The Work of Long Term Care Case Managers:

The Two Faces of Case Management

by

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Abstract

This study examines work of Long Term Care Case Managers in British Columbia, Canada. Long Term Care is a publicly funded program. That program's mission is to care for chronically ill adults. This care includes allocation of resources such as homemaker services, adult daycare and care facilities. The everyday lived experiences of Case Managers were the entry point to exploring their work. Ethnographic methods were used to collect data including observations of work with clients and caregivers, interviews of Case Managers, and documentary analysis.

The research revealed two facets of Case Managers' work. One facet is the completion of paperwork to meet the organization's need to be accountable. Standardization of people, both clients and Case Managers can be seen as the effect of completing LTC documentation. 'Pixel reality' named for the smallest square of light on a computer screen, is the ultimate outcome when information on LTC documents is computerized. The documentary process strips information from having any resemblance to a real person. However, this stripped-down information is used to make budgetary decisions that dramatically affect the life of real people.

Diametrically opposed is the second facet of Case Managers' work involving support for caregivers/clients. The unpaid caregivers who are shown to be the primary focus of Case Managers' work, do 80-85% of the work of caring for the LTC client. These unpaid caregivers also do some of case management such as monitoring and assessing clients' needs. This uptake of work by families enables LTC Case Managers to 'manage' caseloads of 200 -300 clients.

Case Managers are the human link necessary to adapt the formal Long Term Care program to meet the needs of the unpaid informal caregivers. Analysis of ethnographic field notes revealed work by Case Managers to maintain the delicate balance between allocating scarce LTC resources and "propping up" caregivers to continue their participation in client care thereby fulfilling the mandate of Long Term Care. All of Case Managers' work, the visible documentation and the invisible support of caregivers is essential to meet goals stated in the mission statement of Long Term Care.

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PROLOGUE TO THE THESIS

Prologue

This master's thesis represents a narrative of discovery on the work of Long Term Care Case Managers. The thesis consists of many of the observations, thoughts, conclusions and feelings that were part of the qualitative research process. Like an archeological expedition I would uncover and explicate one level of understanding, only to reveal another layer beneath it.

This research is located in the social world of work and caring. I am a part of the Long Term Care world as a worker; stakeholder in the organization I am examining. The problems and pleasures of the work of Long Term Case Managers are part of my daily life. I care about my work and the people whose lives are touched by that work. Feminist scholars have written extensively about the invisibility of caring in academic texts. One way in which this caring is made invisible is through the "writing up" (Smith, 1975) of research in which all feelings are removed. As caring is a feeling, it too is removed.

I have chosen to allow my caring to remain visible in this thesis. As a reader of this narrative, you may become acutely aware of how I feel about a subject. This is however, not just a thesis about feelings. Other factors are as thoroughly researched. For example, early on in my explorations into the work setting within which Case Managers operate, I observed how the relations of power influenced the conditions of work. The thesis represents an analysis of the ruling relations, both of the formal organizations that control the documentary work of LTC Case Managers and of the informal power within families. This exercise of power between Long Term Care and the family takes place at the 'sites' for caring. Although quite different in their manifestations, these two forces, organizational power and family power, command Case Managers' work. Unfortunately for Case Managers, the thrust of the two powers is usually in opposite directions - one oriented to meet the needs of the organization , the other oriented to needs of client and caregiver (spouse, daughter, neighbour or even paid homemaker). Janus, the Roman god, shown looking in opposite directions would be a fitting insignia for Long Term Care Case Managers.

Chapter 1

Introduction

This study arose from my curiosity, frustration and fascination with the work of Long Term Care (LTC) Case Managers. I had been employed as a LTC Case Manager for two years. When I undertook this examination of the role, I was on leave of absence from a position in Long Term Care in which I was in daily contact with Case Managers. When I was first employed as a Case Manager, I remember being confused for three months as to how to do the job; then suddenly I knew what to do. Saying 'I knew,' does not mean that I was consciously aware but rather that I had somehow assimilated the necessary tasks. I still did not know why I was doing it or -- or even what I was doing.

In master's level classes at university I was introduced to interpretive research. Here finally was a research method that was congruent with my approach to the world. It was familiar and at the same time foreign - familiar and comfortable in its focus on people in a social world, yet foreign and frightening in asking that the researcher participate in the research process and be accountable for her own views. Interpretive research is not tidy and symmetrical, fitting into geometrical 2 X 2 boxes. Rather it is similar to fractionals in mathematics that continue to reveal increasingly complex asymmetry. Using a interpretive approach, close examination of Case Management revealed increasing complexity.

Discussion of the Research Question

Case Management is a complex job requiring multiple skills and extensive knowledge. Case Managers are the front line workers implementing LTC policies in their everyday work with clients and caregivers. Case Managers must meet the needs of caregivers and clients as well as those of the organization. Organizational needs are primarily represented in the LTC form Case Managers fill out on home visits. Case Managers apparently meet clients' needs by setting up services; however a great deal of less visible work is also taking place. The pervasiveness of this less obvious work suggests its essential role in the effective functioning of the LTC program. The extent this work is rendered invisible suggests a deeper, systematic purpose is being served. To date, the exact nature of this work has not been explicated nor has its relations with the more formal work been examined. As LTC is beginning to utilize information technology, it is imperative that all the work of Case Managers, visible and invisible, be more fully recognized before the job is tracked and possibly changed by the anticipated computer systems. This all culminates in my research question-

Research question

1. What is the full nature of the work of LTC Case Managers?

2. How does that work of LTC Case Managers relate to the official mission statement of the LTC program?

The LTC program which I researched operates in Victoria, British Columbia. I have described the setting in detail later in this introductory chapter. As part of the social world in which this research took place, the setting is integral to the reader's understanding of the work. In addition, the phrase LTC means very different things in each province of Canada, and in different countries of the world. It is necessary that these variations be delineated so that the research can be correctly situated.

In chapter 2, I discuss the literature relevant to this study. Numerous writings on activities involved in case management are reviewed in this chapter, along with the equally prolific writings on caregiving. Informal caregiving is usually performed within the family. Foucault (1980) has an interesting perspective on the power of the family in society. Included is a review of writings on the organization of bureaucracies such as LTC and how work is managed. Smith (1975) provides a framework from which to analyze organizations. Standardization and computerization are two of the methods bureaucracies use to manage the overwhelming amount of information.

Case management work in LTC is about to change due to the introduction of information technology for front line use. This may radically change the relationship between Case Managers and caregivers. To examine the current thinking about that relationship, articles on caregiving are included. Some of these writings are descriptions of caregiving and caregivers, others are an analysis of how caregiving in families is constructed in our society. Contemplating the family's role in society led me to the writings of Foucault who analyzes the exercise of power within institutions such as the family.

The review of methodological literature in chapter 3 creates a conceptual framework for my research. Successfully capturing the performance of a Case Manager using a interpretive research method allowed me an examination the activities of LTC Case Mangers. Further analysis links these activities to the guiding forces of power and policies. Institutional ethnography as defined by Smith(1987) made such a connection possible. Using Marx's ontological stance Smith's (1987) institutional ethnography connects the everyday experiences of people to the economic and ruling practices of advanced capitalist society. Expanding the analysis beyond individual data to the power of the organizations in society that direct the work.

In chapter 4, I discuss how my study was organized and carried out. My approach to interviews and personal accountability in the research is discussed. Protection and respect for participants, employees and clients, was an important part of my research. As observations of Case Managers at work forms the majority of my research data, I have included a transcript of one home visit. This is then utilized in the subsequent chapters as data for my analysis.

The first thing that is obvious about the Case Managers' job is the overwhelming amount of work. Thus, chapter 5 is called Case Management On-the-Run. With client numbers of two or three hundred, the LTC offices are always a frantic hive of activity. These activities are the more noticeable tasks of Case Managers - crisis intervention, monitoring and waiting, dealing with the dynamic and complex nature of geriatric health issues. Throughout this melee, the Case Manager must maintain control of the situation to accomplish her work. Playing the role of expert is one method of maintaining control and completing the paperwork.

Analysis of the paperwork and home visits led me to the next layer of case management examined in Chapter 6, The Two Faces of Case Management. My analysis of Case Managers' work revealed two competing forces in case management work. One force is the exercise of power by Case Managers performing work for the Long Term Care organization. This power of the organization is concealed in documents. I use institutional ethnography, to explain the operation of that power. The documents also exhibit the dehumanizing amount of standardization that is omnipresent in LTC. This pervasive standardization includes Case Managers as well as clients and extends further than the documents. Information technology used in LTC eradicates any resemblance of the living person who is being described. Information technology allows remote control of the local LTC programs by the centrally located provincial ministry. Even without information technology, the documents articulate with other government offices, agencies and programs - from the provincial Births and Deaths Registry to the federal government's postal system. For Case Managers, one of the advantages of documentation is that it displaces direct responsibility for the sometimes unpopular decisions that are a component of the work.

These decisions can be unpopular with caregivers who exercise the other power demanding Case Managers' attention. Caregiving can be a never ending task. Not only do caregivers give 80-90% of the care (Chappell, Strain, & Blandford, 1986)) they also perform many of the functions of traditional case management such as monitoring the not survive without help from the informal/unpaid caregivers, the majority of whom are women. In spite of the crucial role caregivers play in accomplishing the mission of LTC, the relationship between Case Managers and caregivers is largely invisible to the provincial LTC organization.

In my concluding chapter, I offer some possible implications for policy and practice in LTC. Of course, as with all research, more questions were revealed as the original questions were being examined. In the process of conducting this research I learned many things about LTC. Considering I had worked in the program for a total of five years, this amazed me. The biggest revelation was the work of caregivers. They are the backbone of LTC and carry out many of the traditional functions of Case Managers. The fact that I learned something about LTC demonstrates to me the value of interpretive methodology. I did not find just what I thought was there; I discovered much more. This new-found knowledge has changed my attitude and has had an impact on my present position in LTC. The intellectual challenge kept me motivated and was a great source of pleasure during the process of researching the work of LTC Case Managers.

Overview of Long Term Care

The generic term Long Term Care is used to describe many programs and organizations. The one commonality is the widely understood intent to assist elderly clients. However, beyond this rudimentary concept, there are many manifestations of LTC.

Each manifestation can function quite differently depending upon the political, financial, geographical and professional milieu in which it is located. The LTC Case Managers' work is embedded in the organizational context in which it is administered.

The Political Organization of Long Term Care

The British Columbia Long Term Care program is a provincially-funded health program for chronically ill people over the age of nineteen. The Capital Regional District, where my research was conducted, is a region of 432 sq. mi. area encompassing Victoria and the Gulf Islands in the province of British Columbia. The LTC program is provincially-funded but administered by the Capital Regional District Health Board (the Capital Health Region as of Apr. 1, 1997). Part of the provincial funding is provided by transfer payments from the federal government. The majority of funds come from the provincial tax base. Therefore, three levels of government, federal, provincial and regional are involved in setting policies for the CRD LTC program. Basically, CRD LTC follows the provincial policies. However, there are exceptions and some policies used in CRD are only applicable locally.

One of the most obvious differences between the CRD and the rest of British Columbia is that the provincial policy allows the client to go on waiting lists for two facilities. One is the Preferred (number one choice)and the other, the Alternate (number two choice). The provincial LTC policy stipulates that if the client is offered a place at her number two choice, she may refuse but still remain on the list for her number one choice.

In contrast, Capital Regional District clients are only allowed one facility choice. However, if after being in a facility for six weeks the client or her family still wish to have the client transferred to another facility, the client's name will be put on the list for the preferred facility and keep the original wait list date. All admissions to facilities are in chronological order according to the date placement was requested. The client may need to accept placement in a less desirable facility because the more desirable facilities with private rooms and private bathrooms have waiting lists of one to three years long. The client may not be able to wait that long. If the client cannot wait, the Case Manager's work is to 'explain' the lack of choice at this moment as compared to the client's previous apparent 'choice.' This kind of policy change, such as having only one facility choice, happens in consultation with the Ministry of Health LTC program. Often, the CRD LTC program is used as a testing ground for policies and programs that then become provincial policy.

Day-to-day operations

LTC offices are housed with the preventive and home care nursing programs in four health units located throughout the Capital Regional District. There are twenty-five Case Managers in the Capital Regional District LTC program along with three Assistant Managers and a Manager. The Case Managers have individual offices or open space cubicles, each equipped with a desk, a chair and a telephone. The Case Managers are assigned a geographical area and are responsible for setting up and monitoring all homemaker and daycare services to clients, along with new referrals, and re-assessments of both the care levels and financial information of clients in that geographical area.

When the Case Manager goes on a first home visit, she must fill out a five page assessment on the client (see appendix A). Part of the assessment process is assigning a 'care level' to the client according to the LTC care level criteria (see Appendix B). There are five possible categories, personal care, intermediate I, intermediate II, intermediate III and extended care. All clients must fit into one of the five categories. The five page assessment form was designed by the Ministry of Health staff when the program started in 1978. Theoretically, the forms can be filled out during the home visit or afterwards in the office. However, the large workloads and the resulting myriad of telephone calls make it impossible to complete the forms in the office during working hours. To manage large caseloads, Case Managers must complete as much of the form as possible during home visits.

Home visits are arranged by individual Case Managers phoning clients to make a mutually agreeable appointment time. This process is initiated with Case Managers when they receive a referral form. This has been filled out by a worker in Central Intake. Central Intake receives all initial referrals from the community for all Care programs of CRD, one of which is LTC and anyone, a daughter, a doctor, even a neighbour, may call to make a referral. When receiving a referral, the intake workers who are 'experts' in the criteria of the various programs screen calls for eligibility. For example the referral form asks if the client has been in B.C. for one year and if she is a Canadian citizen. If the reason for referral turns out to be an acute one such as a broken leg, the referral would be canceled and the person referred to other sources depending on the specific need. If the reason for referral appears to be within LTC's criteria, a referral form is completed. At that time a seven digit number is assigned to the person. That number will remain the same throughout their lives and remains theirs even when they die. The number will follow the person if admitted to a facility, move within the province or even if no service is started.

Because anyone can refer someone to LTC, there is a specific question asking if the person referred is aware of the referral. Many times they are not. The Case Manager must contact the referring party first, to gather information and hopefully to have the person present during the interview. LTC does not have a mandate to care for people who refuse help. This can become an issue, particularly with clients with mental health problems or without relatives. Everyone around the client wants LTC to do something for the client. However, policy decrees that the Case Manager cannot act without the client's co-operation. It is the Mental Health program's mandate to care for mentally incompetent adults. If the person is deemed incompetent by two doctors, under the Mental Health Act the person can be committed to care without consent. If the person has not been deemed incompetent, there is no recourse to see that the client receives proper care. Someone must initiate the process to have the client deemed incompetent. If there is no family, or if they are not involved, there is no one to initiate the process. As caring professionals, Case Managers do not like to see clients in situations that are perilous and yet LTC does not have any legal authority to impose resources or care on anyone.

