community services is also included in the content. (Ministry Of Health, 1994) (Appendix H).

4.2.4 Organization Of The Curriculum Content

Miller and Seller (1990) recommend approaching the organization of selected curriculum content and teaching strategies from the perspectives of scope and sequence.

4.2.4.1 Scope

"Scope refers to horizontal relationships in the curriculum and the attempt to maintain an appropriate balance in the curriculum" (Miller & Seller, 1990, p. 198). Curriculum workers working from a transaction perspective move away from subject matter to focusing on developing students' problem-solving skills. The teacher selects the problems that will be central to the curriculum (Miller & Seller, 1990). For example, case managers move from definitions and terminology to analyzing.

communication skills when interacting with clients. It is more difficult to organize the scope of a curriculum from a transformation position (Miller & Seller, 1990). Instead themes emerge, and include the integration of cognitive and affective experiences, and issues that are identified as socially relevant. An example is that client-centred care is really about how case managers treat individuals. This is socially relevant to health care practice.

4.2.4.2 Sequence

"Sequence refers to vertical relationships in the curriculum" (Miller & Seller, 1990, p. 198). Vertical relationships refer to the cumulative and continuous learning that occurs as students move through the curriculum. In the transaction position, sequencing examples are found in content that focuses on the development of mental processes (Miller & Seller, 1990). Evidence of this form of sequencing is found in the curriculum content related to being reflective and communicating therapeutically. It is more difficult to identify sequencing that represents the transformation education position.

4.2.4.3 Summary

In summary, organization of the content from the perspectives of scope and sequence as they relate to the development of the client-centred care curriculum have been described. The fourth component of

curriculum development, teaching strategies/learning experiences, will be discussed next.

4.3 Teaching Strategies/Learning Experiences

Teaching strategies in this project reflect the Miller and Seller Model's (1990) transaction and transformation education positions (Appendix E). The transaction position can lead to the development of new skill sets. For example, case managers are required to enhance their skills in building relationships, and interacting with clients. The transformation position provides a holistic curriculum perspective where case managers are encouraged to promote clients' growth and autonomy by honoring personhood, setting goals with clients, and enhancing their own client-centred qualities.

As cited in Miller and Seller (1990), Joyce and Weil (1980) define a model of teaching as "a plan or pattern that can be used to shape curriculum, to design instructional materials, and to guide instruction" (Miller & Seller, 1990, p. 190). In selecting an appropriate teaching model, curriculum workers should select one that is congruent with one's aims and developmental goals. For criteria related to the transaction orientation, the role of the teacher is to stimulate probing by students. Transformation criteria include teaching models that involve students in social awareness and social change (Miller & Seller, 1990).

In order to stimulate probing by case managers and to involve them in social awareness and change, teaching strategies in this project need to facilitate transformative and self-directed learning. Examples include: case studies, critical incident exercises, small groups, journal keeping, and role-playing.

4.3.1 Case Studies

Case studies are an ideal method to encourage transformative learning (Cranton, 1992). By including questions to focus discussion, exploration of issues is facilitated. Case studies provide a non threatening way for learners to increase awareness of their assumptions (Cranton, 1992). Questions related to client-centred care can be reviewed specific to selected scenarios. Case managers are already familiar with using case studies in learning situations, and they could be a very useful teaching strategy for the client-centred care curriculum.

4.3.2 Critical Incident Exercises

"A critical incident is a learner's description of a significant event in his or her life" (Cranton, 1992, p. 158). The incident is explored for the assumptions that underlie behaviour and reactions during the incident, at the time, and in retrospect. By analyzing significant events in their lives, learners will develop heightened self-awareness (Cranton, 1992). In reality, this is really about being reflective.

By being reflective, case managers should be better prepared to engage in reflective practice. Reflective practice is the process of using one's practice to self-assess and identify learning needs (Witmer, 1997). In order to assist nurses to engage in reflective practice, The College Of Nurses Of Ontario has designed a prescriptive thinking map: LEARN (Witmer, 1997). There are five LEARN steps of reflective practice: 1. L - look back on an event that happened and review it; 2. E - elaborate and describe what happened during the event, including how you felt (verbally or in writing); 3. A - analyze the outcomes and consider how to improve the outcomes next time; 4. R - revise your approach and decide how or if you will change it; and 5. N - new trial, when required, by implementing a new approach (Witmer, 1997, p. 14).

Another prescriptive tool that may assist case managers to gain insight about themselves in their roles with clients is A Critical Incident Self-Assessment Exercise (Appendix I). If critical incidents are shared in small groups, group members can question each other's assumptions.

4.3.3 Small Groups

Callin (1996) suggests problem based small group tutorials in an educational setting have the potential to support the self-esteem of students in a way that facilitates perspective transformation. In small groups, students may share events from past experiences and explore the

meaning in a specific situation. This promotes a change in behaviour or beliefs, and facilitates perspective transformation.

One of the roles of the educator is to foster effective group processes (Cranton, 1992). Guidelines or strategies to encourage effective group behaviour include: 1. set a relaxed supportive tone within the group; 2. support openness in communication; 3. encourage the group to satisfy the needs of individuals within the group; 4. give nonjudgmental feedback; 5. practise supportive listening; 6. prevent group think; 7. avoid dominating by talking too much; 8. be warm, responsive, involve all, reconcile differences, compromise and be flexible; and 9. encourage awareness factors that effect group performance (Cranton, 1992).

Group work is conducive to learning interpersonal team and team building skills that are needed for one's lifetime (Woods, 1994). Much of the worklife of case managers is in teams or small groups. They share caseloads with a partner, and are part of a larger community team. Much informal learning occurs at the team level, and formal education in small groups would likely be viewed as a valid and relevant learning strategy. Case managers may even share information written in journals in a small group setting.

4.3.4 Journal Keeping

Journal keeping fosters critical reflection in adult learners (Mezirow et al, 1990). "Keeping a journal may help adults break habitual modes of

thinking and change life direction through reflective withdraw and reentry" (Mezirow et al, 1990, p. 213). In the process of being reflective, and reflective practice, case managers may find writing about their experiences with clients helpful.

Journals may be used for catharsis, description, free writing and reflection (Mezirow et al, 1990). Learning is enhanced when the learner writes something down. Leading language scholars have discovered that humans find meaning by exploring it through their own easy, talkie type of language instead of the language of texts. Role-playing may be a useful strategy to enact what is written in one's journal.

4.3.5 Role-Playing

Role-playing is a technique that encourages learners to view situations or issues from perspectives other than their own (Cranton, 1992). Case managers can use case studies to simulate walking in the client's shoes when exploring the client-centred approach to care. Role-playing can be anxiety provoking but this reaction is fairly typical of any strategy that fosters critical reflection (Cranton, 1992).

Guidelines for role-playing include: 1. ensure objectives of the role-play are clear; 2. ensure participants receive a description of the situation along with a description of the part to be played; 3. ask for volunteers as opposed to assigning; 4. state up front, the expected length of time for the role-play; 5. upon completion, ask the players to report on what happened

and how they felt when they were playing another person; and 6. explore

the validity of the role-playing, and the real life assumptions (Cranton,

1992). Using these guidelines, role-playing could also allow case

managers to simulate what clients experience when approached in a non

client-centred manner.

4.4 Summary

In summary, the plan for the development of the client-centred care

curriculum has been guided by the literature relevant to adult learners,

and transaction and transformation education positions. The aim of the

curriculum was identified and Miller and Seller's (1990) four components

of curriculum development were followed and discussed, including the

scope and sequence. This sets the stage for the plan for implementation

and evaluation that follows in the next chapter. Chapter 5 describes the

Innovation Profiles Model For Curriculum Implementation by Leithwood

and Montgomery (1980). and Patton's (1997) Utilization-Focused

Evaluation Model.

Chapter Five

Curriculum Implementation and Evaluation

5.1 Introduction

This chapter will outline the plan for implementation and evaluation of the client-centred care curriculum. Implementation and evaluation of an educational session for case managers is also provided. The frameworks and strategies discussed in the previous chapters form an important part of a holistic and consistent approach to implementation and evaluation of the curriculum in this project.

5.2 The Innovation Profiles Model

According to Leithwood and Montgomery (1980), implementation is the "process of reducing the gap between images and outcomes" (as cited in Miller & Seller, 1990, p. 255). Images refers to the images held by society of an "educated person", and curriculum guidelines in school programs translate into what society thinks an educated person should know (Miller & Seller, 1990, p. 264). Implementation of a new curriculum "involves teachers changing their practice in accordance with the new program" (Miller & Seller, 1990, p. 264). Implementation is really the attempt to narrow the gap between society's goals and the achievement of students.

5.3 The model's relevance to this project's curriculum

The Innovation Profiles Model is selected for the framework to guide implementation in this project because it consists of a series of steps and identifies obstacles (Miller & Seller, 1990). Although the focus of the model is teachers' activities, Leithwood and Montgomery (1980) assume implementation is really a process of mutual adaptation (as cited in Miller & Seller, 1990). In this project, the adaptation is between the novice curriculum worker/teacher and community case managers. Other assumptions in the model follow. All teachers will not be at the same level of readiness to use a new program. Neither will all case managers. Different teachers will have different needs during implementation. Different case managers will also have different needs. Finally, the size of the gap between current and future case management practice will vary from case manager to case manager.

In order to close the gap, the model's strategy consists of a number of steps. Individual teacher or case manager growth occurs in the movement from one step to the next. The key to successful implementation is what stimulates or inhibits this growth (Miller & Seller, 1990). A brief discussion of the steps in the model is next.

5.4 The steps in the Model

The Innovations Profiles Model consists of six tasks or steps, and evaluation steps (Miller & seller, 1990). Evaluation is discussed later in this chapter. The six steps are subdivided into two phases: steps one to three constitute the diagnosis phase, and steps four to six form the application phase.

In the diagnosis phase, goals to be accomplished, relevant differences between practices suggested by the innovation and actual practice, and obstacles that prevent the differences from being reduced are identified (Miller & Seller, 1990). In order to complete the three diagnostic steps, Leithwood (1982, p. 249, as cited in Miller & seller, 1990) believes a set of nine criteria, or what he calls curriculum dimensions, are required: 1. the orientation on which the curriculum is based; 2. objectives; 3. student entry behaviours; 4. content; 5. instructional material; 6. teaching strategies; 7. learning experiences; 8. the amount of time the student is to spend on activity; and, 9. the means to assess student achievement. The first eight criteria have been discussed throughout the previous chapters, and criteria nine will be discussed in the section on evaluation.

The application phase follows the initial examination and analysis in the diagnosis phase (Miller & Seller, 1990). The purpose of the application phase is to facilitate a change in practice, and to develop

strategies to overcome the obstacles. Procedures are designed and carried out to overcome the lack of knowledge and skill and to restructure incentives and rewards. For example, in this project, a questionnaire was designed to survey case managers.

In the Client-Centred Care Curriculum Learning Needs Assessment discussed in the last chapter, 55% of the case managers who responded to the survey selected therapeutic use of self as the topic for an educational session. The provision of necessary materials and organizational arrangements is also included in the application phase (Miller & Seller, 1990). Arrangements were made with the CCAC for the use of audio visual materials for the therapeutic use of self workshop. Implementation obstacles follow.

5.4.1 Identifying implementation obstacles

The biggest obstacle to implementing the entire curriculum was probably the timing of this project. Before the CCAC, client-centred care was an initiative of the Home Care Program, and workshops were provided to staff during working hours. In comparison, the CCAC was supportive but in a much more limited way than previously. For example, there was support to educate case managers in the workplace, after working hours, and about one content area, only.

In addition, the organization was in contract negotiations with the union, and relationships between management and staff were somewhat

strained. Therefore, the workplace climate was really not conducive to volunteer attendance at a workshop. Other obstacles that could impede implementation were already discussed on page 25.

Fortunately, obstacles can be reframed into opportunities. There was support from the CCAC to provide one educational session to community case managers. In keeping with Leithwood's application phase (as cited in Miller and Seller, 1990), my intent was to make it worthwhile for case managers to attend a workshop by providing them with incentives related to learning, and adult learners.

5.4.2 Summary

The Innovation Profiles Model was described, and it was noted that the frameworks and strategies discussed in the previous chapters need to be considered. Timing was also identified as an important obstacle to implementation. The implementation of an educational session for case managers follows next.

5.5 Request for volunteers

Following identification of the topic, a request for up to 12 volunteers to attend a two hour workshop about therapeutic use of self was included in the survey results distributed to all community case managers. The education was to be provided after regular working hours (4:45 p.m. - 6:45 p.m.) but could be held in a workplace meeting room.

5.6 Therapeutic use of self workshop

Twelve case managers attended the therapeutic use of self workshop. Although the agenda (Appendix J) was followed, dialogue and discussion were very much encouraged. This was quite a reasonable expectation because the attendees all knew each other quite well. Based on the premise that the more self-understanding one has the more available they will be to focus on the client, case managers were the focus of the workshop. Objectives for the workshop were: 1. to promote self-awareness; 2. to facilitate therapeutic use of self; and 3. to introduce implementation strategies. In order to achieve the objectives, the content was related to definitions of therapeutic use of self, intrapersonal relationships and relationship building, transformative learning, and being reflective. Each case manager was given a folder (Appendix K) with handouts relevant to the topic.

As previously discussed, the concept of therapeutic use of self is about how one uses oneself to help clients (Whall, 1988). In keeping with the "know thyself" theme, attendees were given time to complete a self-assessment exercise (Appendix L). This was congruent with being reflective and with the transformation orientation position because it involved case managers in social awareness: their own. Self-assessment can also lead to transformative learning where case managers actually question the way they see the world. The exercise was intended to

increase their own self-awareness and self-knowledge which are prerequisites that may lead to self-improvement. Attendees were given an extra self-assessment form and encouraged to use it another time.

Next, a role-play was used to reinforce transformative learning and meaning perspectives. Attendees observed a simulation of a case manager self-assessing or critically reviewing an experience she had, out loud, while supposedly sitting in her office. The process of interpreting the experience led to much discussion and sharing of personal experiences.

The next role-play was meant to simulate an encounter between the angry daughter of a client and a case manager. The purpose of this role-play was to increase attendees self-awareness of how they feel, think and act in similar interpersonal relationships with clients. A case manager volunteered to introduce the scenario to the group by reading a script with background information that was provided (Appendix M).

Following the role-play, case managers divided into two small groups. Each group was given a handout with five questions for discussion (Appendix N). A recorder was selected in each group and answers were written on flip charts. Upon returning to the large group, information from the small groups was shared and discussed.

Small groups were chosen in order to facilitate perspective transformation. The questions for group work generated discussion about past experiences with clients, and attendees were able to view

perspectives other than their own. These questions were also well within the transaction and transformation orientations.

Near the end of the workshop, a number of strategies to facilitate heightened self-understanding were discussed: 1. case reviews; 2. journal keeping; 3. check lists; (Appendix O) 4. self-assessment instruments; and 5. focus groups. Journal uses were described, and there was discussion about having focus groups in the workplace.

Finally, food and fun were very much a part of this workshop. A catered hot meal was served, and the incentives selected were four McMaster University book store gift certificates. These were awarded in a draw.

5.6.1 Summary

The therapeutic use of self workshop for case managers has been described and the stage has been set for the final guiding framework: Patton's utilization-focused evaluation. The plan for evaluation of the entire client-centred care curriculum, and the evaluation that was conducted of the therapeutic use of self workshop, follows.

5.7 Utilization-focused evaluation

Utilization-focused evaluation is a "process for helping primary intended users select the most appropriate content, model, methods, theory, and uses for their particular situation" (Patton, 1997, p. 22). Primary users are identified and the intended use of the evaluation

becomes the central theme. According to Patton (1997), evaluation findings have been largely unused, and his intent is to "narrow the gap between generating evaluation findings and actually using those findings for program decision making and improvement" (Patton, 1997, p. 6).

Patton's (1997) approach is a humanistic one, and most congruent with the client-centred care curriculum. It is people, not organizations who use evaluation information, and he identifies "the personal factor" (Patton, 1997, p. 44). Personal factor is defined as an identified person or group of people who care about the evaluation and its findings. When such a person or group was present, evaluation findings were used. If a person or group was not present, evaluation impact was absent.

Eight steps are included in Patton's (1997) framework: 1. determine primary intended users; 2. negotiate a process to involve primary intended users in making evacuation decisions; 3. determine the primary purposes and intended uses of evaluation; 4. make design methods and measurement decisions; 5. collect data; 6. organize data to be understandable to users; 7. actively involve users in interpreting findings; and 8. facilitate intended use by intended users (p. 378-379). Clearly, stakeholders are the central focus throughout the evaluation process just as learners are the central focus within the transformation position. In this project, the learners are the primary intended users.