Personal Perspective

I know this is difficult work as I was a Case Manager ten years ago and I developed an ulcer which I attribute to the stress of the job. I returned to LTC as a facility coordinator for three years before returning to university. When I did the job ten years ago, we had twice the case load Case Managers have now, but there were not the expectations to follow-up on referrals with doctors and other agencies. Also, the severity of illnesses being treated at home was not as intense as at present. For example, now Case Managers frequently have more than one client who is imminently dying. Ten years ago, these clients would have been in hospital. As well, hospitals are discharging patients so early that they are often still very incapacitated when they return home.

At times, hospitals make unilateral decisions without consulting the LTC program that will affect community Case Managers. Two years ago, the Greater Victoria Hospital Society hospice unit unilaterally decided not to admit imminently dying patients; patients were to be admitted for symptom control only, then sent back home to die. This had an immediate and dramatic impact on district Case Managers. They had to fit these very special palliative care clients' needs into the LTC program guidelines and were overwhelmed trying to manage these cases. Sometimes daily case conferences are needed with the visiting nurse in order to keep up with the needs of palliative care clients.

Palliative clients often require more homemaker services than the regular LTC client and by appealing to the Assistant Managers in person, Case Managers may have the usual hours extended on a case by case basis. However, Assistant Managers are not readily available. Also, it is a real guess as to whether clients are about to die immediately readily available. Also, it is a real guess as to whether clients are about to die immediately or if they may rally again. In order to stay within the mandated guidelines, the monthly funding for homemaker hours, Case Managers are required to make 'educated guesses' about when the client will die. If death is indeed imminent, then homemaker hours can be increased but not go over the monthly limit. If, however, the client rallies, it is very difficult to cut the number of hours to someone who is dying.

Summary

The Case Manager's job is a very complex one that requires more skills than merely filling out the Long Term Care form. However, the only officially recognized work of Case Managers is filling in 'the form'. The fact that the form does not 'capture' the real nature of the work is of immediate concern as there are two provincial pilot projects under way to computerize Case Managers' work. The only part of that work which is officially recognized is the documentation, thus rendering much of Case Managers' work invisible. The bulk of case management work is barely visible. This invisible portion is the first to be eliminated when staffing is short due to holidays or illness. All of the work is important for the effective delivery of services. Unfortunately, caring is invisible at the organizational level. Before the work can be successfully computerized, the work must be more completely understood. Having painted the backdrop for enactment of the LTC Case Managers' work, let's look at what the literature says regarding this work.

Chapter 2

Review of Relevant Literature

Literature on a specific subject can be considered the thoughts of writers organized into a prescribed format to convey to the reader a particular message. The books and journal articles reviewed here contain research and conclusions drawn from studies of case management and related subjects. I have selected these pieces of literature because they describe case management, caregivers with whom Case Managers work, the power of the family and the societal context in which case management operates. This literature sets the stage for my research by creating an intellectual backdrop in front of which my research was performed.

Case Management

Definition

There are many definitions of case management. A brief one that appears to match the duties of the LTC Case Managers can be stated as a professionally staffed program whose mandate it is to offer "those services that provide initial client needs assessment, care planning, making arrangements for services and ongoing monitoring of clients needs" (Mutschler & Callahan 1990). Many of the studies on case management are done in the United States. Since the USA does not have a socialized health care system as Canada does, the comparisons are limited, however they are often helpful as they can examine groups receiving different kinds of service delivery. An example of this is a study done in the United States that looked at two groups of service users. One group utilized case management and the other group did not (Mutschler & Callahan, 1990). This scenario would not be possible in Canada with its universal access to health care. In Canada, there is a professional obligation to inform clients of their right to receive services. We could not withhold services from clients simply to provide a control group for research. It would be considered unethical. The result of the US study on case management is interesting. The group which did not receive case management did not show any differences in mortality, morbidity, and institutional use from the group that did receive case management (Mutschler & Callahan, 1990). The focus of the study's evaluation was client indicators and even those were simply quantitative, with no consideration for quality of life. My research in studying the work of Case Managers has a broader focus, including the Case Managers, caregivers and clients.

Numbers Crunch

It is common in the research of case management not to specify the number of clients on caseloads. This suggests there is a common idea which is taken for granted. When numbers of Case Managers caseloads are mentioned, they are between thirty and seventy-five clients. I have found no studies on case management of 200-300 clients such as the CRD Case Managers have. Although the actual numbers are not often mentioned, one study went so far as to say that forty to sixty was the ideal number for case management (Ellis 1984). The CRD Case Managers are carrying caseloads five times that number. What kinds of clients do these numbers represent? How can CRD Case Managers do work even approximating the work of case managers with thirty clients?

My own experience with a large caseload is one of almost constant crisis management. This happens partially because of the frailty of the clients and the sudden changes in their health. The numbers also contribute to clients not being seen until there is a crisis. These enormous case loads do not allow for close follow-up except in the most extreme cases-- in other words, situations that require crisis management.

In thinking about crisis it is helpful to have a theoretical framework in which to consider the situation. For this I will use Caplan's crisis theory (Infante 1982) which divides crisis into three stages-- pre-crisis, crisis and post-crisis. It must be kept in mind that the "crisis arises from the person's emotional reaction to the event not the situation itself."(Infante, 1982, p.11). Ideally, the time to intervene in a crisis is in the pre-crisis stage when the client's "disequilibrium" can be returned to the state of equilibrium that existed before the event. However, by the time the Case Manager is involved the client is past the pre-crisis stage and is in full blown crisis. As Infante so succinctly puts it "Crisis is a call to action"(p. 11). LTC Case Managers are constantly being 'called to action'. With a case load of three hundred, at least one or more clients is on crisis in any given day. Case Managers, the workers could truly be called Crisis Managers.

Dynamics

The dynamic nature of the patterns of service used by the frail elderly also contributes to the crisis nature of the work. In the study by Mutschler and Callahan (1990) both the services used and the health of the frail elderly changed constantly throughout the year in which the data were collected. Service patterns were defined as use of homemaker services, case management, and medical services both in the community and in the acute care hospital. After one year, one third of the sample was lost, twenty-six percent had died and another twelve percent could not be located by researchers. Six months into the study, nearly three in ten elders of the available sample used a different pattern of services than they had at the beginning. These findings led the authors to question whether workers in a case management/assessment single entry point into the system would be overwhelmed by the dynamics of the changing needs of the frail elderly (Mutschler & Callahan, 1990). CRD LTC has such a single entry system as clients must be seen and assessed by Case Managers before they can receive LTC benefits.

LTC Case Managers do appear to be overwhelmed at times by the demands of the clients. CRD Case Managers do not have the time to do standard case management as described in the literature. However, somehow the job gets done. Perhaps the caregivers, who are the ones closest to the client, are performing many of the duties of case management for the frail elderly.

Complexity

The majority of LTC clients are elderly. These people have lived a long time and are possibly the most complex of all human beings (Falcone 1984). The complexity is due to the fact that the longer we live the more experiences and adjustments we have had to make in response to the physical, psychological, social and environmental events that continue to occur throughout our lives.

The LTC system also represents a complex bureaucratized set of relations. This coupled with the primary client grouop make case management a demanding job (Garner 1984). The frustration of trying to meet the expectations of clients and caregivers is reiterated in a study which used occupational therapists as primary Case Managers (Ellis, 1984). In Ellis' study, cost effectiveness was of primary consideration. The aim of the research project explicitly stated that care at home must cost less than institutional care. Occupational therapists, with a back-up team of nurses and social workers, were very effective in providing case management services in terms of the stated goal of the project. However, case management took up all of their time and therapists estimated that they were only able to follow-up 15% of the referrals made to them for specific occupational therapy. Ellis (1984) states "The project's time limited design did not permit provision of a greater amount of direct service."(p. 3). This overwhelming of workers by the needs of clients is a frequent theme in studies of case management.

Gatekeeeping

One of the articles on case management written in the United Kingdom pointed out that studies done in the United States do not mention resource allocation as part of the work of Case Managers (Ellis, 1984). Although we have a different funding arrangement in British Columbia than in the United States, here as well resource allocation is an important part of the Case Managers' job. This allocation is well organized through the LTC assessment form. The form designates the care levels of the clients, and this in turn dictates the number of homemaker hours that a client may have per month or the type of facility the client may enter. Within LTC facilities, the care levels determine the funding level for the facility. Care levels also regulate the type of staff employed and the amount of staff-time a client may receive.

Frequently, studies on case management directly state that cost saving is a goal of the project(Mutschler & Callahan, 1990). Other studies only allude to the cost of operating homemaking services. For instance, Anglin (1992) states that case management's goal is to "manage a number of clients within a given amount of time and provide optimum service"(p.84). The Ontario Association of Case Managers refers to case management as "the key approach to resource allocation" (Ontario ,1993, p.1). Although case management has been proclaimed the answer to the problem of trying to do more with less, several studies have shown that it does not save money. Halamandaris (1990) argues that case management does not curb costs but in fact only creates a "bloated bureaucracy"(p.6) that eats up savings. The savings represent the difference in cost of caring for the elderly at home as opposed to institutional care. She also posits that case but also increases costs. Halamandaris' conclusion is that "case management is a signal that money is more important than people, paperwork is more important than hands-on care"(1990, p.7)

Unfortunately Halamandais may be correct in her assertions. Case management in the CRD LTC program does appear to be functioning for the benefit of the organization not the clients. And certainly there is an incredible amount of paperwork which again appears to be meeting the organization's needs not the needs of clients.

Caregiving

Caregiving is a difficult word to define. Some of the difficulty lies in our unconscious expectations about families and women's work. The definition is further obscured by the scholarly designation of informal and formal caregiving, a set of words that themselves subvert reality. Caregiving is women's work the vast majority of the time, that much is indisputable. However, it is often not acknowledged as work. Furthermore, in a reversal of our usual expectations of being paid for work, caregiving costs caregivers. As well, workers/caregivers are often punished when they can no longer cope with the demands of the job. In spite of these obviously negative qualities about caregiving, women relentlessly continue to perform this function in our society.

Women and Caregiving

The majority of caregivers are women (Aronson 1990; Stoller 1990). Very few men remain caregivers once the tasks become personal such as toiletting. The female domination of this field is taken for granted; often in studies it is alluded to by indirect means. In Cattanach and Tebes' (1991) study, a caregiver was defined as either a daughter or a daughter-in-law. Both these words denote a woman, and the subjects were all women. The fact that the definition itself did not include men as a possibility, was not even commented upon. This demonstrates the insidious assumption that caregivers are inevitably women. Another way this fact is disregarded, is when caregivers are involved as research subjects. Caregivers are referred to by gender neutral terms such as 'family members' 'middle-aged children' or 'extended family' (Cony 1991); often there is no acknowledgment of the fact that the majority of caregivers are women.

The Invisibility of Caring

This invisibility of caring is a problem that recent feminist analysis makes evident. The weaving of love and labour into women's caring, socially constructs the two facets of caring (Baines, Evans, & Neysmith 1991a). This message to care is transmitted to females at a very early age (Reitsma-Street, 1991). As Susan Reverby (1990) states, women "have been given the order to care in a society that refuses to value caring"(p. 133). One factor influencing this lack of value given to caring is the modern industrial society's emphasis on money making. This gives prominence to the public "productive" work of men (Baines, Evans, & Neysmith, 1991b) and renders the private "processive" work of women invisible as it is not remunerated. The invisibility of the caring work arises from being hidden in the home, undervalued by society and associated with women.

It is not only caring that is invisible. Even clients are in many ways invisible. As Kathy Ferguson says in her article "The Client as the Second Sex" (1984) "the lowest rung of the organization's internal class structure is occupied by the clients."(p. 40). All too often, organizational charts neglect to include clients, as if their presence were somehow superfluous to the running of the organization. The title refers to Simone de Beauvoir's book, 'The Second Sex' that explicated some of society's prejudices against women. Ferguson's article discusses prejudices against clients in the welfare system. In my analysis of LTC, I found the same kind of thinking; the client is often invisible.

Love and Labour

Caregiving includes caring *about* someone as well caring *for* someone (Baines, 1991; Abel & Nelson, 1990). This overlay of emotional ties can conceal the hard work that is done in the instrumental or task-oriented portion of caregiving when it is done by family members (Rutman, 1995). Family caregivers of the elderly do not usually seek the job. Nor do they generally foresee what changes time and deteriorating health will bring to their role (Rutman, 1995). While it is work that caregivers are performing, it is "...embedded within long-time, evolving social relationships." (Rutman, 1995, p.2). The primary social relationship of caregiver and care receiver further obscures the fact that the tasks and activities of caregiving are work.

Likewise, the emotional or caring *about* portion of caregiving is rendered invisible when remunerating formal caregivers. When caregivers are paid, only the tasks performed are considered valuable. Caregiving like housework, is considered unskilled (Stoller, 1990). As well, these low status and poorly recognized activities tend to be poorly remunerated (Rutman 1995). The complex interactions required to support the care receiver when caring *about* a person are not taken into consideration when remunerating.

When women enter the public domain, 'caring' roles are simply an extension of their role in the family. In spite of progress in women's equality, employers still do not expect women to be breadwinners (Baines, et al., 1991b). This is often used as justification for women's lower wages (Baines, et al., 1991b). The private and public sectors of the formal care industries heavily rely on disadvantaged women of the work force. Thus immigrant and visible minority women are often hired at poverty-level wages (Neysmith, 1991). The poor pay and working conditions of paid homemakers are reflected in the turnover rate in homemaker agencies. Over 50% of employees leave their jobs every year (Neysmith, 1991). LTC clients, most of whom are fragile and frail elderly women, must continuously re-establish relationships and routines with an endless succession of 'new' homemakers. Clients must continually re-orient new homemakers who are employed in a supportive role. In fact, the constant turnover results in an unremitting drain on the clients' energy. Therefore a major impact on the quality of the care received by LTC clients is apparent. This devaluing of women's caring work affects women in the work force as homemakers, women who have informally cared for others and those who now require care themselves (Neysmith, 1991). Paid or unpaid, caregiving is labour.

Caregiving, as analyzed using Foucault's (1980) definition of labour, takes on some interesting angles. He delineates labour functions as having three parts. The first is the productive function. Caregiving produces particular types of relations between people. The second aspect is the symbolic function. There is a perception that women are not 'good women' unless they are caring for someone (Reitsma Street, 1991). The last function is the *dressage* or discipline. Caregiving produces relations that hold people together through linguistic (i.e. symbolic) means which people enact together via regimes of discipline collectively defined. The marriage vow of "until death do us part" serves to bind caregivers to clients, no matter how difficult caregiving may become. The labour of caregiving is as applicable to informal caregiving as it is to formal caregiving.

History of Formal Caregiving

The historical developments that make caring work invisible are rooted in our patriarchal capitalist society. In "The Politics of Health in the Eighteenth Century" Foucault (1980) describes how hospitals developed as supporting structures for permanent staffing of the population by medical personnel. Development of the medical profession was built on the acquiring of power due to exclusive knowledge (Muff, 1988). But as Foucault states, power cannot be "made sense of outside of economic processes and the relations of production."(1980, p.188). It was necessary to control the health of the population in order for individuals to be productive in the new ways of organizing work that emerged during the Industrial Revolution. Hospitals were no longer places "...to give assistance but of therapeutic action. The hospital would function as a 'curing machine' "(Foucault, 1980, p. 180). In this way, the hospital became "an essential element in medical technology" (Foucault, 1980, p. 180). This emphasis on 'curing' in the hospitals replaced the traditional 'caring' regimes (Foucault, 1980). What is implied is that curing becomes the goal of health care. The aim is to have functional workers. Furthermore, 'curing' becomes a well-remunerated medical male domain; 'caring' becomes a poorly-paid invisible female domain, both professionally and personally (Reverby 1990).