5.7.1 Primary intended users

As mentioned previously, the primary intended users/learners in this project are community case managers. The case managers are the "personal factor" (Patton, 1997, p.44). In addition to case managers, anyone else who is affected by any aspect of the curriculum should have an opportunity to participate in the evaluative process, including myself as a primary intended user, and secondary stakeholders.

Secondary stakeholders would include clients, families, and other health care professionals who work in partnership with community case managers. For example, if the results of the evaluation indicated that case managers' used a client-centred approach in their daily practice, clients should benefit.

How the stakeholders could be involved in the evaluation process should be determined by them. Some examples of ways they could be involved are: focus groups, individual interviews, pre-evaluation surveys, and evaluation questionnaires. These are all methods to get stakeholder input so they can make decisions about the purpose and process of evaluation, and contribute to ongoing communication between the evaluator and stakeholders.

5.7.2 The primary purposes and intended uses of evaluation

The primary purpose of the evaluation process in this project is to determine whether the client-centred care curriculum improves case

management approaches to client care. It is assumed that case managers care about clients and are interested in professional development to improve the quality of care they provide to clients. The intended uses of the evaluation would need to be determined by the primary users and the outcome would include making changes in the curriculum to reflect the evaluation findings. These changes may include eliminating, expanding, or adding to the curriculum. Also, the intended uses of the evaluation in this project would be more meaningful if they were facilitated by the primary intended users, the case managers.

In The therapeutic use of self workshop, one component of the curriculum content was pilot tested with twelve case managers. The primary purposes and intended uses of evaluation for the workshop were explored informally during the session. The primary purpose was to heighten case managers' self-awareness, and the emphasis was on self-assessment. Case managers were encouraged to determine how insightful they were by being reflective. Checklists were provided to help them in the process of self-discovery. Focus groups were one other strategy discussed where case managers could use case studies or critical incidents in an attempt to heighten their self-understanding and self-knowledge. However, in the limited time available for the workshop, formative or process evaluation was completed, and the participants were only formally evaluated about their satisfaction with the workshop itself.

Similarly, the intended uses of evaluating the workshop were to determine whether positive change occurred, whether more education about therapeutic use of self was required, or whether the concept was even useful for their case management practice or not. For example, one case manager asked me how a supervisor would know whether a case manager had heightened self-awareness or not. It could be that the supervisor may never know but may observe improved case management performance, such as more sharing of oneself in client encounters. Many case managers believed the workshop was only the beginning, and more presentations would be beneficial while others stated that all case managers could benefit from the workshop. Ideally, when all the educational modules in this project are completed, case managers could be surveyed to determine whether they perceive themselves to be more client-centred than previously. As secondary stake holders, clients could also be surveyed to determine their satisfaction with case managers' care.

5.7.3 Design methods and measurement decisions

In utilization-focused evaluation, "an evaluator is committed to research designs that are relevant, rigorous, understandable, and believable" (Patton, 1997, p. 297). Patton (1997) describes the paradigm debate between quantitative and qualitative data in considerable detail. It is quite likely that both design methods would have value in this project.

Any use of a measure that provides numbers is quantitative. In the quantitative paradigm, the many human experiences are captured along standardized scales (Patton, 1997). This experimental paradigm may involve comparing a treatment group to a control group statistically (Patton, 1997). For example, participants would be randomly assigned to the treatment group (client-centred approach is provided by case managers who have attended client-centred curriculum education), and the control group (conventional approach is provided by case managers who have not attended client-centred curriculum education). In this way, the extent to which the treatment accounts for measurable changes in participants in order to determine the value of the curriculum in producing the desired change could then be made. Although ideal, this method is likely not practical or realistic in today's CCAC but could be most worthy of striving toward in the future.

The focus of the second paradigm, the qualitative/naturalistic paradigm is the uniqueness of individuals or the program itself (Patton, 1997). This paradigm "conceives of programs as dynamic and ever developing, with "treatments" changing as staff learn, as clients move in and out, and as conditions of delivery are altered" (Patton, 1997, p. 286). The definition of this paradigm could be used to describe the CCAC, and is also very relevant to the curriculum in this project where the focus is on improvement and exploring the effects on participants. In the plan for

evaluation for the project, it is anticipated that there will be changes made to the curriculum, "as practitioners learn what works and what does not, and as they experiment, grow, and change their priorities" (Patton, 1997, p. 286).

For the entire curriculum in this project, both quantitative and qualitative data could be collected. The interviewing method would be helpful for capturing qualitative responses, and an evaluation questionnaire could be used to collect quantitative data. Clearly, the evaluator needs to have a large repertoire of research methods available that can be used on many different problems (Patton, 1997. Different methods are quite appropriate for different situations and purposes.

5.7.4 Summary

In summary, Utilization-Focused Evaluation by Patton (1997) has been described and its relevance to the plan for evaluation of the client-centred care curriculum has also been outlined. Within this project, the primary intended users are the learners and they were also described. Finally, the quantitative and qualitative paradigms and their relevance to this project were discussed. Next, evaluation of the therapeutic use of self inservice/workshop is provided.

5.8 The workshop

It is helpful to revisit the workshop objectives: 1. to promote self-awareness; 2. to facilitate therapeutic use of self; and 3. to introduce

implementation strategies. As previously discussed, the emphasis in the workshop was about individual self-assessment. Self-assessment gives the full responsibility for the whole assessment process to the individual case manager. According to Woods (1994), "whatever knowledge, skills, and attitudes you want to develop, their acquisition should be self-assessed" (p.8-3).

If case managers assess whether they are self-aware, and use themselves therapeutically, the educator evaluates the worthiness of the workshop based on feedback from the participants. In the end, the educator should be able to determine whether the lesson objectives were achieved. In other words, the focus of the evaluation was on process, and not on outcomes, such as possible behaviour changes in case managers, and possible changes in how they provide care to clients.

5.8.1 Workshop evaluation

Twelve case managers participated in the workshop and were asked to complete a Therapeutic Use Of Self Inservice Evaluation form (Appendix P), either immediately following the workshop or within the next few days, whatever they preferred. All twelve case managers completed evaluations.

The evaluation form was divided into four categories: 1. content; 2. instructional methods; 3. learning experience; and 4. environmental factors. Space was also provided for comments.

Under each category, three or four areas were listed on the evaluation form. For example, the following were listed under content: 1. captured my interest; 2. heightened my self-understanding; 3. met my expectations; and 4. met the workshop objectives. Four areas were listed under instructional methods: 1. captured my interest; 2. appealed to my learning style; 3. handouts will be used for future reference; and 4. provided a variety of meaningful methods. Under learning experience: 1. was positive; 2. was relevant; 3. will help me in my work; and 4. conveyed respect for my knowledge and experience. Finally, the three areas listed under environmental factors were: 1. relaxed atmosphere; 2.physically comfortable; and 3. adequate refreshments.

Participants were asked to circle the most appropriate number, based on a scale from 1 to 5. Above the number scale, three happy faces were used as symbols: 1 was symbolized by a frowning face; 3 was symbolized by a face that was neither smiling or frowning; and 4 and 5 were symbolized by a happy face. In other words, 1 was poor, 3 was OK and 5 was excellent. Happy faces were used as symbols because they have been used in evaluating other workplace educational sessions for case managers.

5.8.2 Results

The twelve case managers who participated in the workshop completed the evaluation forms. All of the categories listed on the

evaluation form were ranked as excellent, rated with a 4 or 5, by the case managers who participated in the workshop. The comments that were received are listed next.

Comments:

felt very rushed, needed more time	N=1
longer sessions needed, spread through the office	N=1
divide into smaller groups, i.e.pairs	N=1
need more education available without work stress	N=1
when is the "encore"	N=1
sparked further questioning, future learning	N=1
useful for the diploma in case management program	N=1
thanks, well done	N=3
useful inservice	N=1
use of role play very effective	N=1

Interestingly, all case managers completed the comments section, and some provided suggestions about how the workshop could be improved. The complementary comments and positive ratings attributed to the workshop probably reflect volunteer bias plus the participants were all seasoned practitioners striving for excellence in their roles. The comments about feeling rushed and needing more time were quite valid because it did seem as though participants were being hurried in order to adhere to the agenda in a timely fashion. My concern centred on the fact

that the participants had already worked a full day, and their attendance

was on their own time, therefore, the inservice had to finish on time.

Fewer agenda items would have been better. For example, in order to

allow more time in small groups to analyze the simulated client encounter,

observing Merrill's self-assessment could have been deleted.

Prior to providing the workshop to another group of case

managers, the suggestions for improvement need to be incorporated into

the program. Also in future workshops the results will be shared with the

participants. As discussed by Patton (1997), processes need to be

developed in order for the results to be used by primary intended users.

5.9 Summary

All twelve workshop participants participated in formative

evaluation by completing an evaluation form to determine their

satisfaction with the workshop. During the workshop, there was informal

discussion about what to evaluate, and the intended uses of evaluation.

Results of the workshop evaluation were also provided. In the final

chapter, conclusions, limitations, practical implications, research

implications, recommendations, and the significance of this project to

case managers and clients are provided. Chapter 6 is next.

Chapter Six

Final Perspectives

6.1 Conclusion

This project has described the plan for the development, implementation, and evaluation of a client-centred care curriculum for community case managers at the Hamilton-Wentworth Community Care Access Centre (CCAC). Implementation and evaluation of one of the curriculum components, a therapeutic use of self workshop, was also provided.

Client-centred care is really about how we treat one another, and is supported in the literature. In this project, curriculum was defined as, "an explicitly and implicitly intentional set of interactions designed to facilitate learning and development and to improve meaning and experience" (Miller & Seller, 1990, p. 3). The client-centred care curriculum in this project was designed to provide a set of skills and practices to case managers so clients can benefit. Being client-centred, is an approach to health care that is based on assumptions also used in some approaches to education. For example, the following assumptions are used to describe invitational education, and are equally descriptive of client-centred care:
    People are able, valuable and responsible
    and should be treated accordingly
    People possess untapped potential in all
    areas of worthwhile human endeavour
    Human potential can best be realized by places,
    policies, programs, and processes specifically

designed to invite development, and by people who are intentionally inviting with themselves and others, personally and professionally (Purkey & Novak, 1996, p. 144).

According to Purkey and Novak (1996) the P's of invitational education are people, places, policies, programs, and processes. The P's are also relevant to client-centred care, and provide the framework for what follows.

6.2 Recommendations For Further Consideration

There are general recommendations that would facilitate implementation of the client-centred care curriculum within the CCAC, for further consideration. It is also important to note that all of the recommendations are not related specifically to what was done in this project but are refelctive of my beliefs and values regarding the CCAC. The recommendations are categorized into people, places, policies, programs, and processes.

6.2.1 People

Throughout the course of this project, organizational transformation within the CCAC has been an ongoing process. Restructuring occurred, key managers were replaced, the Chief Executive Officer was hired, and eighteen months later he resigned. Although many outcomes of this process are measurable, those that matter the most are often intangible. One of these is the impact on the people within the organization. The

CCAC's greatest resource is its' people, and after struggling to survive the tumultuous changes, the quality of work life for all staff needs to be revitalized. In order to do so, it is my recommendation that all of the people in the organization receive education about the entire client-centred care curriculum, during regular working hours.

The components of the curriculum: honoring personhood, communicating therapeutically, being reflective, setting goals, and therapeutic use of self are really about building and nurturing relationships. By providing the client-centred care curriculum to staff, the CCAC has an opportunity to model how much it values them. In turn, the education may enhance the abilities of staff to work together within the organization, and to provide optimal customer service to clients. Being client-centred, also needs to be modeled by all of us within the organization, as well as to our community partners, service provider agencies.

Similarly, client-centred care education needs to be provided to our service provider agencies so they know what it is we expect for our clients, and the curriculum in this project could provide the foundation. The staff in these agencies not only represent their own agencies but they are the good will ambassadors of the CCAC as well. All people also need to have a functional place where they want to go and work.

6.2.2 Places

The CCAC moved to a modern, spacious, building over a year ago. Although there have been growing pains, it is an esthetically pleasing and inviting place to work. Being client-centred extends to those within the CCAC, and reaches beyond the curriculum in this project. It is for this reason that I recommend that the CCAC enhance the work environment by having a library on site that would serve as a resource for staff, service providers, and clients and families. Just as the client-centred care curriculum is meant to facilitate learning and to improve meaning so would an on site library. A library would also be congruent with the client-centred theme by heightening the awareness of CCAC staff about new client-centred approaches to care, and by giving them opportunities to review current literature about other health related topics. Another excellent recommendation from CCAC staff has been to develop information packages for clients and families. Clients and families need information to make informed choices. A librarian could prepare packages that provide information about the CCAC itself, client-centred care, specific treatment protocols, or anything else that clients and families believe would be useful. They could also be printed in different languages to reflect the diverse multi cultural population served by the CCAC.

6.2.3 Policies

Currently, CCAC policies and procedures are being designed and developed. It is my recommendation that these policies and procedures need to reflect being client-centred. Ways need to be sought to ensure that all "rules, regulations, and requirements are inclusive, positive, encouraging and involving" (Purkey & Novak, 1996, p. 146-147). Even though all departments within the organization are not involved with external clients, they still need to adhere to client-centred principles. For example, the contracts department are responsible for the Request For Proposal (RFP) process, and are instrumental in awarding contracts for service provision. All of the documents in the RFP process should reflect client-centred care, and only those agencies who demonstrate that they provide client-centred care should be awarded contracts.

6.2.4 Programs

As transformational changes occur within the organization so does the need for changes in educational programs. As previously mentioned, one change in educational programs could be implementation of the entire client-centred care curriculum. The client-centred care curriculum really focuses on a set of skills and practices in order to improve the health and well-being of clients. Prior to implementing one component of the curriculum, the therapeutic use of self workshop, with another group

of case managers, revisions and changes would need to be made to the

program so there were fewer items on the agenda (see page 73).

The CCAC also has a new education coordinator who is

responsible for educational programs, on a half time basis. It is my

recommendation that the organization make this a full time position.

Currently, the coordinator spends much of her time coordinating off site

workshops for staff, and there is little time left to develop organizational

learning skills. If the education coordinator position was full time, she

would be able to actually live the principles of client-centred care, as

outlined in this project's curriculum, and foster learning for everyone

within the organization. In the spirit of inquiry, with a library and a full time

education coordinator, the CCAC would be closer to becoming a learning

organization.

6.2.5 Processes

Within the CCAC, processes can sometimes be cumbersome and

plentiful. It is my recommendation that processes within the organization

be re-evaluated from a client-centred perspective. What value do the

processes add? Are they client-centred, and user friendly? For example,

the majority of case management assessment and service planning tools

are not reflective of the strengths, interests and abilities of clients. If we

are truly client-centred, all of our forms, and processes need to be re-

evaluated and altered accordingly (Appendix D). Consumer strengths

should be viewed as integral "to the planning process so that services are provided and activities structured to maximize and promote existing or potential strengths" (Fast, Chapin & Rapp, 1997, p. 123). Finally, prior to hiring new staff, interviewing processes need to be re-evaluated to determine whether client-centred questions are included on the instrument.

6.3 Limitations

There are two major limitations in this project. The first limitation concerns the timing of the project. As previously discussed on page 59, client-centred care was an initiative of the former organization and not the CCAC. Had this project been completed sooner, under the umbrella of the former organization, it would have been possible to pretest the entire content areas of the curriculum with case managers. Therefore, although the literature supports client-centred care, the client-centred care curriculum remains largely untested and unevaluated.

The second limitation was the lack of opportunity for follow up after the therapeutic use of self workshop. Therefore, this writer is unable to draw conclusions about the effectiveness of the workshop, or whether therapeutic use of self is reflected in case managers' interactions with clients. Although all workshop attendees completed the evaluation, the results are limited. The formative evaluation process only determined case managers' satisfaction with the workshop, and future research is

required to test and evaluate the entire curriculum with a larger sample size to determine whether case managers' personal effectiveness improves and whether clients benefit or not.

6.4 Research implications

According to Cranton (1992), all educators can be researchers. Similarly, all practitioners can "formulate hypotheses, collect information in a systematic way, and come to conclusions which are generalizable to his or her practice" (Cranton, 1992, p. 218). Client-centred care curriculum has several implications for research, and examples of research questions follow. To what extent does client-centred care impact on clients? To what extent does client-centred care compare and contrast with other approaches to client care? Is client-centred care more humanely effective than other approaches? To what extent do case managers know they are client-centred, and what does client-centred care look like? These are only some of the questions that could be addressed by future research.

As the population grows older, lives longer, and values community tenure, future research will become increasingly important to explore humane approaches to client care that are both effective and efficient. Research could also be useful to help identify a common definition and another term that better reflects this holistic approach to care instead of \

client-centred. Person-centred is an example of a term that some health care professionals believe is less jargon oriented.