Formal and Informal Caregiving

The differentiation between formal and informal caregivers, as defined by researchers, is really the difference between those paid and unpaid. These categories were created by researchers, and reflect their view of the world. Caregivers may disagree. *Formal* denotes a correct, if somewhat stilted and aloof performance, whereas *informal* suggests a casual, cozy and natural act. The use of words such as *formal* and *informal* belies the essence of caregiving, paid or unpaid. In one day, caregivers may switch from informal caregiver role to formal caregiver role and back again, as needed. The caregiver must still find the energy for all the demands made upon her, paid or unpaid. The words themselves, namely *formal* and *informal,* are a smoke screen for the realities of caregiving.

Caregiving involves economics and emotions in equal quantities. The economic aspect of informal caregiving should be acknowledged. Caregiving women are paying a large personal price. Time, relationships, economic opportunities and their lives are sacrificed in the name of informal caregiving. Formal caregivers are grappling with the same economic and emotional sacrifices. Their emotional support of clients must be recognized. Paid caregivers require a reasonable wage as compensation for their work and recognition for the important role they play in the lives of clients.

Formal care represents only 15-20% of the care given to the elderly. The other 80-85% is given by informal caregivers (Chappell, et al. 1986). In the literature, some references suggest the informal-unpaid system saves money (Aronson 1990; Ellis 1984; Braithwaite 1992). There is acknowledgment that it is public funds being saved at the expense of informal caregivers. Informal caregiving is essential to the whole system of caring for the elderly.

The invisibility of caring exists at the personal level, the family level, the LTC system level, within the political system and in society as a whole. Without the unpaid labour of informal caregivers, the LTC system would be bankrupt overnight. It is this unremunerated labour that allows clients to remain in the community, thus avoiding costly placement in care facilities. Foucault's notion of 'discipline' provides an explanatory framework for understanding how such extensive work comes to be incorporated into societal practices and expectations. The number of homemaker hours would increase astronomically if wives, husbands, daughters, daughter-in-laws and neighbours did not carry the majority of the caregiving burden.

Even in respite care the covert assumption is caregivers should be doing the majority of this work. LTC is benevolent in allowing caregivers the occasional break from 24-hour, 7-day a week duty. The minority of time given by formal respite care is paid by LTC. Women never perceive they have a choice to be a caregiver or not (Neysmith, 1991). Perhaps they are not given a conscious choice because the cost of caregiving is so high..

The Cost of Caregiving

Women's work of caregiving is so invisible that it is the norm for informal caregivers to pay a price for doing the work. This is highly unusual in our capitalistic pay is a decrease in physical and mental health, decreased satisfaction with their other relationships and lost opportunities to work at paying jobs.(Cattanach and Tebes 1991; Smith, et al. 1991; Walker & Allen 1991). It is understandable that rates of depression are higher among caregivers as compared to their peers (Whitlatch, Zarit, & von Eye. 1991). Caregiving is hard work physically and mentally, a fact which is not acknowledged by society. It is understandable that caregivers often feel helpless and frustrated.

The negative consequences of caregiving are so common that this phenomenon has been given its own phrase - caregiver burden. There have been several studies focusing on this aspect of caregiving (Cattanach & Tebes, 1991;Vitaliano, Young, Becker, Maiuro. 1991a;Vitaliano, Young, Russo 1991b). Vitaliano (1991) went so far as to devise a screening tool to measure the amount of distress, or caregiver burden, being experienced by caregivers. Some of the research findings resulted in measuring variables of caregivers with low resources and high vulnerability. It was found that caregivers with this combination of factors were especially at risk for high caregiver burden. When the caregiver does not have the usual resources to do the job, she 'pays' with her physical health, her mental health or stress in her own relationships (Smith, et al. 1991; Walker & Allen 1991; Whitlatch, et al. 1991)

When the caregiver can no longer physically or mentally care for the client researchers call the situation, 'caregiver burnout'. Caregiver burnout is the most extreme form of caregiver burden. Significant consequences to the formal caregiving system has led to a wealth of research in the area. When caregiver burnout occurs, the informal caregiver can no longer function and the formal caregiving system must replace the informal caregiver (Braithwaite 1992). This is of concern to governments and funding agencies because of the enormous increase in cost when informal care escalates into full-time formal caregiving. As previously mentioned 80-85% of caregiving in Canada is informal. If that were to suddenly cease, the LTC budget would have to be increased to pay for the equivalent formal care. Even the capital costs to build facilities to house all these clients would be prohibitive.

Rewards of Caregiving

In spite of the well documented negative effects of caregiving, the question of why caregivers give care is seldom asked. There is the feminist viewpoint that women are socialized to caregive. If they don't, there is personal and societal punishment for failing at the job (Baines, Evans et al. 1991). The message that it is a woman's duty to care is transmitted at a very early age (Reitsma-Street, 1991). An existential view is that caregiving is suffering and suffering is a way to find meaning in life (Farran & Keane-Hagarty, 1991). At the other extreme is the market economy standpoint that women make less money than men and therefore, the lost opportunity cost is less for women. A caregiver "engages in family health production to receive utility (that is, satisfaction) from providing services to the physically impaired elderly" (White-Means & Thornton 1990), p. 759). Women therefore are caregivers because they are cheap labour.

In my search of the literature, the closest researchers have come to actually asking the caregivers was recorded in Rutman's (1995) research carried out in Victoria. The purpose of the research was to hear from caregivers themselves regarding the caregiving role and ideal environment in which to peroform the role, with a special focus on the experiences of powerfulness and powerlessness. The subjects were formal and informal caregivers of elderly people and children. Although the question asked was not "What do you get out of the caregiving relationship?", the answers revealed five themes of powerfulness that may shed some light on the subject of caregiving rewards. Caregivers reported feeling powerful when they

- were able to effect positive change to benefit the care receiver
-recognized and valued their own capacities and expertise
-were able to share their knowledge and skills to assist others
-knew that their knowledge and opinions were valued by others; and
-recognized their own needs in terms of self-care and made time for themselves.

(Rutman, 1995, p. 37).

These show themes of caregivers being effective and respected for their knowledge. The results were the same for formal caregivers and informal caregivers.

Although not mentioned specifically, it is apparent when reading over the list of the rewards of caregiving that maintaining control is important to the caregiver. Control over the client is a small aspect. More importantly, caregiver control the *care* of an incapacitated client. The caregiver can say when the help will come and if it is satisfactory. She can complain and can correct inappropriate care services. This is especially needed when the care receiver is demented, but even a severe chronic illness can leave the care receiver little energy to deal with others. Much of the caregiver's power is lost once the client leaves the home and is placed in a LTC facility.

Summary of Caregiving

To encapsulate, informal/unpaid caregiving is an absolutely essential part of the care of LTC clients. Without it, the government program would be completely overwhelmed with the current and escalating demands. Women, who remain the vast majority of caregivers are unrecognized in their contribution to the functioning of the LTC system. With scant organizational acknowledgment of their contributions, caregivers suffer physically, emotionally and financially for their efforts. In spite of the negative consequences of caregiving, women continue to give care. By caregiving they can control the care given and protect the care receiver from difficult situations. Validation for the tremendous amount of work that caregivers perform within the family may help to lighten the burden for all involved. The family as the location of informal caregiving, has its own relationships and power.

Power of the Family

I am using the word power as defined by Foucault (1980). Power is " in reality an open, more-or-less coordinated... cluster of relations." (p.199). In my study, the power of the State is explicated in the relationship between LTC Case Managers and clients/caregivers/families. However, in this study, family power is confined to the home. Family power is exercised through the constitution of relationships between family members. This power is revealed in concrete actions such as, placement of a family member. The 'incorporation' (Foucault, 1980, p. 125) of the power was necessary during the Industrial Revolution. 'Incorporation' in this context denotes the bringing into the body (corps). To govern workers' everyday behaviour, access to the actual bodies of people is necessary. It is the concrete nature of acts of power that are able to be used for analysis. The State and the family both have power but in different spheres. ,

The power of the family has existed for much longer than the relative newcomers to human relations, state bureaucracies. As Foucault contends there are absolutely specific forms of power exerted within the family. This power is constituted through and used by the superstructure of society. The forms of power exerted within the family have been developed and expanded by the state in institutions such as education and health care(Foucault 1980).

As previously mentioned, Case Managers cannot force a resistant client to accept homemaker help or placement in a LTC facility. The family must convince the client. Families have the power to coerce the client to go into a care facility or accept homemaker help. This point is very evident when there are no family members to compel the client to accept help. Case Managers spend hours on the phones listening to neighbours, friends, and sometimes even the police telling the Case Manager "something must be done" about the client. However, nothing can be done if there are no family members to exert that specific kind of power that is the exclusive domain of the family or someone with committeeship of the person. According to Foucault(1980) " the family is assigned the linking role between general objectives regarding the good health of the social body and the individual's desire or need for care" (p.174). Without the link of family power to State power, LTC Case Managers are powerless.

There is a reciprocity between the power of the family and the power of the State (Foucault, 1980). The State supports the family as long as the family supports the state/capitalism. The power of the family must be taken into consideration in any analysis.

> Absolutely specific forms of power are exerted within the family...State and familial forms of power have each retained their specificity and have only been able to interlock so long as the specific ways in which they each operate have been respected.
>
> (Foucault, 1980, p. 189)

The family is a "privileged segment, because whenever information is required concerning the population, it has to be obtained through the family."(Foucault, 1991, p.100). The state is the "meta-power" (p.122); the codification of many other power relations.

Long Term Care as a provincial government program, is dependent upon the power of the family in order to function. Case Managers are compelled to do the family's bidding even though it is in direct opposition to the client's wishes. LTC has power outside the home. For LTC matters, it is the family that has the ultimate power for its family members. This family power is necessary for the functioning of Long Term Care in society.

Societal Context of Case Management

Ruling relations are the practices necessary to govern, manage and administer our advanced capitalist society (Smith, 1987). These organizational processes are accomplished by "a loosely co-ordinated apparatus that we will call the ruling apparatus" (Smith, 1987, p.61). This apparatus includes all levels of government, systems such as health care, and professional bodies. The " co-ordination is achieved by inscription in a record." (Smith, 1987, p. 62). The inscription or recording, in the case of LTC is done on the LTC1 form. This form that Case Managers complete lends itself well to documentary analysis. Smith's work on the "social relations" can be used to explicate how the assessment of a LTC client can be connected to the ruling relations and economic practices of our society.

Ruling Apparatus

Long Term Care, the Ministry of Health, the provincial government and the federal government are a part of the ruling apparatus. Dorothy Smith (1987) defines these institutions as a complex of relations forming part of the ruling apparatus, organized around a distinctive function--(for example)... health care..." (Smith, 1987, p. 160). Foucault (1980) in his book "Power and Knowledge" defines the apparatus as

> ...a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions - in short, the said

as much as the unsaid. Such are the elements of the apparatus. The apparatus itself is the system of relations that can be established between these elements.

(p. 194).

In my research, I have followed the "complex relations forming the ruling apparatus" (Smith, 1987, p.160) that govern health care through to the everyday experiences of those engaged in the work of applying them. The organizations involved in these "ruling relations" are various levels of government contributing to health care of the population.

Documentary Reality

An essential part of the organization of social relations is the 'documentary reality' that is created (Smith, 1975). The creation of documents produces a knowledge that is socially constructed, not a simple recording of the facts. " The LTC 'client' does not exist until the Case Manager completes the LTC1 form thus creating a 'client' out of a person who was referred to Long Term Care. (Smith, 1975). Documentary reality also removes the local and the historical from the documentation. These documents mediate between the known and the knowers which in this case are the workers of LTC and its service providers. Case Managers are absolved of any direct personal responsibility for restricting resource allocation by the documents that externalize consciousness (Smith, 1975).

When exploring the concept of 'documentary reality', it is important to remember that documents used by workers in organizations such as LTC are " not initially an event or object that is subsequently given objective form" (Smith, 1975). The process of producing the document itself " influences the production of 'facts' "(Smith, 1975, p.101).

An 'extended care' client does not exist until the Case Manager labels her as such. A label of extended care does not begin to describe this woman or any other LTC client. The very process of attaching a care level label to a client does not reflect the client's needs and desires but rather the LTC program's policies and practices.

The first step in the LTC process is an assessment (see Appendix A). Documentation of this assessment is then filed in the LTC records. The record is used to order homemaker services, daycare, or request placement. A copy of the record is sent to the appropriate service provider. The LTC assessment form (LTC 1) is the first information any worker in those diverse settings would receive about the client. However, they are not reading about the human interaction that took place between two people, the Case Manager and the client. They are reading about the 'client' (Smith, 1975) who has been socially constructed into the documentary reality of the LTC assessment form.

According to Dorothy Smith (1987) this "documentary reality" removes the local and the historical from the documents. "The text's capacity to transcend the essentially transitory character of social processes and to remain uniform across separate and diverse local settings is key to the distinctive social organization and relations they make possible" (Smith 1990, p.168). The original interaction was between two people, the Case Manager and the client. But in the documentary reality, the historical and local have been removed. The resulting recorded information is treated as though it had been acquired without any human interaction.

The creation of documentary reality mediates relations between the knower and the known (Smith, 1975). The information so constructed is only understandable to those within the organizations and is not made to be self-supporting outside of the organizational context (Smith, 1975). Other LTC workers would understand the document but not necessarily anyone outside of the LTC organization and its service providers (homemakers, daycares and LTC facilities). This documentary reality is the only information that is available to the service providers who are then expected to meet the needs of the real person. At best, the client or caregiver then has to repeat all the information. At worst, the client is completely misunderstood and her care mishandled. The care provider thinks that the assessment form is about the client when really it is about the LTC program's administrative needs.

The form also serves to externalize consciousness. The documentary base objectifies and organizes decisions made. In that way no one person is directly responsible for the decisions. The document constructs the extended care client and therefore, she must go to the extended care facility. Case Managers can rationally justify this move by using care level criteria. These care levels categories do not necessarily reflect an increase in the amount of care for clients. Rather, they are simply cues to the LTC program that increase the funding for the client. This would not be so devastating to the client's life if the facilities were not segregated according to care level. However, different levels of care are currently provided by separate facilities. The client must move from one facility to another to accommodate definitive funding formulas.