The CCAC values research, currently participates in research projects, and is interested in quality client service. It is quite possible that the organization may be interested in future research about client care interventions, and this could include testing and evaluating the entire client-centred care curriculum.

6.5 Practical implications

As adult learners, case managers want practical answers that are relevant to their every day practice. As discussed on pages 25 and 26, client-centred care is not without controversies, and some case managers believe being client centred is too time consuming. The challenge is to help case managers see the value in this approach. From a practical perspective, the curriculum in this project does provide content areas that move beyond a philosophical approach into concrete, and practical strategies that are useful in the practice of case management. Clearly, research has shown that the client-centred approach to care needs to be consistent with the realities of daily practice (Clemens et al, 1994). In general, organizational support is essential in the daily practice of case management, and even more so when changes in practice are required.

6.6 The significance of this project

Although the numbers of case managers and clients who might benefit from this curriculum is significant, the actual significance of this project to both groups is yet to be discovered. The project does have the potential to make a significant impact on the personal effectiveness of case managers, and the well-being of clients.

This project has definitely provided significant learning opportunities for myself, and has also served to heighten my passion for the topic. The review of the literature has enriched my knowledge base, and reinforced my interest in life long learning. More specifically, I have learned about the process of curriculum development, implementation, and evaluation; transformative learning; self-directed learning; and teaching strategies reflective of the transaction and transformation education orientations. Also, I am better prepared to educate others, and more aware that there is no such thing as a cookie cutter approach to client-care. In other words, one approach will not and can not meet the needs of all individuals.

This project has also been significant to me because it has sparked my interest and enthusiasm for research in health and social services related to humanistic approaches to care. Canadian demographics show us there will be a dramatic increase in those who are over 80 in the year 2000 to 2010 (14.3% compared to 11.7% in 1991) (Elliot, Hunt &

Hutchison, 1996). We need to start preparing for this increase of aged

citizens, and find out what approaches are humanely effective in helping

elders to take care of themselves. As Canadians, they deserve nothing

less.

6.7 Summary

Although the journey of this project has come to an end,

transformation to client-centred care will only begin "when the fullness of

the human capacity is realized in thought, language, and actions" (Fast,

Chapin & Rapp, 1997, p. 19). According to Martin Luther King, Jr.:

> if you want to move people, it has to be toward
> a vision that's positive for them, that taps
> important values, that gets them something they
> desire, and it has to be presented in a
> compelling way that they feel inspired to
> follow (cited in Fast, Chapin & Rapp, 1997, p. 1V).

In summary, as the new millennium fast approaches, client-centred

care provides a way to move people toward fulfilling their human

potential.

Bibliography

Battle Smith, L., Drake, M.A., & Diekemper, M. (1997).
The responsive use of self in community health nursing practice.
Advanced Nursing Science, 20, 75-89.

Baumann, A., Johnston, N.E., Antai-Otong, D. (1990).
Decision Making In Psychiatric and Psychosocial Nursing. B.C.
Decker Inc.: Toronto.

Bohlin, R.M., & Milheim, W.D. (1994). Analysis of the
institutional motivation needs of adults. Canadian Journal Of Education
Communication, 23, 47 - 55.

Boyd, M.A., & Nihart, M.A. (1998). Psychiatric Nursing Contemporary
Practice. Philadelphia: Lippincott-Raven   Publishers. pp. 60 - 74.

Browne, G., Roberts, J., Byrne, C., Weir, R., Majundar, B., Gafni, A.,
Watt, S., William, D., & Siuji, Y. (1995). More effective and less
expensive community approaches to care of chronically ill: Lessons
from nine studies, working paper series. McMaster University: Hamilton.

Brundage, D.H., & Mackeracher (1980). Adult Learning Principles and
The Application To Program Planning. Ministry Of Education. Toronto:
Queens Park.

Butler, C., Rollnick, S., & Stott, N. (1996). The practitioner, the patient
and resistance to change: Recent ideas on compliance. Canadian
Medical Association Journal, May, 154-159.

Buzzell, M., & Gibbon, M. (1991). Personhood . The Canadian Nurse,
32 - 33.

Buzzell, M., Meredith, S., Monna, K., Ritchie, L. & Sergeant, D.
Personhood A Teaching Package. McMaster University: Hamilton.

Callin, M. (1996). From RN to BSN: Seeing familiar situations in different
ways....Mezirow's Theory Of Perspective transformation. Journal Of
Continuing Education In Nursing, 27, 28-33.

Candy, P.C. (1991). Self-Direction For Lifelong Learning. San Fransisco:
Jossey-Bass Inc.

Cappell, E. (1994) . "What do you mean by quality of care?" It depends on who's asking. Perspectives, 18, 2 - 5.

Clark P.G. (1995) . Quality of life, values, and teamwork in geriatric care: Do we communicate what we mean? The Gerontoligist, 35, 402-411.

Clemens, E., Wetle, T., Feltes, M., Crabtree, B., & Dubitzky, D. (1994) . Contradictions in case management. Journal Of Aging And Health, 6, 70-88.

Cooper, S.,S. (1988) . Teaching tips. Continuing Education In Nursing, 19, 188-9.

Cranton, P. (1992) . Working With Adult learners. Toronto: Wall & Emerson Inc.

Elliot, G., Hunt, M. & Hutchison, K. (1996) . Facts On Aging In Canada. Hamilton: McMaster University.

Evans, L. (1996) . Knowing the patient: The route to individualized care. Journal Of Gerontological Nursing, 22, 15-19.

Fast, B., Chapin, R. & Rapp, C. (1997) . A Model For Strengths Based Case Management With Older Adults: Curriculum and Training Program. Lawrence, Kansas.

Gage, M. (1994) . The patient-driven interdisciplinary care plan. Journal Of Nursing Administration, 24, 26-35.

Gerteis, M., Edgman-Levitan, S., Daley, J. & Delbano, T. (Eds.) (1993) . Through The Patient's Eyes. San Fransisco: Jossey-Bass.

Hamilton-Wentworth Community Care Access Centre Agency Service Plan (1998). Monitoring, Evaluation, Research And Education.

Higgs, J. (1992) . Managing clinical education: The educator-manager and the self-directed learner. Physiotherapy, 78, 822-8.

Jacono, B., & Jacono, J. (1994) . Holism: The teacher is the method. Nurse Education Today, 14, 287-291.

Joshi, A. (1998) . Client-centred case management: Are we there yet?
Aging, Health & Society: News and Views,3 Hamilton: McMaster
University.

Kane, R. & Degenholtz, H. (1997) . Assessing values and preferences:
Should we, can we? Generations, 19-24.

Knowles, M. (1980) . The Modern Practice Of Adult Education.
Englewood Cliffs, N.J.: Cambridge Adult Education.

Knowles, M. (1975) . Self_Directed Learning. Englewood Cliffs, N.J.:
Cambridge Adult Education.

Lauterbach, S. & Hentz Becker, P. (1996) . Caring for self: Becoming a
self-reflective nurse. Holistic Nursing Practice, 10, 57-68.
Law, M., Baptiste, S., & Mills, J. (1995) . Client-centred practice: What
does it mean and does it make a difference? Canadian Journal Of
Occupational Therapy, 62.250 - 257.

McWilliam, C. (1998) . The Challenges and Opportunities. Sackville
Seniors Centre Workshop. Hamilton, Ontario.

McWilliam, C. L., Stewart, M., Brown, J.B., McNair, S., Desai, K.,
Patterson, M.L., DelMaestro, N., & Pittman, B.J. (1997) . Creating
empowering meaning: An interactive   process of promoting health with
chronically ill older   Canadians. Health Promotion International, 12,
111 - 123.

McWilliam, C., Belle Brown, J., Carmichael, J.L., & Lehman, J. (1994) . A
new perspective on threatened autonomy in elderly persons: The
disempowering process. Social Science Medicine, 38, 327-382.

Mezirow, J. (1991) . Transformative Dimensions Of Adult Learning. San
Fransisco: Jossey-Bass Inc.

Miller, J.P., & Seller, W. (1990) . Curriculum Perspectives and Practice.
Copp Clark Pittman Ltd.: Toronto.

Ministry Of Health (1994) . An Act Respecting Long Term   Care: Bill 173.
Queens Park: Toronto. pp. 7-8.

Mold, J.W. (1995) . An alternative conceptualization of health and health care: Its implications for geriatrics and gerontology. Educational Gerontology, 21, 85-101.

Northouse, L. & Northouse, P. (1998). Health Communication Strategies For Health Professionals. USA: Appleton & Lange.

Parse, R. R. (1981) . Man-Living-Health: A Theory Of Nursing. Delmar Publishers Inc. : Pittsburgh.

Patton, M. Q. (1997) . Utilization-Focused Evaluation The New Century Text. Sage Publications Ltd. : Thousand Oaks, California.

Premier's Council On health, Well-Being and Social Justice (1993) . Nurturing health: A new understanding of what makes people healthy.: Ontario.

Purkey, W.W. & Novak, J.M. (1996) . Inviting School Success. USA: Wadsworth Publishing Company.

Rapp, C. (1998) . The Strengths Model. Oxford University Press, Inc. : New York.

Roberts, J., Browne, G., Streiner, D., Gafori, A., Pallister, R., Hoxby, H., Jamieson, E., & Meichenbaum, D. (1995). The effectiveness and efficiency of health promotion in specialty clinic care. Medical Care, 33, 892-905.

Redelmeier, D., Molin, J.P., & Tibshirani, R. (1995) . A randomised trial of compassionate care for the homeless in an emergency department. The Lancet, 354 , 1131-34.

Rogers, C.R. (1951) . Client-Centred Therapy. Cambridge Massachusetts: The Riverside Press.

Rushton, C., McEnhill, M., & Armsrong, L. (1996). Establishing therapeutic boundaries as patient advocates. Pediatric Nursing, 22, 185-189.

Stewart, M.A., Brown, J.B., Weston, W.W., McWhinney, I.R., McWilliam, C.L., & Freeman, T.R. (1995) . Patient-Centred Medicine: Transforming The Clinical Method. Thousand Oaks, Ca. : Sage.

Tanner, C., Benner, P., Chesla, C. & Gordon, D. (1993) . The phenomenology of knowing the patient. Image, 25, 273-280.

Tarnow, K., G. (1979) . Working with adult learners. Nurse Educator, 34-40.

Uys, L. (1980) . Towards the development of an operational definition of the concept "therapeutic use   of self". International Journal Of Nursing Studies, 17,   175-180.

Weinberg, L.,A. & Stone-Griffith, S. (1992) . Alternate methods of teaching: Use of self-learning packets. Journal Of Post Anaesthesia Nursing, 7, 392-397.

Weisel, L.P., & Joshi, A. (1995) . Shifting to client-driven case management services: From vision to reality. Geriatric Care Management Journal, 6 - 10.

Whall, A.L. (1988) . Therapeutic use of self . Journal Of Gerontological Nursing, 14, 38 - 39.

Wilkins, S., & Evans, M. (1997) . Client-Centred Care, Aging And health: Annotated Bibliography. McMaster University: Hamilton.

Witmer, D. (1997) . Reflective practice What does it mean for me? Communique, College Of Nurses Of Ontario: Toronto.

Woods, D. (1994) . Problem-Based Learning: How To Gain The Most From PBL. VStL. Griffin Printing Limited: Hamilton, On.

Appendix A

THE MILLER-SELLER MODEL

Orientation

Evaluation

Aims
Developmental Goals
Instructional Objectives

Implementation
Plan

Teaching
Models
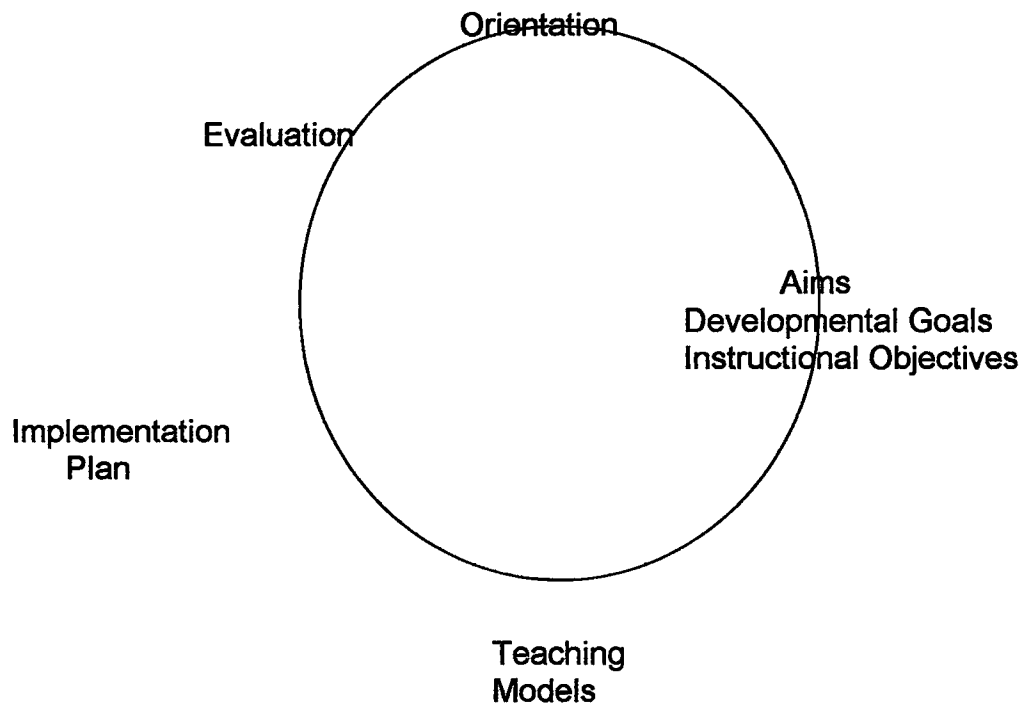
Appendix B

THE INNOVATION PROFILES MODEL

DIAGNOSIS PHASE

- Identify Goals

- Identify Gaps

- Identify Obstacles

APPLICATION

- Design Procedures to Overcome Obstacles

- Restructure Incentives

- Provide Materials

EVALUATION

- Assess Procedures Used in Application Phase

- Summative Evaluation

Appendix C

THE HEALTH PROMOTION PARTNERSHIP
INTERVENTION STRATEGY

*   Building trust and meaning:
    - the client tells his/her story
    - the professional facilities understanding

*   Connecting and caring:
    - the client ventilates struggles with lise and health
    - the professional's role is one of actively listening and
      presencing by using prompts, reflection, and conveying
      understanding

*   Mutual knowing:
    - continuity of relationship between the professional as
      caregivers and the client, not the continuity of the care
      plan

*   Mutual creating:
    - the client and the professional create the client's health by
      "reframing ways of doing and being, and of seeing one's
      self"

Appendix D

Study	Design	Summary of Findings	Implications for CCACs and Case Managers
1	RCT	Specific client-centred interventions can be targeted to clients who will benefit the most.	Future research is needed to determine what client-centred interventions are best for what CCAC populations.
1	RCT	Poor psychosocial adjustment to chronic illness has been associated with life stress, social isolation unfavourable self concept, and poor coping and functioning abilities.	CCAC services that are directed toward improving clients' coping capacity, social support, functional abilities and personal health practices may enhance clients' psychosocial adjustment to illness.
1 2 3	RCT Historical Cohort Analytic RCT*	High utilization of health care services is a type of help seeking behaviour that reflects the unmet needs of some chronically ill clients.	During assessments/ reassessments for CCAC services, clients' psychosocial adjustment to illness, capacities and strengths should be considered. CCAC forms should be refined to include documentation about clients' psychosocial adjustment to illness, capacities and strengths.
3	RCT	Creating client success means building continuity of relationships, participatory decision-making, considering larger life contexts, focusing on health and strengths, and listening versus questioning.	CCAC Case Managers, therapists and service providers need to be aware of the emotional, intellectual and perceived needs of clients by listening to their story. The CCAC's RFP* process will focus on client-centred indicators such as continuity of relationships and participatory decision-making.
4	RCT	The provision of compassionate care improved patient satisfaction and decreased visits to emergency.	Information and data from client satisfaction surveys can be helpful in identifying behaviours clients associate with client-centred care.