The decision to transfer the client appears to be that of the Case Manager. In reality, the Case Manager is only filling out the paperwork; the decision is the LTC organization's. Although it appears to clients that Case Managers are making the decisions, this decision-making is organized by the documentary reality to meet organizational goals. How little input they really have is revealed in comparing research studies into the values of professionals used as assessors (Wilcox & Taber 1990). The LTC Case Managers were originally called assessors. In studies of professionals in their roles there was evidence of personal values affecting the professional judgment of nurses and social workers,(Wilcox & Taber, 1990). Surprisingly, in Wilcox and Taber's (1990) study of those same professions as assessors, the results showed no evidence of personal values in the assessments. It would appear that the assessment form is organized to reflect the values of the organization not the specific assessor's. In LTC, the guidelines for extended care are totally based on mobility. Even if the Case Manager does not feel an extended care facility is appropriate for the client, there is no choice. The Case Manager might be reluctant to reassess a client as extended care as intermediate care facilities have private rooms and ensuite bathrooms whereas extended care facilities have four people to a room and one bathroom. However, there is no option if the client is not mobile: the client is assessed as extended care on the documents and must be placed in an extended care facility. The documentary reality of the assessment form is so strict as to prevent the assessor's values from affecting the process. (Wilcox & Taber, 1990). This everyday experience of assessing clients and assigning care levels is part of the " ruling relations" (Smith 1987) that organize the work of Case Managers and the everyday lives of clients.

Professionals working as employees of these large bureaucratic organizations, as seen in the previous example, are restricted in their ability to help clients by the ruling practices of those organizations. This results in what Smith(1987) has termed "bifurcated consciousness". The workers are trying to assist the client with one hand, while doing the work of the organization with the other. The minds of the workers are 'split' because the ways of thinking about and the needs of the clients and those of the organization are often in opposition to one another. In case management, the conflict is clear. Case Managers are accountable to the organization for fiscal management. They are also responsible for the client clinical management (Halamandaris 1990). The organization has the winning hand because the forms of the documentation which organize the work are set by the organizations and therefore reflect their standpoint.

Documents play an important role in my research by helping to explicate how social relations work. By following the documentary evidence, it is possible to see how the "ruling apparatus"(Smith et al. 1991) extends its extralocal control over the work of LTC Case Managers. This type of documentary analysis transforms "our understanding of the nature of power when power is vested in a documentary process"(Smith, 1975)" which is then processed into a computerized information system.

Information Technology

Computerization standardizes LTC information and at the same time implements increased control by the provincial Ministry of Health. The ease of computer access to locally generated information and payment authority allows the provincial Ministry to exert control over every minute operational detail of the LTC program. This apparently complex computer programming is completely devoted to management's agenda and is incapable of performing even the simplest task required by a Case Manager. For example, when I required information on seventy-six residents of a personal care home that was closing down, I was forced to type in each person's name to ascertain whether they had been previously seen by LTC. The computer system does not allow information to be accessed by address - which is what I required. At present it is not possible to produce a report listing clients by address. Also when the boundaries of Case Managers' districts change which happens at least once a year, it would be expedient to be able to access clients by address. Clients could be reassigned using the information accessed by address. The system was programmed to meet the Ministry of Health's needs not the LTC Case Manager's.

This access to details of clients' lives is analogous to the "Panopticon" mentioned by Foucault (1980). The "Panopticon" is an architectural concept that was designed to increase the surveillance of people. The center of the building is a glass tower from which guards, supervisors etc. could easily observe the surrounding glass cells. The backlighting of the person in the cell made the scrutiny of the occupant effortless. Information technology is often employed in the same way as the glass cell, to scrutinize workers' performance and performance of the program. The fallacy in this concept is thinking that the computerized information is like the glass cell.

In reality, computer information represents the equivalent of a tidied-up livingroom in the average Canadian home. From observing that tidied-up livingroom, some family life can be observed but not in its totality. Missing from the observation would be the kitchen with its preparation, cooking and consuming of food, the bathroom for elimination, the bedroom for repose and the basement for all the left overs. All of those activities would be missing if only the livingroom was observed. The livingroom-information, like information technology would reveal only the tidy, not the lived-in, details of family life. The problem with the current Ministry of Health information system is decisions are being made under the misconception that the whole workings of the family are revealed when only a very small tidied-up area is revealed. The administrators who use these slivers of standardized computer information are developing important policies that have far-reaching implications in caregivers/client's lives and the practice of Case Managers.

Future of Case Management

The nascency of my research question began as I read Lucy Suchman's(1987) book "Plans and Situated Actions: Human /Machine Communication". She was discussing the question of how we really do things as opposed to how we represent those actions. Until recently, this was an esoteric question, of interest only to philosophers and a benign area of curiosity with no obvious societal implications (Dreyfus & Dreyfus 1986). This has organizations. As computer scientists try to replicate human knowledge, new problems appear (Suchman 1987). Representation of how people act turn out to be prospective or retrospective rationalizations, not accounts of what we actually do in situated actions (Mead G., cited in Suchman, 1987).

Phrased in terms of information technology, the problem is collection and formal organization of the human expert's understanding of the subject into a computer program (Laver 1989). This has proven difficult because "much of that (knowledge) lies below the threshold of conscious thought, particularly where value-judgments have to be made"(Laver, 1989,p. 72). This however, has not stopped information technology specialists from trying. Computers themselves do not "think" but simply follow the rules that have been programmed into them (Laver, 1989). Attempts to encapsulate professional skills in program packages and replace the professional have had very limited success. However, information technology is being used to organize the way professionals work. The format used to structure these programs can severely limit the way in which professionals can work. Before computer experts even try to capture the work that LTC Case Managers do "we have to agree which social objectives are to be sought and which avoided" (Laver, 1989, p. 168).

When an agency or company decides to implement information technology, it is rarely a front line worker request but one made by management (Campbell, 1992). The objectives of the computer programs then reflect the views of management not the front-line worker. They are very much "management's tools not the workers' tools" (Campbell, 1992). When talking about increased productivity, there is no part of the definition that addresses the issue of product quality. The underlying assumption is that quality is not impaired(Laver 1989). But the real question is-- who is defining quality?

Management's objective is *to manage* which is defined as "to have under effective control"(Oxford, 1979, p.494). With an increased demand for accountability in the public sector there is an increased demand for more control of public spending. Using information technology, management can expand its control over each individual worker by controlling definitions of legitimate 'work'. Management's objectives of cost containment can become the number one priority. Information technology makes it possible to compare the work of different professionals and to evaluate their 'efficiency'. When the work is evaluated on 'objective results' (via electronic information monitoring) then the workers' professional commitment to clients must become a second priority (Campbell, 1992).

The work of LTC Case Managers is very similar to the work of social workers in the Case-weighting study done by Marie Campbell (1992) in 1988 for the union local of the Metro Toronto Children's Aid Society. In that study she demonstrated that an increase in cases along with a decrease in staffing resulted in increased stress for the workers. The organization's top priority became not adequacy of services but management's ability to contain costs. Information technology allowed management to closely monitor individual social workers' performance. Campbell points out that " By bringing management closer to the field (through electronic information transfer), computers could make one-to-one supervision virtually redundant"(p.198). Information technology gives management the ability to have more direct control over the workers at an increasing distance. Her conclusion was that "it is crucial to understand that the way in an increasing distance. Her conclusion was that "it is crucial to understand that the way in which social work activities are measured will have a lasting effect on changes in work organization, based on information technology"(p.167). Likewise, the increased use of information technology could profoundly change the way LTC Case Managers work.

Information technology has also played an important role in the study of the Unemployment Insurance Commission (UIC) (Banks, Chester,Flynn, MacLean, Mann, Shragge, & Woodsworth, 1985). Researchers found that the organization worked very hard to remove client orientation from UIC workers. The result was a relationship between client and worker which never stepped beyond strict adherence to UIC policy. In performing legitimate work, the only facts to be considered by UIC workers were ones contained within the "documentary reality"(Smith, 1975). Compliance to policy was required even in instances when workers thought such policies weren't in the best interest of their clients. However, UIC workers were powerless because every decision was being monitored. This amount and type of control over individual workers was made possible because of computerization of the work (Banks et al, 1985). The proposed changes in the use of information technology in the LTC program could result in Case Managers being equally incapacitated, as in the case of UIC workers. This would leave LTC clients vulnerable to the non-discriminating application of bureaucratic rules. Professional discretion is removed from the Case Manager-client interaction, leaving only clerical tasks. The policies of federal and provincial governments, can be shown in the day-to-day work of LTC Case Managers. If information technology reflects the organizations'

Currently, Case Managers have some discretionary power when assessing clients in the home setting. Some categories, such as extended care are rigidly defined. Others allow for more professional judgment. Intermediate care categories have more flexibility. In his study of over 5,000 LTC records, Beebe (1994) found that within the intermediate care levels there was no documentary correlation between boxes ticked and care level assigned. Beebe's figures suggest Case Managers may be taking into account more than the 'objectively derived' functionality of the client. Beebe does not have an explanation for this lack of correlation. In my study, I observed all the work of Case Managers, not just the documents produced as Beebe did.

Laver's plea in his final chapter is"... as they design IT (information technology), systems must act at all times to ensure that they serve men and women, and not use (or abuse) them."(1989, p. 85). Case Managers need more not less flexibility to meet the needs of caregivers/clients. Nurses and social workers in the Case Manager role must be able to use their professional discretion in meeting individual client's needs.

Chapter 3

Methodological Literature

Introduction

I believe that the world of LTC Case Managers does not exist without their presence. This belief led me to conduct my research in the interpretive paradigm where traditional measures of research are not applicable. Reliability, which is the replicability of traditional research, becomes auditability in the interpretive paradigm due to the belief in the importance of understanding individual experience. Auditability is defined as the ability to follow the researcher's process and reasons for following it. In the interpretive research, validity can be replaced with what I call "credibility". Credibility shows the reader connections between data, conclusions and the social world researched. This thesis documenting my experiences as an indigenous ethnographer, meets Clifford's (1988) criteria of ethnographic writing. Case Managers, caregivers, clients, and myself are all part of LTC culture. However to analyze the organizational aspect of Case Managers' work, I turned to institutional ethnography as delineated by Smith (1987). Using institutional ethnography, I was able to trace the ruling relations starting from Case Managers' work, through various levels of government upwards and downwards from Case Managers to caregivers and clients.

Approaches to Analysis

I have used two approaches to writing about my topic. One is an ethnographic approach, in which my experiences and the discourse are brought into writing (Clifford, 1988). This approach is augmented by institutional ethnography where social practices that organize people's everyday lived experiences are explicated (Smith, 1987). Analysis using institutional ethnography reveals the ruling apparatus that directs LTC Case Managers' work. Two methods were necessary as the research revealed two very different types of work done by LTC Case Managers. The organizational aspect was best investigated from the institutional ethnographic approach. Clifford's (1988) ethnographic approach was used in researching the relationship between Case Managers and caregivers. Each analysis style is suited for each type of work. Although these two analysis styles differ in their approaches, both are congruent with the interpretive paradigm and my role as participant-observer.

Ethnography

Ethnography is a research method of participant-observation that enacts "a delicate balance of subjectivity and objectivity" (Clifford, 1986, p. 13). Not only was I a participant-observer, but as a former Case Manager and current employee in the system, I could also be considered an indigenous ethnographer (Clifford, 1988) in the cultural environment of LTC. In writing this account, my voice can be heard. As stated above, I have analyzed my research using Clifford's (1988) criteria of ethnographic writing. He gives us six ways to test to determine if the writing is "the inscription of coherent ethnographic fiction" (p. 6). The very use of the word "fiction" can upset readers who have not worked through the deconstructionists' analysis of the truth. The 'writing up' of an account sets up an image in the *reader's* mind which may or may not be what the *writer* wished to convey. This research represents the truth from my standpoint as an insider of LTC.

As an insider studying my own culture I brought "new angles of vision and depths of understanding" (Clifford, 1988, p. 9). I was aware of nuances of meaning and understanding that an outsider may have missed. For example, I was motivated to interview one Case Manager because of her statement at coffee time that she had had a long interview. To an outsider that would not have seemed strange because Case Managers work with people and the interviews can become very lengthy. However, I knew this Case Manager well and she is very direct in her approach. She would not have had a lengthy interview unless it was to serve some very concrete purpose. My interview with her was very productive in learning about Case Managers' attitudes towards caregivers and clients.

On the other hand, being an insider has its disadvantages. As Clifford notes, "Their accounts are empowered and restricted in unique ways" (p.9). I am sure there are many examples, but the most obvious one to me was revealed in the interview with the previously-mentioned Case Manager. She did not directly answer one of my questions. Instead she said " You know" -- which of course I thought I did. So all I did was nod when I should have asked her to clarify her point. The Case Managers, who agreed to participate in this research, are all my co-workers and some are personal friends. That fact must be considered when reading this research.

To qualify as ethnographic, the writing must meet the following six determinants specified by Clifford (1988). These are the six ways:

> (1) contextually (it draws from and creates meaningful social milieu);
>
> (2) rhetorically (it uses and is used by expressive conventions);
>
> (3) institutionally (one writes within and against, specific traditions, disciplines, audience);
>
> (4) generically (an ethnography is usually distinguishable from a novel or a travel account);
>
> (5) politically (authority to represent cultural realities is unequally shared and at times contested);
>
> (6) historically (all the above conventions and constraints are changing).
>
> (Clifford, 1988, p.6)

This research does fit the above criteria delineated by Clifford. My thesis is drawn from and creates a social milieu of LTC and its organizational context. Rhetorically, several metaphors are used to convey meaning in my research. This account is written to be read as a thesis encumbered with the university's academic traditions, literary discipline and the prescribed audience. As importantly, I anticipate the narrative would be recognized by the research subjects, Case Managers and caregivers. Clearly, this is written in the format of a thesis and could not be mistaken for a novel or a travel log. Politically, my findings are in sharp contrast to official governmental LTC statements. I am reflecting the world of Case Managers and caregivers as I observed it. A world constantly evolving, as the context in which it exists changes. As I worked through the writing process, metaphors were selected and replaced, as my understanding of my findings evolved.

My work is also ethnographic in the allegorical nature of the writing. As Clifford (1988) argues "Ethnographic texts are inescapably allegorical, and a serious acceptance of this fact changes the way they can be written and read." (p. 99). He posits and I concur, that "the very act of ethnographic writing -- seen as inscription or textualization -- enacts a redemptive Western allegory" (p. 99). Clifford (1988) uses the term allegory in an expanded sense as any story that will engender another story in the reader's mind. The author releases the story to the reader's mind. "Power and history work through the writings, in ways the authors cannot fully control." (Clifford, 1988). As I peel back the layers of meaning in my research I felt less control over readers' interpretations. One layer of meaning relates to the organizational side of Case Managers' work. This aspect of Case Managers' work is best examined using institutional ethnography.

Institutional Ethnography

Foucault (1980) states that " the only problem is to provide oneself with a grid of analysis which makes possible an analytic of relations of power"(p. 199). Smith(1987) provides that "grid" in institutional ethnography. Using Marx's ontological stance to connect the everyday experiences of people to the economic and ruling practices of advanced capitalist society, institutional ethnography allows the researcher to expand the analysis beyond individual data. The ruling relations can be traced upward from the work of an individual Case Manager through the LTC organization, to provincial Ministry of Health, the federal government.

Institutional ethnography has three primary procedures. First is an analysis of how organizational procedure renders its work accountable (Smith, 1987). Second, the ways in which the concrete everyday world is produced by these institutional processes. Finally the idea of social relations used to analyze local work practices "as articulated to, and determined by, the generalized and generalizing relations of economy and the ruling apparatus."(Smith, 1987, p. 167)

There are " not only common bases of experience but also bases of experience that are not common but are grounded in the same set of social relations"(Smith, 1987, p.176). This commonality of social relations makes it possible to take everyday experiences, discover in them the social relations of the setting and increase knowledge about the way society is organized. It also illuminates individuals' experiences in the same way. The explication of social relations holds a light to the organizing practices of everyday life which are rendered invisible in our day-to-day experience (Smith 1987).

In my research I have used institutional ethnography to connect the policies and procedures of the ruling apparatus such as the provincial and federal governments, to the everyday work of LTC Case Managers. Experiences of Case Managers may not be identical, however social relations that organize them operate through the same sources. Invisible ruling relations that control the daily labours of Case Managers appear in the documents, and talk of Case Managers. On-the-spot observations, one-to-one interviews and documentary analysis help to explicate how control is expressed in the day-to-day work of Case Managers.

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Interpretive Paradigm

The interpretive paradigm is based on the belief that the social world does not exist outside of our participation. Jackson (1984) states "... this embeddedness of individual experience is central to a research strategy" (p. 120). This view of the world dictates my research methodology. I believe there is not an objective world waiting to be discovered; the world is created *inter*actively by us all. Both researcher and subjects are re-formed and changed by interaction (Moccia 1988). I was part of the social world of Case Managers, caregivers and clients. The milieu had an effect on me, as I had an effect on it. This is the reflexivity of my research ; an extension of my belief I am a part of the social world (Hammersley & Atkinson 1992). The social world does not exist without my participation. Kirby and McKenna (1989) state, "Methodology, theory and ideology are intertwined. How you go about doing your research is inextricably linked with how you see the world (p. 63). Hammersley and Atkinson (1992) go so far as to say that "this is not a matter of methodological commitment, it is an existential fact" (p.14). My belief in the creation of the social world by the interaction of participants dictates my research method.

Reliability/Auditability

As I believe in the embeddedness of individuals in their world, the researcher, research and controlled environment are part of the context in which the subjects are situated. Qualitative researchers emphasize the meaningfulness of the research project rather than the control of the process (Sandelowski 1986). Identical replicability is replaced by auditability as a research criterion. Auditability as conceived by Guba and Lincoln (Sandelowski 1986) is more consistent with interpretive methods. It is defined as a "decision trail" left by the researcher. Another researcher should be able to follow the line of thinking when reading the study (Sandelowski, 1986).

Credibility

Credibility shows the reader connections between data, conclusions and the social world researched. The reader should be able to clearly see how the researcher connected the data delineated and the conclusions drawn. As well as, to have credibility, the research should create a credible picture of the social world in which it takes place. A reader, such as a Case Manager in this thesis, should recognize the social world. However, the conclusions drawn may not be acceptable to individual Case Managers due to their embededness in the work.

Summary

Control of LTC Case Managers , their work, and caregivers is essential to Long Term Care. The critical role of caregivers in Long Term Care was a surprise to me. This suggests that the research methods I used, were effective. I found what I expected. I also found facets of this work which were a complete revelation to me. I was able to analyze interactions with caregivers. For the first time, I could see the essential role of caregivers. My own role as a participant-observer as delineated in ethnographic research was vital to this discovery. Using institutional ethnography as defined by Smith(1987), I connected Case Managers' and clients/caregivers/family's everyday experiences to organizational, governmental, and societal practices.

In the following chapters, I will show my decision trail (auditablity) in a way which invites the reader to explore her/his own understandings and to mutually engage in validation of my research findings.

Chapter 4

The Study

In this chapter I will discuss how my research was conducted. The process of developing questions for interviews and who was actually interviewed is presented. Throughout my research, protecting and respecting participants has been an important consideration. Before commencing my research I had a plan of observing and interviewing the same Case Managers. As with most interpretive research, the plan was modified as the research progressed. These changes are integrated into the discussion of each section. I consider the ability to follow new leads to be one of the most attractive features of this type of research, especially while conducting interviews.

Interviews and Observations

Two types of interviews were implemented in this study: interviews of *clients* by Case Managers and interviews of Case Managers themselves as part of my study. I observed but did not participate in interviews of clients. My non-paricipation was in respect for the Case Managers and thier work. My interviews of Case Managers followed the guidelines for an interactive interview set out in Kirby and McKenna (1989):

a) *Formation and clarity of questions*. These questions arose from

i) Personal reflection and conceptual baggage. This is my own standpoint on the question, e. g. I felt that the informal aspect of the work was not captured in the documentary reality and therefore

I asked Case Managers about that. When I was interviewing a Case Manager about the interview she had the day before, I asked her "Why did you have such a long interview?"

ii) **Questions people asked me as I described my research.**

e.g. How did you get your paperwork done?

iii) **Reading I have done on the subject** e.g.- How do you decide on what the client needs? the difference between plans and actual situated actions. Suchman (1987) posits that we make plans, we act and then we construct post-situation explanations but the pre- and the post-representations do not really capture what we actually did.

b) **Egalitarian setting and the relationship between the interviewer and the participant.** Effort was made to ensure the optimum condition of participants guiding the interview. My experience as a LTC worker and a co-worker of the Case Managers added to my credibility. Good listening was important.

c) **The participants needed to know the intention and process of my research.** The LTC employee participants were informed they could withdraw from the project at any time. Client participants were advised by their Case Manager, during the first telephone contact, participating in my research project did not affect their eligibility for any Long Term Care benefits. The clients were again asked in person if they wished to participate. Withdrawing might have been eligible. A separate request was made regarding the taping of the interviews. Each client, Case Manager, administrative support person and Assistant Manager interviewed, signed a specific consent form. For clients, this form was read aloud if there was any doubt as to their literacy. The font size for clients' consent was larger to accommodate for lack of visual acuity.

d) **The sharing of information was important.** This enriches the experience for participants, as well as myself. I shared some of the frustrations I had as a district Case Manager to demonstrate I did understand the work. As a Case Manager, I had often felt overwhelmed by the volume of work and by the information overload. I questioned if they too felt overwhelmed and how they handled the stress. Actively listening to the Case Managers after a home visit was beneficial to us both.

e) **Recognition of the investment made by all.** The Case Managers asked me to come to a meeting where they discussed their case loads. It was decided that the problem of overload might be alleviated by a workload measurement study. I declined to be involved but cautioned them of the pitfalls that can occur in doing a workload measurement study. In other work settings, management have used it to increase everyone's workload to the maximum tolerated not decrease it to the minimum desired.

f) **Accounting for yourself as you research.** I have been a LTC Case Manager and feel that the participants' identification with me was very helpful. My introduction to this thesis clearly states my previous experience and also my feelings about this job. I found myself in many diverse situations. One day I was reciting the twenty-third psalm with a ninety-nine year old missionary dying of cancer. On another day I was having a gun pulled on me because an old man didn't "want anyone interferin" in his life. Often, I felt I would cry if I received yet one more phone message from someone in crisis.

g) **It is essential that the interviewer and the participants get what they need out of the research experience.** I was very honest with participants about what I needed in my research and the questions I would be asking Case Managers. The participants expressed a need for "Someone to talk to". Case Management work in the CRD is very isolated work. They were delighted to have someone with whom to discuss their cases. Our discussions were held before and after client interviews when I had requested permission to observe and tape client interviews. Out of respect for the work of Case Managers I was quiet during interviews in client's homes.

h) The research process is a dynamic one, continually changing in response to new information and new participants. I had planned to interview only Case Managers with whom I had gone on home visits. However, when another Case Manager remarked on her long interview, I changed my plans. I interviewed her . It was a good decision as that interview was very insightful for me.

i) Collaborators are an essential component. In the fall of 1993 I attended a research class taught by Marie Campbell. This was very helpful and necessary for me. The formal setting of the data collection class and the informal support of interested fellow students and a faculty member were invaluable in helping me to persist in continuing my research.

Participants

The participants were LTC Case Managers, Assistant Managers, administrative support staff, caregivers, clients and myself. I have included myself in the list of participants because I believe that I am part of the research and as such must account for myself. Also I have used the term participants because it better reflects my belief that we were all participating in the research (Kirby and McKenna, 1989).

Sample

As to the question of sample size (i.e. How many Case Managers did I interview?); the number of interviews necessary was dictated by the knowledge obtained. I continued until the necessary information was gathered to answer the research question. As in all qualitative research the sample was small; my interviews were conducted with Case Managers, Assistant Managers, administrative support staff and LTC clients. Within the interpretive paradigm, the number of interviews is not an important factor. The quality of information to properly examine the problematic is more significant. In retrospect, I feel following one experienced Case Manager could have been sufficient.

Data Collection

I observed the work of Case Managers from two LTC offices and accompanied them on home visits. The Manager of LTC for the CRD had given her approval for my research, referring me to the Assistant Managers for permission to attend staff meetings. After granting me permission to attend staff meetings, the Assistant Managers requested that I meet with them before hand. Their concerns appeared to revolve around the question in which I asked Case Managers about their relationship with Assistant Managers. As Assistant Managers supervise Case Managers, I thought that this would be a relevant question. The Assistant Managers objected to the word ‘relationship' because they felt it could be answered to reflect their personalities rather than the operations of the

My initial contact with Case Managers was at a staff meeting. This was with each Assistant Manager's approval. At the meetings I gave a short synopsis of my research and asked for volunteers. I had anticipated having to approach Case Managers on an individual basis to have enough participants. However, two Case Managers volunteered from each office. Knowing the Case Managers personally reduced the amount of time needed for Case Managers to 'forget' I was there. This was important because I wanted to observe them on a business-as-usual basis.

As I had done the job myself, I felt I did not need to spend time familiarizing myself with the environment or the language. My own experience as a Case Manager allowed me to 'hear' the information the same way the Case Manager did (Jackson 1984). However I did have to be extra vigilant about not to take information for granted. I needed to make the situation 'strange' in order to question how it 'works'. The 'talk' of the Case Managers gave me an entry point as it demonstrated the "taken for granted understanding" (Jackson 1984) within the organization.

My methods of data collection involved interviews, direct observation, audio taping and document analysis. Audio taping was used for Case Manager interviews and the interviews of clients by Case Managers. Direct observations took place on home visits and in the LTC offices. These were typed into a notebook computer or written in an exercise book. Documentary analysis was conducted on various LTC forms used by Case Managers.

Chapter 4

Case Study

The case study is based on data gathered while I accompanied a LTC Case Manager on a home visit. During this visit I observed the actions and interactions that are the work of the Case Manager. The only element of the Case Manager's work that is visible to the Ministry of Health LTC program management is the documentation. This information gathering is often called 'assessing the client,' but I would argue it is actually constructing the eligibility of the client for the LTC Program. The Case Managers gatekeep and perform crisis intervention for a very complex and dynamic group of clients. However, there are tasks of case management which Case Managers cannot accomplish given their large caseloads. These necessary functions are carried out by caregivers who are taught by Case Managers what is relevant to LTC. Case Manager functions such as training and support for caregivers, are vital for the success of the LTC program but are not recognized by the LTC organization.

Home Visit

This home visit was done by a Case Manager at eleven o'clock on a Monday morning. On Thursday of the previous week the Case Manager had received a telephone referral from a Hospital Liaison Nurse regarding this prospective client. The usual routine of referral through the Central Intake department was bypassed by the Hospital Liaison Nurse due to the urgency of the referral. This man was in hospital at the time of referral and was going home as a palliative patient. As a palliative patient, no active treatment was being initiated, beyond the control of symptoms such as pain. The man and his wife had been seen by the Hospital Liaison Nurse. Normally, she would have completed the five page Application and Assessment (LTC1) form. When the Case Manager checked the computer terminal to see if the information from the assessment had been 'posted' (in other words, entered into the main LTC computer data banks) there was no entry to show that assessment had been done. The home visit was urgent because homemaker services would have to be purchased by the client until the Case Manager could complete the financial assessment form. The financial assessment determines if the client is eligible for homemaker cost subsidy (see Appendix C for the financial form). The client signs the form agreeing that the information is correct and also agreeing to pay the per diem rate that has been calculated. In this case when the Case Manager could not find the client's name on the computer list, she phoned the Hospital Liaison Nurse to see if the assessment had been done. The Hospital Liaison Nurse was paged through the beeper system but had not responded before we left for the appointment to do the home visit.

When we arrived at the apartment, the Case Manager buzzed the apartment and said " This is the Long Term Care nurse." We are shown into the apartment by a tiny, frail-looking woman who was the client's wife. We followed her into the bedroom and were introduced to the husband (client) who was in bed. He was a tall heavy looking man who was wearing clean pajamas. The Case Manager asked him if he was in pain. He answers "no" but his wife had given him an Ativan "to help him." The wife tried to bring another chair into the bedroom so the Case Manager and I could sit down but the Case

Manager said it would be better to work on a table. The Case Manager, the wife and myself went into the dining room and sat around the dining room table. The wife apologized for forgetting the Case Manager's name. She explained saying "I'm quite rattled with all the people coming and going. I have a book of course but I'm not the type to sit still for very long".

The Case Manager commenced the interview by inquiring what the wife did for fun before all this started. The wife described going to a cabin on a lake up island with her husband. Then she became very teary and started to cry. She said "This happened so quickly". The Case Manager responded with "It's OK to cry. We see tears on almost every visit. We should have a box of Kleenex as standard equipment for us". The Case Manager then said "I understand your husband is a veteran on a disability pension". The wife responded "Yes, we've had quite a time of it". She then mentioned several names of people who had been to see them regarding the pension and things such as wheelchairs and walkers.

The wife had been told by the Hospital Liaison Nurse that the Case Manager would do a financial assessment form and to have the previous year's Income Tax form ready. She gave the income tax form to the Case Manager and said "I don't know very much about this". The Case Manager copied the information from the income tax form onto the LTC Financial form.

The Case Manager asked the wife how much the client receives a month in DVA pension. This money is not considered income when calculating income for the federal government income tax but is used by the provincial government LTC Program to calculate the client portion of the cost of LTC homemaking services. The wife got up to ask the husband and came back with their bank book which has an automatic deposit in it. The Case Manger wrote down the amount.

The wife said she "has a son in town but he is not taking this very well. He hasn't worked much. He was burned severely two years ago. All on his chest and back. It happened up at our cabin. We had to get the helicopter in to take him to hospital."

The door buzzer rang. It was her husband's brother who had come to visit. The wife jumped up to answer the door and went to talk to him.

When she returned, the Case Manager asked if the Medical Services Plan cost is deducted from her husband's pension "at the source." The wife leaped up again to ask her husband. While she was out of the room the Case Manager said to me "I would imagine DVA pays the whole shot".

The wife came back and said yes. Then the wife went on to say everyone in the condominium has been great. "Whatever I need they will come and do. This man downstairs wanted to get my groceries but I can do that so he came up and sat with my husband. The unfortunate thing is that I have a problem too. I have a chronic lung condition. I've had it for years. Dr. C. says not to take deep breaths, and breathe out my nose. He figures I am hyperventilating so he tells me only to breathe through my nose. He was the one years ago who told me to breathe through my mouth with a big breath." The Case Manager did not acknowledge the wife's statement in anyway.