RCT*   Randomized Controlled Trial
RFP* Request for Proposal

Appendix E

CURRICULUM CONTENT: HONORING PERSONHOOD

Goal:　　　**Case Managers will honor clients as persons.**

Lesson Objectives	Content	Teaching Strategies
• To facilitat relationship building • To optimize strengths, abilities, interests • To analyze the meaning of knowing client	• Personhood Portrait • Facilitative attitudes • The Strengths Principles • Philosophical concepts of personhood • Bill of Rights (Bill 173, 1994) • Review of the literature • The Health Promotion Partnership Intervention Strategy • How to avoid threats to personhood	• Critical Incident Exercises • Case Studies • Small Groups • Role Playing

Appendix E

CURRICULUM CONTENT: ENHANCING CLIENT-CENTRED QUALITIES

Goal: **Case Managers will enhance their client-centred qualities.**

Lesson Objectives	Content	Teaching Strategies
a) <u>Communicating Therapeutically</u> • To promote meaningful client interactions • To review communication techniques • To analyze interactions	• definition and principles • principles of interpersonal communication • communication techniques • how to facilitate therapeutic communication	• case reviews • small goups • role playing
b) <u>Being Reflective</u> • To heighten self-awareness • To facilitate reflective practice • To improve personal effectiveness	• definition and purposes • explore self-assessment, self-correcting, and self-improvement behaviors	• critical incident exercises • self-assessment exercises • journal keeping • small groups

Appendix E

CURRICULUM CONTENT: SETTING GOALS WITH CLIENTS

Goal: **Case Managers will set goals as defined by clients.**

Lesson Objectives	Content	Teaching Strategies
• To define goal-setting • To provide rationale for goal-setting • To promote individualized client goals • To facilitate goals that are meaningful to clients	• goal definition • why set goals • goal-setting assumptions • CCAC goals • service provider goals • client-based outcomes • evaluating case management goals	• small groups • goal-setting exercises • case studies • role playing

CURRICULUM CONTENT: THERAPEUTIC USE OF SELF

Goal: **Case Managers will use themselves to help clients.**

Lesson Objectives	Content	Teaching Strategies
• To promote self-awareness • To facilitate therapeutic use of self • To introduce Implementation Strategies	• definitions • review of the literature • transformative learning • meaning perspectives • Implementation Strategies	• Self-assessment exercises • role playing • small groups

Appendix F

MEMORANDUM

TO: Community Case Managers

FROM: Sheila Lancaster

DATE: December 10, 1998

RE: Client-Centred Care Curriculum Learning Needs Assessment
    For Case Managers

In order to complete a project for a Master of Science (Teaching) Degree (M.Sc(T)) at McMaster University, I require volunteers to complete and return a questionnaire to me.

My project is about the development, implementation, and plan for evaluation of a client-centred care curriculum for case manager education. For the purpose of my project, curriculum is defined as a set of interactions designed to facilitate learning and improve meaning and experience.

In my project, client-centred care is really about moving clients toward directing their own care, and in the process, enhancing case managers' therapeutic use of self. Client-centred care in my project also means honoring personhood, enhancing client-centred dispositions, and setting goals with clients. Client-centred dispositions foster client autonomy and improve the practitioners' effectiveness. Two of these dispositions are: reflective practice and therapeutic communication.

The CCAC is supporting me in my educational endeavours by providing me with access to you in our workplace. The views expressed here are my own related to my project, and do not reflect the CCAC's understanding of client-centred care.

If you are willing to share your feedback, complete the attached questionnaire. Completion of the questionnaire is strictly voluntary.

The results of the survey are to be:
• reported back to you
• written about in my project
• used to identify a topic so I can facilitate an educational session with a small group of case manager volunteers

If you have any questions, please contact me at extension 3620.

I very much value your feedback, and than you in advance for your participation. Please complete the questionnaire and return to me by _____.

Thank you.

M.Sc.(T) Programme Client-Centred Care Curriculum Learning Needs Assessment For Case Managers

By answering the following questions, you will help me to plan a staff development session. Please indicate the extent to which you agree with the following statements by circling the most appropriate answer.

1. **Therapeutic use of self** - relates to case managers' personal effectiveness with clients, and extending out of self to others.					
I understand the concept of therapeutic use of self.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
I am able to demonstrate therapeutic use of self in client encounters.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree

2. **Personhood** - is about an individual's values, spirituality, history, strengths, and life experiences.					
I understand the concept of honoring the personhood of client.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
I honor the personhood of clients in my practice.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree

3 **Therapeutic communication** - is about communicating in a manner that is meaningful to clients.					
I understand the concept of therapeutic communication.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
I communicate therapeutically with clients in my practice.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree

4. **Reflective practice** - is the process of using health care practice to self-assess, self-correct, and to identify learning needs.					
I understand the concept of reflective practice.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
I use reflective practice in my case management role.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree

5. **Goal-setting with clients** - provides an end that clients strive to achieve.					
I understand the concept of goal-setting with clients.	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
At the time of assessment, I set goals with clients	Strongly agree	Agree	Undecided	Disagree	Strongly disagree

6. The following are five potential topics for a staff development session. Please rank them in order of priority, considering both your level of knowledge and skill in each area and their relevance to your case management practice. (1 is the highest priority and 5 is the lowest):

Therapeutic use of self: ☐
Personhood: ☐
Therapeutic Communication: ☐
Reflective Practice: ☐
Goal-Setting: ☐

7. Please list additional topics you believe would be useful.

Appendix G

MEMORANDUM

TO: Community Case Managers

FROM: Sheila Lancaster

DATE: February 23, 1999

RE: Survey Results and Request for Volunteers

Results of the Client-Centred Care Curriculum Learning Needs Assessment for Case Managers

Many thanks for responding to the Survey Questionnaire give to you in the New Year. The response rate was excellent, 59.6%. For you information a copy of the survey results are attached.

Request for Volunteers

Once again, I am seeking you assistance. I am requesting up to 12 volunteers to attend an educational session. Based on feedback from the surveys, the topic will be Therapeutic use of SELF.

Here is the information about the inservice:

Topic: Therapeutic Use of SELF

Location: Flamborough Room

Date: Tuesday, March 23, 1999

Time: 4:45 p.m. - 6:45 p.m. (super and other incentives(!) will be provided)

If you are willing to attend, please add your name to the sign up sheet posted on my office door.

See you there.

Results of the Client-Centred Curriculum Learning Needs Assessment for Case Managers
February 22, 1999

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1.	**Therapeutic Use of Self:** I understand the concept.	12(39%)	13(42%)	5(16%)	1(3%)	
	I demonstrate its use in client encounters.	8(3%)	16(52%)	7(22%)		
2.	**Personhood:** I understand the concept.	20(64%)	11(35%)			
	I honor the concept in practice.	16(52%)	15(48%)			
3.	**Therapeutic Communication:** I understand the concept.	17(55%)	12(39%)	2(6%)		
	I use the concept in practice.	13(42%)	17(55%)	1(3%)		
4.	**Reflective Practice:** I understand the concept.	10(32%)	20(64%)	1(3%)		
	I use the concept in practice.	7(22%)	23(74%)	1(3%)		
5.	**Goal-Setting with Clients:** I understand the concept.	17(55%)	14(45%)			
	I set goals with clients.	12(39%)	19(61%)			

n=31

Rankings (%) For Completed Surveys

Topics	% Ranked 1st and 2nd choices	% Ranked 3rd choice	% Ranked 4th and 5th choices
Therapeutic Use Of Self	55	10	34
Personhood	24	17	58
Therapeutic Communication	51	20	24
Reflective Practice	41	20	37
Goal Setting	17	27	55

n=29

Suggestions For Additional Topics

1. Spirituality

2. Conflict resolution/management   2 respondents

3. Negotiating skills for goal setting

4. Cultural views of health, disease, major religions

5. Ethical issues in case management - ie. benefit to individual vs. family vs. good to client vs. good to the community.

6. Legislation as it applies to case management.

7. Leadership and case management - how to identify need for and participate in policy and procedure change.

8. Partnership with clients.

9. Hope and control - are 2 important values that are important client's quality of life. Are these captured under personhood?

10. The value of a client-centred approach to case management. How does a client-centred approach improve the quality of care to the client?

11. Barriers to implementing a client-centred approach and how to overcome them (ie. systematic determinants).   2 respondents

12. Risks and risk management in relation to a client-centred approach.

13. Working through different situations when client and family refuse to be client-centred (ie. use of contracts).

Appendix H

Bill 173 - Long Term Care

Bill of Rights

1. A person receiving community services has the right to be treated with courtesy and respect and to be free from mental and physical abuse.

2. A person receiving community services has the right to be treated in a manner that respects his or her dignity and privacy and that promotes his or her autonomy.

3. A person receiving community services has the right to be treated in a manner that recognizes his or her individuality and that respects cultural, ethnic, spiritual, linguistic and regional differences.

4. A person receiving community services has the right to information about the community services provided to him or her to be told who will be providing the community services.