The Case Manager responded by saying the daily rate or client portion would be $50.44 because of the income. She explained if they needed twenty-four hour care, this would be the cost. However, it would be more reasonable to arrange the service privately if only two hours of care were needed per day. An agency would only charge the client $17.00 per hour if ordered privately. The Case Manager was not sure how this worked with DVA, but DVA would likely be paying the whole bill. The Case Manager asked to use the phone and called DVA leaving a message regarding the care level and required homemaker hours. The Case Manager was not sure if the LTC Assessment had been done because it was not on the computer. She decided to do "a quickie" to save coming back if it's not done. The "quickie" was to fill out the five pages of the LTC Application and Assessment form (LTC1).

To complete the LTC1 the Case Manager used the Hospice Book which is a large binder that resembles a hospital chart with different sections such as medications, Nurses Notes and Lab reports. All Hospice clients have one of these charts in their home which is taken to hospital if they are admitted. The Case Manager copied information from the Hospice book into the appropriate categories on her form such as diagnosis, medications etc.

The Case Manager then requested her husband's regimental number. Once again the wife got up to find the information. The regimental number is needed for the LTC Application and Assessment form and also for the Department of Veteran's Affairs (DVA) Release of Information form. The DVA Release of Information form allows the LTC 1 pages 1-5 to be sent to the client's DVA worker. The DVA worker's role is analogous to the Case Manager's but funded by the federal government and only veterans are eligible for assistance. The DVA program requires the same information as LTC. Providing the DVA worker the LTC information saves DVA a home visit.

While completing LTC1 form, the Case Manager asked if the husband has any allergies. And once again the wife jumped up to get an ID bracelet from her husband to see what the allergy was.

From the Hospice Book, the Case Manager copied medications being taken by the client. She makes a mistake, not seeing that one of the medications has been canceled. The wife, who is giving the medication, corrected her. The strength of one of the medications was not in the book so they both went into the bathroom to look at the label on the prescription bottle.

The Case Manager asked if the husband's tongue was sore. The wife said yes and he's sore "down below" too. She then talked about her frustrations with the Attends (disposable incontinence products). The Case Manager and the wife went into the bedroom to examine the husband's scrotum for irritation.

When they came back the wife started to talk about her son who showed up at the apartment drunk last week. She began to cry and said she had had to call somebody from the condo to ask him to leave. The wife showed us pictures of her grandchildren. "They live with their mother and my son has them every second weekend".

Then the wife confessed "I did smoke but I gave it up, but with all of this I feel like one. My friend I mentioned who is a nurse gave me one of hers. She didn't want me to but I tried a drag. It was Menthol and it tasted terrible". The Case Manager responded with "How long have you lived in BC?". The wife answered and then got up to go into the kitchen. The wife looked at a sheet on the refrigerator door with a CRD logo on it and a Home Care Nurse's name. "Do you know when Mary Smith (pseudonym), the Home Care Nurse is coming? I know she's coming today but I just wondered when." The Case Manager responds that she does not know when the Home Care nurse will arrive and suggests the wife could phone the office to ask.

The Case Manager filled out a blue form which described to the wife what they had "discussed" and what plans had been made. The Case Manager also left her business card with the wife. As we were about to leave, the Case Manager realized she had not written her visit in the Hospice Book. Having found a section called professional reports she wrote that she "visited" and "assessed" the client at the Extended Care level.

Chapter 6

First Layer -- Case Management on the Run

The first impression of Case Managers' work is constant activity, telephones ringing, client/caregiver in crisis and situations constantly changing. Clients, and often caregivers, are chronically-ill seniors with complex medical conditions and equally complex lives. The lack of monitoring by LTC Case Managers, along with the complex and dynamic nature of disease processes and lives of LTC clients, contribute to the resulting crises. Case Managers are called upon to assist families resolve these crises.

Crisis Intervention

The situation for many LTC clients becomes a crisis before the Case Manager becomes involved. This was very obvious on the Monday morning I observed. Crisis calls piled up on the Case Manager's desk. The office had been closed over the weekend. Monday morning brings two days worth of crises for Case Managers to resolve. The definition of a crisis as 'a call to action' (Infante 1982) is a very fitting description of what Case Managers do. Monday morning is crisis management. The Case Manager received 15 phone calls in one and a half hours, all regarding crisis situations. She arranged homemaker services, expedited an emergency placement and recontacted everyone with a crisis to tell them what had been arranged.

Monitoring and Waiting

Some of those crises could have been averted if the Case Manager had been able to monitor the client's situation. In the literature about case management, the researched caseloads are obviously much smaller than those at CRD. Those Case Managers could manage daily or at least weekly contact with clients. Close monitoring of cases is standard practice for case management. If the situation can be monitored at least weekly, a potential crisis may be averted. The monitoring standard for provincial LTC is to reassess the client once a year. If a client has not been reviewed within a year, a computer printout comes from the Ministry LTC saying that these clients must be reviewed. One of the purposes of these reviews is to re-calculate the client's financial assessment. There are no repercussions from any level of management if a review is not done. The lack of staff to do close monitoring of frail clients contributes to the chaos that surrounds LTC. Constant crisis management is stressful for Case Managers as well as clients. It must be kept in mind that some of crises are client oriented and are not the result of poor case management monitoring.

Clients' constantly changing conditions precipitate some of the crises. One of the clients had become increasingly ill at home on the weekend but refused to go to the hospital. The final straw for his wife was when he was involuntary of stool in his bed at six a.m. Monday morning. This was an unexpected event. His sudden change in health became a crisis for his already overburdened wife. According to the Case Manager the wife didn't love him, she didn't want to care for him, but she was stuck in the situation because of her financial situation. His deteriorating health and refusal to be hospitalized was a crisis for her.

The other precipitating factor in these crises is the caregiver's own perception of the situation. The Case Manager may have suggested that the client be waitlisted for placement. With her experience and knowledge of the disease process, she expects that there will be a point when the caregiver will no longer be able to cope. The caregiver rarely has the same background of experience as Case Managers and she may be strongly motivated to continue caregiving. Sometimes the caregiver and Case Manager may be in complete agreement and the client's name has been placed on a waiting list for a care facility. However, the waiting period for many facilities is one to two years and the situation may change considerably in that time. This was the case in another Monday morning crisis. The husband was becoming slowly demented and the wife had placed his name on a list (called waitlisting) of a very good facility. Like all good single room facilities, the waiting time was two years. Meanwhile, over the weekend he had been up all night wandering around and his wife did not get any sleep. Monday morning she was ready to consider emergency placement. This means there would be no choice of placement facility. It would most likely that the client would be placed in one of the less desirable shared-room facilities, with two or more people to a room and over 200 residents in the building.

Crises are partly generated by the lack of monitoring of clients and partly due to the fragile health of the client population. Also, caregivers themselves are often in frail health and emergency placement may be needed because the caregiver has died or been taken to hospital with a serious illness. Both the client and the caregiver are often in precarious health leading to unstable situations.

Dynamic and Complex

The dynamic and complex nature of disease processes in the elderly population is very relevant to this discussion. There is usually more than one disease process effecting the client's health. These may combine in unexpected ways to create a problem. One Case Manager took a demented client to the Emergency department of an acute care hospital. The client had just moved into new apartment from her home where she had lived for thirty years. The move, combined with her paranoia, resulted in a life threatening situation. She could not remember moving and was threatening to burn down the apartment building. This was a serious threat and she had the means to carry out her plan.

Other diseases have a very sudden in the onset. A stroke or heart attack can quickly incapacitate a client or caregiver. This would dramatically change the caregiving situation. The medical progress of a disease can usually be predicted. However, when this interacts with the client's lifestyle, living conditions and coping skills, the result is largely unpredictable.

As stated in one of the research articles (Mutschler & Callahan, 1990), Case Managers frequently feel overwhelmed. When I asked one Case Manager about this factor, she responded by saying how overloaded she felt at times. She felt this overload was directly responsible for an accident that she had after work one night. As she was pulling out of her parking space, she hit a cement post in the parkade. It had been a particularly stressful day, according to her, and she was not concentrating on where she was going or what she was doing.

<u>Formulating a Care Plan or Resource Allocation?</u>

In the case study, the Case Manager discussed plans for care of the dying man with his wife and later by phone with his doctor. These initial plans of the Case Manager are very general and do not include any specific clinical details that would be in a nursing care plan such as how his irritated scrotum would be treated. The Case Manager's plans are concerned with managing the care, not giving the care. There is no safeguard to ensure that homemaker service is used. If the client or family cancel service, the homemaker agency may alert the Case Manager, but there is no formal safeguard in the system to ensure that notification occurs.

The only safeguard in the system regarding homemaker usage, is one in which there is notification of the Case Manager if the homemaker agency bills for more hours than the Case Manager authorized. This very telling detail reveals that 'care planning' is really only authorization. Resource allocation, is central to case management. A British article (Canadian, 1985) points out that articles written in the United States do not mention resource allocation as part of the case management process, in spite of the fact that it is often stated as one of the primary goals of case management research projects.

Resource allocation is part of all case management but it is an issue I have never heard Case Managers mention.

As trained professionals, social workers and nurses who are LTC Case Managers will say they are putting the client's welfare first. The reality is that the organization of the program allows them to do only what is best for the client as defined within the parameters of LTC. By classifying clients into care levels that restrict resources available to clients, the organization very effectively controls how Case Managers perform their work. The parameters of the program as stated in the documentation severely limits what Case Managers can do. This is apparently never questioned by Case Managers. In fact, I have heard Case Managers become incensed because a client/caregiver dares to insist on more homemaker hours than LTC allows for that client's care level. Perhaps part of Case Managers indignation stems from the client/caregiver questioning their opinion.

Summary

All these activities are very obvious at a busy CRD LTC office. Case Managers are completing forms, doing crisis intervention, placing clients on waiting lists for LTC facilities, rationalizing resource allocation to clients/ caregivers and giving support to caregivers. The overwhelming demands made upon Case Managers reveal two opposing 'directions' demanding Case Managers' attention. How Case Managers deal with these demands will be discussed in the following chapters

.Chapter 7

Second Layer-- The Two Faces of Case Management

The two diametrically opposed facets of Case Managers' work became apparent to me while writing this thesis. One facet is the completion of paperwork and meeting the needs of the organization, a document and task oriented function. The other facet is dealing with clients and caregivers, a people and holistically oriented approach. Clients can only see the relationship they have with a particular Case Manager and what she can or cannot do for them. They do not see the organization except through these contacts with Case Managers. On the other hand, the organization only sees the documents produced by Case Managers and what those documents do for the organization. Because the forms only reflect the Ministry of Health's needs, the LTC organization has a very limited understanding of the circumstances of clients and caregivers. Both clients and the organization feel they have first claim on a Case Manager's time.

Caught between these conflicting expectations, it is not surprising that the job is a very stressful one. If Case Managers focus primarily on caregivers/clients as one Case Manager told me she did, the paperwork suffers. That particular Case Manager had spent her whole day off in the office, catching up on her paperwork for the past month. She would not request any overtime. She was personally paying for the time she had spent interacting with clients. If however, Case Managers focus primarily on paperwork they acquire a reputation in the community as 'the Case Manager from hell' (as one Case Manager is known). She focuses on getting her paperwork done efficiently, giving limited attention to clients/caregivers. Clients think Case Managers have power but they are as trapped in the system as clients. "It's a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised." (Foucault, 1980, p. 156). No matter what Case Managers do, there is never enough time to keep everyone happy.

Like women everywhere Case Managers are trying to keep everyone happy by trying to be all things to all people (Baines, et al. 1991). It is the opposing demands for Case Managers' time that partially causes stress. Caregivers/clients' and organizations' demands can be seen as being mutually exclusive when considering the gargantuan caseloads of 200 -300 clients. Case Managers are constantly deciding who or what is their first priority; then live with the outcomes of not meeting the other's needs.

In the two examples of work mentioned, the Case manager who gave up her own time to catch up on her paperwork and the Case Manager "from hell", the Case Managers made very clear, consistent choices. One had chosen the people aspect, the other had chosen the organizational aspect, and they were willing to live with the consequences of their decisions. Most Case Managers waver back and forth between the two directions. Their training and humanitarian instincts leads them in one direction, the documentary imperatives command them in another. However, on a home visit, it is the caregiver/client that the Case Manager faces first.

Facing the Client/Caregiver

Although the LTC Program's Mission statement focuses on the disabled client, it is my contention that the real client of Case Management is the caregiver. Support for caregivers is demonstrated by Case Managers listening to caregiving problems and setting up support services to provide relief for caregivers. Support of caregivers as a component of Case Managers' work that is not documented on the Application and Assessment form. As it is not documented, it is not visible to LTC management. This invisible work of supporting the caregiver is one of the ways in which the Case Managers work to accomplish the mission of the LTC Program.

Long Term Care could not adequately care for the thousands of clients on Case Managers' caseloads without informal caregivers. Caregivers give 80-85% of care and perform many of the functions of traditional case management such as monitoring and assessment. Caregivers pay a large price for doing work that is not acknowledged by LTC. In spite of the caregivers' pivotal role, there is little LTC documentation on the Assessment and Application form concerning caregivers and their functions. As a result of this lack of documentation, the work of Case Managers with caregivers is invisible to the LTC organization. However, this work is crucial for attainment of the mission of LTC.

Even when the caregiver is a formal/paid caregiver, LTC expects Case Managers to give supporting them first priority. In my interviews with Case Managers one of them mentioned an incident in which she was verbally reprimanded by an Assistant Manager. The Case Manager had taken the Mission statement of LTC seriously and lodged a complaint against a homemaker agency on behalf of her client. The client had complained to her about an agency and the Case Manager was following this up with the agency. After the Assistant Manager heard the phone conversation, she called the Case Manager into the office. The Case Manager was told not to complain about homemaking agencies. When the Case Manager protested, the Assistant Manager told her "It wasn't done." This demonstrates another instance of the caregiver, not the client, is the focus of Case Managers' work. The Assistant Manager was adamant that the formal caregiver, like the informal caregiver, is suppose to be the number one priority for LTC Case Managers

The Mission of Long Term Care

The LTC Program is one of the programs funded by the Continuing Care Division of the Provincial Ministry of Health. The draft form of the Mission statement of the Continuing Care Division states "The Mission of the Continuing Care Division is to provide an effective, efficient and affordable continuing health care and support services for: persons who have or are at specific risk for chronic disabilities..." (see Appendix D). The Mission statement of CRD LTC Program is very similar to the Continuing Care Provincial parental counterpart. CRD LTC mission statement states "The LTC Program offers a choice of supportive services to maximize the well-being of the client disabled by chronic health conditions." The support services referred to in the Mission statement are formal paid services which include homemaker services, adult day care, and facility placement. In spite of these services, most caregiving is done outside of the LTC program.

Informal/unpaid caregivers provide approximately 80-85% of the care in Canada, while 15-20% is provided by formal programs and services (Chappell, N., Strain, L. & Blanford, A., 1986). As a result LTC does not pay for the majority of care LTC clients receive. Informal caregiving is the primary source of care and formal government program is a much smaller, secondary resource.