5. A person receiving community services has the right to refuse consent to the provision of an community service.

6. A person receiving community services has the right to raise concerns or recommend changes in connection with the community services provided to him or her and in connection with policies and decisions that effect his or her interests, to the service provider, government officials or any other person, without fear of interference, coercion, discrimination or reprisal.

7. A person receiving community services has the right to be informed of the laws, rules and policies affecting the operation of the service provider and to be informed in writing of the procedures for initiating complaints about the service provider.

8. A person receiving community services has the right to have his or her records kept confidential in accordance with he law.

Appendix I

Critical Incident Self-Assessment Exercise
(Cranton, 1992)

Think back over recent critical incidents that have occurred in your case management role and answer the following questions:

1.   What was the most rewarding incident, because it resulted in satisfaction and pleasure for you?

     _____

     _____

     _____

     _____

2.   What was the most distressing incident, because it resulted in distress and frustration for you?

     _____

     _____

     _____

     _____

3.   What were the behaviours of others at the time of the incident that were most helpful?

     _____

     _____

     _____

     _____

4.   What were the behaviours of others that were least helpful?

     _____

     _____

     _____

     _____

5.   What did you learn about yourself in your most (and least) rewarding incident?

     _____

     _____

     _____

Analyze your responses by exploring the assumptions that underlie your reaction to the Incidents, at the time they occurred and in retrospect.

Appendix J

THERAPEUTIC USE OF SELF

AGENDA

4:45 - 4:50 p.m.	Introduction
4:50 - 5:00 p.m.	A Framework
5:00 - 5:20 p.m.	Self-Assessment Exercise
5:20 - 5:30 p.m.	Observing Merrill's Self-Assessment
5:30 - 5:40 p.m.	A Simulated Client Encounter
5:40 - 6:05 p.m.	Analysis of Client Encounter
6:05 p.m.	Supper
6:10 p.m.	Implementation Strategies
6:20 p.m.	Hypothetical Model
6:30 - 6:45 p.m.	Wrap Up Draw for Prizes Evaluation

Appendix K - Handouts

Therapeutic

Use of

Self

OBJECTIVES

* To promote self-awareness

* To facilitate Therapeutic Use of Self

* To introduce Implementation
  Strategies

DEFINITIONS - Therapeutic Use of Self

* How one uses one's self to help clients

* Employing one's person as a tool

* Using one's person consciously in an attempt to
  establish relatedness

* Know thyself

ASSESSMENT IS:

* Judgement

* required for growth, motivation and progress

"whoever owns the assessment owns the learning"

IMPLEMENTATION STRATEGIES

* Case Reviews

* Journal Keeping

* Check lists

* Focus groups

* Self assessment instruments

JOURNAL USES:

* Catharsis

* Description

* Free writing

* Reflection

* To jog the memory

* Brings lost potentials to the surface

* The key to critical self-reflection

Critical self reflection - is a process of questioning the assumptions and values that form the basis for how we see the world.

* causes use to re-think previous values assumptions.

HYPOTHETICAL MODEL

Therapeutic Use of
SELF

↑   ↓

Client-Centred Care
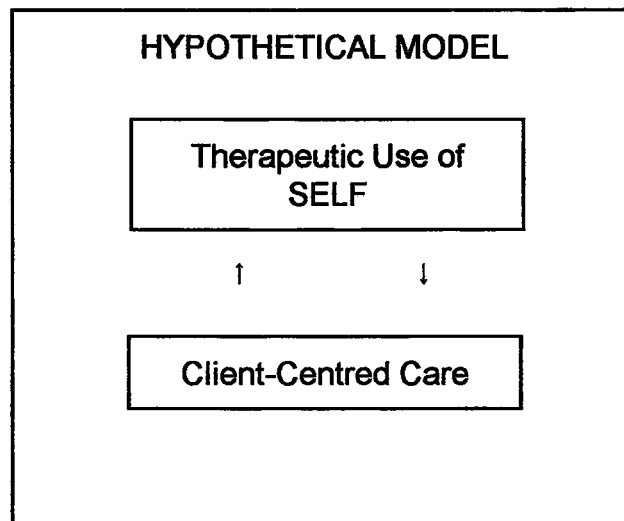
Appendix L

Self-Assessment

On a scale from 1(strongly disagree) to 5 (strongly agree) see how comfortable you are with the following ideas by placing a check mark (✓) in the appropriate box.

IDEA	Strongly Disagree	Disagree	Do Not Know	Agree	Strongly Agree
I am aware of my style.					
I believe in myself.					
I worry about only things I have control.					
I use positive, not negative self-talk.					
I cultivate the qualities I like in myself.					
I avoid cynicism.					
I confront people when I disagree with them when it is something that matters to me.					
I demonstrate caring and concern.					
I am genuine, empathetic and show respect.					
I build trust in client encounters.					
I am open-minded.					
I see things from other's point of view.					
I am aware of my own basic assumptions.					
I actively listen to others.					
I am aware of my own body language and verbal cues and that of others.					
I respond honestly to clients.					
I am skilled (accurate) when I assess myself.					
I know what emotional triggers elicit a negative response in myself and others.					
I know that being self-aware helps nurture empathy, sensitivity and honesty.					
I know that I cannot grow and change until I have faced up to my shortcomings.					
I know that self-knowledge is a life-long process.					
TOTAL					

Appendix M

Introduction To a Simulated Client Encounter

<u>Background</u>

A case manager assessed a client for service last week and determined that 3 hours once a week would be helpful. The client was in agreement with the plan.

Today, the case manager receives a phone call from the client's daughter upset that her mother is not going to get more homemaking. The daughter insists on meeting with the case manager at the CCAC office as soon as possible. An appointment is made for the next morning at 10:00 hours.

<u>The Scenario</u>

Switchboard phones the case managers and announces the daughter's arrival. The case manager takes the daughter to an office she has booked for their meeting.

Let's join them as they begin to sort out the daughter's concerns.

Appendix N

Questions For Group Work

1.   What did you feel and think when faced with the type of behaviour demonstrated in the scenario?

2.   How do you react initially?

3.   How does it make you want to behave?

4.   In the scenario, identify the hot points (triggers) within yourself that would lead you to react the way you do?

5.   How do you manage of cope with the hot points as discussed above?

Appendix O

A THERAPEUTIC RELATIONSHIP CHECKLIST

Here is a 24 item checklist to use to ensure that the principle considerations in a therapeutic relationship are satisfied. An affirmative answer to each question is desirable. You might want to adjust the checklist to your own situation.

1. Am I genuine?
2. Am I empathetic?
3. Am I showing respect?
4. Do I hold the client/family in positive regard?
5. Am I demonstrating caring and concern?
6. Am I building trust?
7. Am I ready to share power?
8. Do I accept differences in client/families?
9. Am I open-minded?
10. Do I see things from others' point of view?
11. Am I aware of my own basic assumptions?
12. Do I really listen to others?
13. Do I pay attention to body language and verbal cues?
14. Am I able to see the person in the assessment process?
15. Do I respond honestly and attempt to be real in my relationship with the client?
16. Do I avoid using medical jargon with clients?
17. Am I aware of the multiple meaning of works and the importance of sharing the same meanings with others?
18. Do I use pictures and written instructions as well as verbal communication?
19. Do I restate what a client has said to check what has been understood?
20. Do I self-assess on a regular basis?
21. Am I reflective after client encounters?
22. Do I alter how I interact with clients based on self-discovery and new insight?
23. Am I willing to learn new strategies?
24. Do I have methods to improve myself in a therapeutic manner?

Appendix P

Therapeutic Use of Self Inservice

EVALUATION

                                  ☹   ☺

<u>Content</u>:

Captured my interest	1	2	3	4	5
Heightened my self-understanding	1	2	3	4	5
Met my expectations	1	2	3	4	5
Met the workshop objectives	1	2	3	4	5

<u>Instructional Methods</u>:

Captured my interest	1	2	3	4	5
Appealed to my learning style	1	2	3	4	5
Handouts will be used for future reference	1	2	3	4	5
Provided a variety of meaningful methods	1	2	3	4	5

<u>Learning Experience</u>:

Was positive	1	2	3	4	5
Was relevant	1	2	3	4	5
Will help me in my work	1	2	3	4	5
Conveyed respect for my knowledge and experience	1	2	3	4	5

<u>Environmental Factors</u>:

Relaxed atmosphere	1	2	3	4	5
Physically comfortable	1	2	3	4	5
Adequate refreshments	1	2	3	4	5

Comments:_____

_____

_____

_____

_____

_____

8451   09