In the Continuing Care Mission statement, there is reference to "effective, efficient and affordable... services". In the Oxford Dictionary the word efficient is defined as "acting effectively, producing results with little wasted effort" (1979, p.257). When used by the government, efficiency usually means reducing services that 'waste' taxpayers' money. As the Continuing Care Division is part of the provincial government, it can be seen in the Mission statement that there is an emphasis on being efficient in LTC. The most effective services in terms of government spending are the ones that accomplish the government's program goals at minimum cost. The care given by informal caregivers to LTC clients meet that criteria. Informal caregiving gets the work done and is not paid for by the government. Caregiving that maintains clients in their homes and as an unpaid service by the informal caregivers, provides "support services for : persons who have or are at specific risk for chronic disabilities..." as stated by the mission statement of the Continuing Care Division.

Bifurcated Consciousness

Conflict of goals for professionals is described by Campbell (1996) as bifurcated consciousness. Professionals are trained to help clients. They are also employed by agencies with working policies that are in direct conflict with the best interests of clients. The type of thinking and behaving when supporting caregivers is very different from the behaviour required when doing the organizational work. For LTC Case Managers, the primary conflict occurs between the needs of the caregiver, (not the client) and the LTC program.

Client needs are not the focus ofLTC Case Managers. When visiting the woman who was going into placement, it was very clear that she did not want to go. The daughter said " She wants to be with us more but we can't do that." The Case Manager constructed an excuse for the family by saying " So you're really busy right now with your business." When discussing the case afterwards the Case Manager stated that the family was caring for the woman adequately because "Her basic needs were being met." However, later on in the conversation, the Case Manager used the same phrase "Her basic needs will be taken care of much better at (the facility) than where she is." The Case Manager was justifying the placement in her own mind, allying herself with the decision of the family. But whether or not the Case Manager agreed with the family's decision, it is her work to do the documentation for placement.

Although the client obviously did not want to be placed, the Case Manager was proceeding with the placement. She had arranged four short term admissions to the facility until permanent admission could be completed. This means the client was going into the facility for a one to two week period and then returning home for a few weeks. This was to be repeated four times over the space of a three months. That amount of upheaval could not have been good for this chronically-ill woman. The family's wishes were being carried out against the client's desires and perhaps her best interests, especially in the short term. The Case Manager was exercising her power in favour of the caregivers. However, in my presence, the Case Manager did not show any distress over the conflict.

Another example of Case Managers' alliance with caregivers appears in the application of LTC short term admissions policy. In short term admissions, clients are placed a care facility for a temporary period of 7 to 28 days. Case Managers are very pro-active in lobbying for admissions that are only seven days long in order to meet the demands of families. Sometimes families do not want longer admissions. A week gives a much needed respite for the caregiver. However, the literature about placement states that it takes at least six weeks for a client to adjust to placement in a facility. Six weeks may be too long for a short term admission. On the other hand, seven days only gives the client time to start to settle in before returning home. These clients are in extremely fragile health and frequent relocation stress drains their already low energy. Why do Case Managers promote these short admissions? Because of caregivers' requests. It is very stressful on the clients but it is evident from observations at staff meetings in which this issue was discussed, clients are not the focus of Case Managers' thinking. During the discussion of short term admissions there was not one mention of clients. Caregivers need to have a short break to revive themselves before returning to caregiving. Short admissions that meet caregivers' needs are the goal of Case Managers, not fewer and longer admissions that might be easier on clients. Although LTC Case Managers demonstrate their alliance with caregivers, the alliance is constrained by the parameters set by the organization.

Case Managers regularly inform caregivers and clients of benefits they may receive. I did not hear or observe any signs of internal conflict over the limited resources available to provide these benefits. It appears that the organizational rules are so ingrained in their minds that they do not perceive any conflict. When interviewed, another Case Manager said she felt " quite badly" because she had reduced homemaker hours for a client. The next week the client had ended up in the acute care hospital Emergency department. When asked if she felt badly about cutting the hours she sighed "Oooh, phhhht." and shrugged. The Case Manager did say that she realized she shouldn't have cut the homemaker hours but the client "seemed to be doing so well". This client did not have an informal caregiver (family). Formal caregiving was decreased. There was no one to monitor the client or report the client was not coping. The Case Manager did not appear to feel responsible for the woman ending up in the Emergency department. She was not aware of the situation so she could not act on it.

Propping Up The Caregiver

Support for caregivers is demonstrated by Case Managers listening to caregiving problems and providing relief for caregivers by setting up homemakers, daycare and short term facility admissions. The emotional support of caregivers as a component of Case Managers' work is not documented on the Application and Assessment form. As it is not documented, it is not visible to the central LTC management. This invisible work of supporting the caregiver is one way in which Case Managers accomplish the mission of the LTC Program.

In the first case study, the Case Manager arranged that the interview take place in a room away from the client. When the wife/caregiver tried to bring a chair into the bedroom, the Case Manager responded with "It would be better to work at a table." This excludes the bed-ridden but alert client from participating in a discussion supposedly about him. However, the move away from the client 'frees' the Case Manager from having to deal with the dying man and his needs. Now she can concentrate on the wife and her caregiving duties. The client's name is on the form but the Case Manager arranges it so the wife/caregiver is the only one interviewed. The Case Manager spent two minutes with the client and 68 minutes with the wife/caregiver filling out the form. Again, this shows an emphasis on the caregiver, not on the client. This interest goes beyond the caregiver as an information source. In fact, the wife had to run into the bedroom to ask her husband the answers to most of the questions. The wife was an able-bodied conduit of information that the Case Manager relied on to complete the documentation. Also, the first question that the Case Manager asked was about what the wife/caregiver "did for fun before all this started?" This sets the whole focus of the interview on the wife/caregiver and not on the client. Another question to the wife was "Do you need any more help?" not 'Does your husband need any more help?' Again, this demonstrates that supporting the caregiver rather than the client, is the essential work for LTC Case Managers.

Case Managers support caring 'for' the client not 'about' the client. The wife/caregiver in this case study revealed that her alcoholic son was of great concern to her. The Case Manager did not comment. This is obviously a problem for the caregiver but was treated as though it did not directly affect her caregiving role for her husband. Later, when I asked the Case Manager what she would do with that information she replied "I told the homemaking agency in case the son showed up drunk while a homemaker was there." This leads me to conclude that if the son showed up drunk while a homemaker was not there, it was not the Case Manager's concern. However, if he showed up when the homemaker was there, it would be a problem for the homemaker. Also, when the wife/caregiver discussed her own respiratory problem, the Case Manager did not respond. She changed the subject. The Case Manager was "disciplining" (Foucault, 1980) the caregiver to talk only about her role as caregiver, not her other problems. Support for the caregiver is limited.

However, this nurse-type action of the Case Manager was not documented on the assessment form nor was it noted in the client's chart. It is an invisible act to the LTC organization but a very important one. The Case Manager was encouraging the wife to continue her caregiving duties for her husband. The Case Manager is concretely demonstrating to the wife that the Case Manager will be sympathetic and even helpful, if the wife/caregiver confines her requests to those concerning her husband, the client. This wife/caregiver was an informal caregiver meaning she was not paid for her caregiving. Encouraging caregivers is an important role for Case Managers. If it were not for unpaid informal caregivers the increased in cost of health care would be astronomical. This 'free' caregiving labour is essential for the LTC program to meet its goal of caring for chronically-ill adults.

In another home visit with the same Case Manager, it was interesting to note the amount of time the Case Manager was willing to spend on certain topics. The Case Manager spent 45 minutes debriefing with the client about caring for her husband who had died six months ago. The Case Manager gave the woman emotional support by listening to all her feelings, and was helping her come to terms with what had been a very difficult marital relationship. However, the reason for the visit was to set up homemakers for this woman after she returned home following cataract surgery.

Now, the woman herself was a LTC client, the object of caregiving, not a caregiver. The time given to that segment of the interview was 15 minutes, one third of the time was spent discussing her former caregiving role. When filling out the assessment form, the conversation was carefully controlled by the Case Manager. She was facing the organization, focusing on completion of the documentation. There was no discussion with the woman about how she felt, how she was coping or how she was getting along with her daughter. At that point, the daughter had become the caregiver. The Case Manager said that she would phone the daughter and discuss things with her. It is interesting that even when the Case Manager was dealing with exactly the same person in a different role, her approach changed. At first she focused her attention on supporting the woman in her caregiving role and listening to her feelings. However, when the woman became the client, the Case Manager controlled the conversation. Her focus was to complete the document. The Case Manager's support then shifted to the daughter who would become the next caregiver. In the LTC drama, the roles must be taken up appropriately in order to play out the script. Case managers employ practiced forms of "turn taking" (Suchman, 1987) communication to first elicit different roles (caregiving then client) and then discipline through talk, a person's movement into and out of the roles.

The woman in the previous example, had been transformed from caregiver into client. The caregiver role is left vacant so the Case Manager was 'working' on the daughter to fill that role. It is 'work' to organize the various family members to fill roles preconceived by LTC. The main emphasis of Case Manager's work is to find a primary caregiver. This is usually the person who lives with the client. In our society, that would most likely be the wife as we do not have many extended families. Families most often consist of husband and wife who live with children until the children leave home to have their own families. That leaves the husband and wife alone in their old age, casting the wife as caregiver in most instances. Women have been trained to be caregivers, first for their children and then for their husbands. When the wife becomes ill, the husband has usually died as in this previous example and the next generation of women, daughters then becomes caregivers.

In the LTC drama, the Case Manager is the director. She rehearses and trains family members to play their roles. The caregiver is the heroine and may require coaching. Like the dead body in a murder mystery, the client is essential for the plot, but does not really take part in the action. To quote Smith, (1987) "(S) He is constituted as the object of its work not as a participant."(p. 265). Necessary but not usually interactive. Homemaking services, Home Care nurses and the Palliative response team play supporting parts, entering and exiting the home for brief appearances, going on and off the stage. LTC is producing the show, but the victim (the client) and the heroine (the caregiver) are not paid. Only the director as Case Manager and the 'bit' players are remunerated. This adds to the burden of the director/ Case Manager as she must convince the caregiver that her performance is essential. The caregiver will be the star. All their lives, women have been trained for this moment of glory. Unfortunately, the drama plays to an empty house. No one in our society wants to see death and decay. The victim/heroine (client/caregiver) dyad are often deserted by friends and family as they slip into the finale. The play closes only to re-open with a new cast. The heroine/caregiver is now the victim/client, and her daughter, the next heroine.

This fits with Foucault's definition of government (1991) "Government is defined as a right manner of disposing things so as to lead ... to an end which is 'convenient' for each of the things that are to be governed."(p.95). The 'thing' in LTC is the proper care of the chronically-ill person until death. The 'dispose' does not mean to get rid of but to set into a suitable place. As a governmental organization, LTC's function is "...to arrange things in such a way that, through a certain number of means, such and such ends may be achieved."(p.95).

On the five page Application and Assessment form there is a small section for listing the next of kin and contacts of the client. On the fourth page there is a one inch blank space called "In Support of Relationships". There are no specific questions regarding the identity of the primary caregiver, how often that person visits or most importantly, the state of health of this caregiver. The importance of the caregiver appears to be negated by the provincial organizational body as it is not given prominence on LTC forms.

<u>Narrative Notes</u>

Documentation is another example of the invisibility of the work of supporting the caregivers. *Narrative Notes* are the only documentation of Case Managers' extensive telephone conversations with caregivers. *Narrative Notes* are single sheets of lined paper stapled to the left inside cover of the LTC file. Another sheet is stapled on top when the present one is full. Unlike assessment forms, they are not sent to anyone and they are not entered into LTC computerized data base. Case Managers use *Narrative Notes* to document complex situations such as family conflict. This is a reminder for their own use and documentation in the event of legal action.

Narrative Notes are the only place to document telephone conversations. There is a LTC policy that the LTC1 form may only be filled out if the Case Manager has 'seen' the client. The 'seeing' means physically looking at the client. Therefore, this form cannot be used to document a phone conversation. Case Managers spend hours talking to the caregivers. None of that work will appear in the provincial LTC computerized data base. That data base information is used to compile the central LTC Ministry of Health statistics. Every month provincial LTC sends statistics to the local LTC stating how many LTC1 forms each Case Manager has completed. Only this work of Case Managers is visible to the central Ministry of Health LTC management. The compilation of the number of assessments is sent back to the local CRD LTC management now defined as legitimate work. On occasion, Case Managers are criticized for 'not keeping up their numbers'. This disregards the invisible work with caregivers.

Caseloads

Another way in which support of caregiver work are made invisible is the methods used to determine caseloads for Case Managers. A Case Manager is responsible for LTC clients in a specific geographic area. When work loads appears to be uneven, local LTC management tries to redistribute work. At one staff meeting, Case Managers were asked to bring the numbers of clients along with the care levels. Case loads had been evenly distributed according to numbers (i.e. everyone has approximately 300 clients) but did not seem to be equitable. To my mind, there had been an erroneous assumption that differences in care levels caused differences in workload. There is no organizational recognition of the role caregivers or lack of caregivers, play in Case Managers' work. For instance, clients without informal caregivers need Case Managers to do all case management functions. This is not the case when there is an informal caregiver who can monitor the client's situation. When there is no informal caregiver, there is more work for Case Managers.

Who is the Case Manager?

The preceding analysis suggests that Case Managers are doing some of the job of case management but not all of it. This leaves the question of who is doing the rest of the work. Monitoring the client is the most obvious task Case Managers can not accomplish. This function falls to the caregiver. The caregiver is in constant contact with the client. It is often a call for help when the caregiver does notify the Case Manager. One research project (Seltzer, Ivry et al. 1988) families were trained to be the case manager. The training was formally organized into four components. A similar but less formal process happens in CRD LTC.

In this study the responsible family member was identified by the clients. Although the family member is not formally identified by the client in LTC, the process still happens. In the CRD the client selects who will be present when the LTC Case Manager visits. This allows people present access to the LTC Case Manager but more importantly, to the Case Manager, it designates them as an informal caregivers.

In the second component of the research study the client-chosen family member and social worker work out a care plan. Each task is assigned to a person. This, too, happens here in the CRD but again the procedure is more informal. The LTC Case Manager and the family discuss what needs to be done and who will do it.

Thirdly, family members participating in the research study were given information on community resources. Five training booklets were specifically designed for the project. Certainly the imparting of information about LTC takes place here in CRD. However, there is little written information. The caregiver is given the Case Manager's phone number and is told what the LTC funded services can do. This last part was emphasized for me in an interview with a Case Manager. This Case Manager has a reputation of being very business like and does not 'waste time' chatting to anyone, including her co-workers. I had to change my plans to interview her. She had come in very late the day before and said she had been detained by a very long visit. When asked why, she said that the brother and sister-in-law were from Alberta. They needed to " be brought up to speed about the system in B.C." Obviously imparting this information about the system was crucial. Why was it so important? As the relatives from Alberta were staying, they needed this information. Subsequently, they could function as case managers.

The last item in the research study of family members as case managers, was regular contact between the family member and the social worker. This part is missing in the B.C. LTC system. Contact usually occurs at the instigation of the caregiver. This is not a problem if the caregiver is reliable. However, contact fails if the caregiver won't, can't, or does not know how to monitor the situation. Also, knowing when to contact the Case Manager is essential.

So far, all the caregivers discussed have been informal caregivers. If there is no informal caregiver the task falls to formal, paid caregivers. This is usually the case when the client has no relatives in town. In the interview with a Case Manager, there was mention of a homemaker who went to the Emergency department of the acute care hospital with the Case Manager and the client. This was done because the client really trusted the homemaker. The client would only go with the homemaker. The homemaker had phoned the homemaking agency. They, in turn, phoned the Case Manager to alert her to the seriousness of the situation. Often, the Homemaking Agency will phone Case Managers to say a client needs more service. They will even phone to request that the Case Manager see the client if there has been a substantial change. This change would have been noticed by the homemaker who monitors the client's condition as part of case management.

The ability of the Long Term Case Manager to get others to comply with the unwritten demands/requests of the program must rely on more than the pleasant personality of the Case Manager. From a very early age (Reitsma-Street, 1991) women are taught to be caregivers. They ‘incorporate’(Foucault, 1980) the teachings of society into their minds and bodies. Failure to follow these dictates can cause heavy censure. This fits with the third aspect of Foucault’s (1980) definition of labour -- discipline. LTC Case Managers further train women to be an invisible part of the case management team.

Summary of Facing the Caregivers

When I conceived of this research project, caregiving was not even mentioned in my proposal. Caring was considered from the Case Managers’ point of view but not caregiving. After observing the Case Managers, I realized that the caregivers were doing some of the case management. Caregiving needed to be added to my conceptual framework. The themes mentioned in the literature were evident in my research but not always as they had been portrayed. The blending of love and labour in caregiving, the formal and informal aspects of caregiving, caregiving as women’s work, and the cost and rewards of caregiving appeared, but not always as expected.

The blending of love and labour in caregiving is a common theme in caregiving literature. The labour was very evident. The caregivers all appeared tired, worn out and in one case overwhelmed when we visited them. One of the wives was having her “second bout of flu since last week.” The interesting thing was that she was not in bed, nor was she in her housecoat. She was up and dressed with matching earrings, outfit and makeup. In spite of all her efforts to look good, she appeared tired and haggard. The wife, who had called for help because her husband was lying in feces again, had been cleaning him up all weekend. Now she was worn out and was finally asking for help. Although LTC Case Managers' visits are intended to help the clients and caregivers, caregivers work very hard to obtain the necessary information for the Case Manager. In the interview with the dying man's wife, the wife had to get up fifteen separate times to retrieve information for the Case Manager. The Case Manager didn't move.

The labour of the caregivers is so assumed, women are rarely asked if they will take the role. When the dying man's wife was asked about more help, the question was "Do *you* need any more help?" The wife's contribution as caregiver was assumed. Help would be supplied only if she couldn't cope.

The palliative chart of the dying man shows another aspect of the invisible labour of caregiving. The various professionals who visited the home were expected to record on the chart what they had done. His wife who did all the caregiving could not write in the chart. However, she was the one with the most up-to-date information. She corrected the Case Manager as to the changes in medications. The caregiver was expected to do the work but she did not get any recognition for her skills and knowledge about the client.

The love, involved caregiving is a more nebulous thing to define. I saw nothing that I would describe as an overt sign of love. However, the LTC interview process does not lend itself to the expression of emotions. The caregivers all appeared emotionally flat. The wife of the dying man did cry for about 30 seconds. She then dried her eyes and carried on answering questions. The Case Manager's focus was on completing the paperwork. Her questions did not illicit emotional responses. In fact, when the dying man's wife cried, the Case Manager acknowledged it but did not delve any further.

Two caregivers clearly stated their motives were caregiving out of financial necessity. For the remaining caregivers, it was impossible to differentiate between caregiving out of duty or love. It may have been both. The duty is part of the assumption the caregiver would do this work. A wife is simply expected to care for her husband; she had been 'disciplined' to do so. The dying man came home from the hospital to die. In my experience, the wife would never be directly asked if she would or could look after him. It would be arranged by the hospital liaison nurse and home he would go. The wife is left to cope as best she can. She is on duty 24 hours a day.

I clearly saw financial considerations as a reason for caregiving. The man who needed to be cleaned up Monday morning, had a reluctant caregiving wife. The wife admitted to the Case Manager that she would like to leave the client. However, she could not manage on her own financially. In this case she definitely did not care 'about' him but was forced to care 'for' him. Also, she would continue to a receive a portion of his pension when he died.

The problem with informal caregiving is that the caregiver becomes stressed with the physical and psychological burdens of twenty-four hour a day duty. In 1994, the reason given on over 90% of the emergency admissions to LTC facilities was due to caregiver breakdown -- everything from heart attacks to death (1994 LTC Statistics). Caregivers are particularly vulnerable since acute patients are being sent home earlier. Palliative patients, such as the man in the case study, go home to die. These caregivers are doing twenty-four hour a day duties with clients who were hospitalized in the past. There they were cared for by 2 to 3 shifts of nurses with all the resources of an acute care hospital. If a caregiver can no longer care for the client, then the formal system will be used. This could be an acute care hospital at a cost of $666.00 per day, or a care facility at a cost of $50-$150 per day (Personal Communication, 1994). Supporting the caregiver with homemaking services or adult day care at a cost of $17-$60 per day is in most cases, much more economical. LTC Case Managers' support of caregivers is an efficient government expenditure. It is not recognized as legitimate Case Manager work. It isn't recognized at all.

During my research I saw one caregiver who was not a woman. The one exception was a husband who was living at home with his wife who had Alzheimer's Disease. He had physical problems and was himself in need of caregiving. The wife went to a daycare program two days a week and they both received homemaker services. He could be considered the caregiver because he could live alone without her but she could not have lived alone without him. Although this study has not aimed for a representative sample, the people seen did reflect the literature which states that caregiving is women's work

The people seen, also reflected the high cost of caregiving, physically, emotionally, socially and financially. Three of the caregivers seen were themselves chronically or acutely ill. One of the caregivers had died before we visited. We were visiting the widower who had been cared for by his now deceased wife. The daughter was having to replace her in the role of caregiver. This daughter had her own family and full-time job. It was evident that the Case Manager's visit was important to her. She arrived at her father's home directly from her night shift as a nurse. She was exhausted but felt she had to be present to ensure that her father was properly cared for.

The caregivers we visited appeared depressed or, in the case of the dying man's wife, very close to breaking down completely. Stress was very evident in all cases. The husband who was caring for his wife did not appear stressed but he was not doing much of the work - the homemaker was caring for both of them. The women who were 24 hr. a day caregivers appeared exhausted. These women were well socialized, or to use Foucault's term, "disciplined" into their caregiving roles.

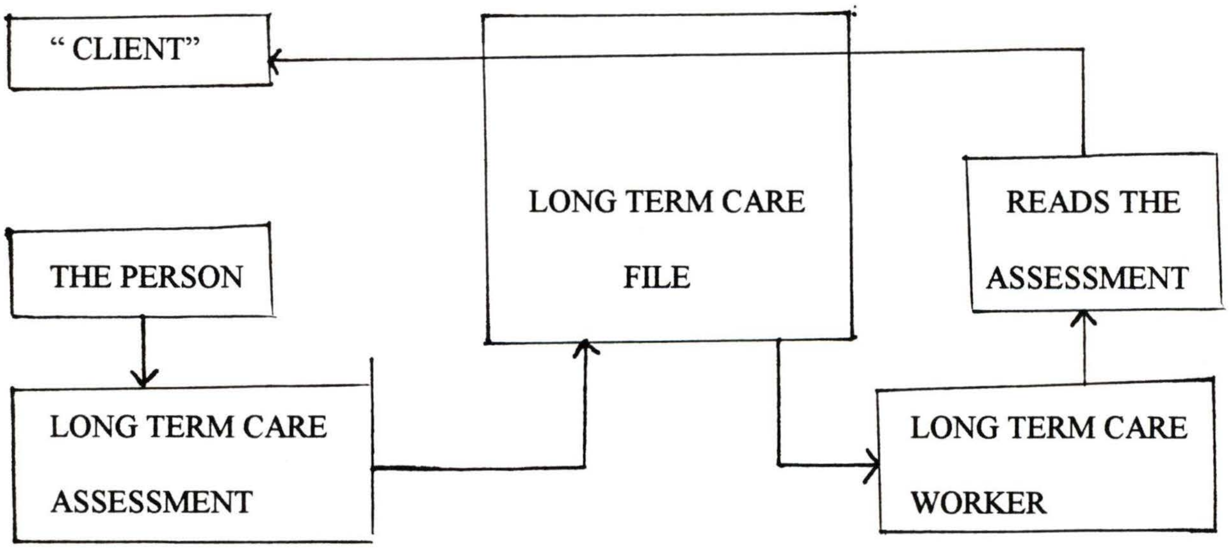
Chapter 8

Turning Around to Face the Organization

Documentation

Documentation is the highly visible part of the work of LTC Case Managers. As Dorothy Smith (1975) points out, "documentary reality" constructs the client (see Diagram 1 below). The 'construction' of the client takes place within LTC documentation but documentation also constructs the work of LTC Case Managers. It is the only part of Case Managers' work that is visible to the Ministry of Health which funds the CRD LTC Program. It is the number one priority for Case Managers. The Ministry of Health LTC only recognizes the organizational work of Case Managers.

The Production of LTC Documentary Reality



- Adapted from D. Smith, 1975

Diagram 1

The first step in the LTC process is an assessment (see Appendix A). Documentation of this assessment is then filed in the LTC records. The record is used to order homemaker services, daycare, or request placement. A copy of the record is sent to the appropriate service provider. In Diagram 1, the line representing reading of the documents goes through the 'LTC file' box to demonstrate the invisibility of the documentation. The LTC assessment form (LTC 1) is the first information any worker in those diverse settings would receive about the client. However, they are not reading about the human interaction that took place between two people, the Case Manager and the client. They are reading about the 'client' who has been socially constructed into the documentary reality of the LTC assessment form. A woman has severe arthritis, cannot dress herself, or walk more than a few feet. These few facts are used to have her assessed at the extended care level in documentary reality. It does not tell us that this woman was a brilliant scientist and still retains all her mental faculties. As well she is intensely claustrophobic because she was tortured in a Nazi concentration camp and all of her family were killed. She also has no living relative to act as a caregiver. All of her personal history has been stripped from her in documentary reality.

Documentary reality Smith (1987) removes the local and the historical. "The text's capacity to transcend the essentially transitory character of social processes and to remain uniform across separate and diverse local settings is key to the distinctive social organization and relations they make possible" (Smith 1990, p.168). The original interaction was between two people, the Case Manager and the person being assessed. But in the documentary reality the historical and local have been removed. The previously mentioned woman is understood in the context of her physical abilities and even her mental abilities but her history/ her story is missing. How did she come to be living in Victoria? Who phoned and requested the LTC assessment? Was her place clean and tidy or was it dirty and smelly? Was she gracious and invited the Case Manager to share a cup of tea or was she hostile because someone was trying to interfere in her life? Was the Case Manager having a bad day because her allergies were bothering her and she had just had a run in with her boss? The answers to all these questions were part of the interaction that took place between two people. The resulting recorded information is treated as though it had been acquired without any human interaction.

The creation of documentary reality mediates relations between the knower and the known (Smith, 1975). The information so constructed is only understandable to those within the organizations and is not made to be self supporting outside of the organizational context (Smith, 1975). Other LTC workers would understand the document but not necessarily anyone outside of the LTC organization and its service providers (homemakers, daycares and LTC facilities). This documentary reality is the only information that is available to the service providers who are then expected to meet the needs of the real person. At best the client or caregiver then has to repeat all the information; or at worst, the client is completely misunderstood and her care mishandled. In the previous example of the woman who was assessed extended care level, the Case Manager does not have to take responsibility for assigning the woman to an extended care facility which houses four people to a room and may not be appropriate for her post-trauma claustrophobia. The care provider thinks that the assessment form is about the client when really it is about the LTC program's administrative needs.

Completion of the LTC Assessment and Application form is absolutely essential on a home visit to a new client. In the case study of the dying man, we can see that the majority of the questions asked by the Case Manager are directly related to filling out the categories on the form. There may be a complete change of subject for the client/caregiver. Several examples of this can be found in the case study presented earlier. The wife/caregiver, who obviously had respiratory problems, revealed she had a drag of a cigarette. In another situation, this could be seen by a social worker as an indication of the amount of stress the woman was under caring for her dying husband. On the other hand, to a nurse it could raise concerns about the woman's own health and how harmful smoking is with a pre-existing respiratory problem. In the interview reported, however, we see the LTC Case Manager ignoring the confession. Wearing her organizational face, the Case Manager responded with "How long have you lived in BC?" This question was absolutely necessary because it establishes residency eligibility for the client. Without establishment of residency, the client could not access LTC benefits. This incident occurred toward the end of the interview. Every category had to be completed before leaving the home. There was not time to be empathetic. The Case Manager was ignoring the woman's utterances and focusing on her own work.

The conversation between the Case Manager and the wife in the case study is interesting in terms of communication analysis as discussed by Suchman (1987).

Communication analysts call doctor -patient encounters 'pre-allocation of turn types' (Suchman, 1987). The physician almost always asks the questions and the patient answers. To quote Suchman (1987) " the effect of the pre-allocation of turn types is to deliver control of the proceedings from the client or layperson back to the expert or specialist." (p.89). By asking a question, the Case Manager is playing the expert role and takes back power to direct the conversation. The Case Manager asks a question and the caregiver must respond to that topic. In the case study, the wife must answer the Case Manager's question "How long have you lived in B.C.?" even though the wife was in the middle of confessing that she had severe respiratory problems and had taken up smoking again. The Case Manager chooses the topic when she asks the questions. After the response, the Case Manager is free to continue on that topic or to change it if she wishes. The agenda is set by the Case Manager and the caregiver must follow. As the 'expert' the Case Manager has the power to direct the conversation (Suchman, 1987).

The Case Manager did follow the wife/caregiver's lead when she voiced concerns about dealing with the incontinence product and the peritoneal lesions of her husband. The Case Manager not only followed the caregiver/wife's conversational lead, she was willing to act on it. The Case Manager got up and went into the bedroom to look at the lesions. She discussed possible treatments with the caregiver/wife. In this instance it appeared that the Case Manager acted as one would expect a nurse to act. The wife appeared to appreciate the Case Manager's advise.

However, this one 'nurse-type' action of the Case Manager occupied a very small amount of time in the total interview. The vast majority of the interview was focused on completion of the LTC forms. This 'assessment' of the person by completing LTC forms creates the documentary reality of the constructed 'client'. This documentary reality meets the needs of the LTC organization not the caregiver or client.

Externalized Consciousness

Documentation also acts to externalize consciousness (Smith, 1975). This means that documents are organized to set limits independent of the person completing the form. The individual Case Manager is not solely responsible for her decisions about resources available to clients. By assessing clients into care levels there is an organizationally constructed barrier that prevents Case Managers from feeling and being personally responsible for limiting resources for clients. If the client is assessed 'personal care' level, there are only so many homemaker hours available to the client assessed at that care level. Justification could be made to give the client more, but the care level dictates a particular amount. The Case Manager can ask for more hours for the client but that would be done as an exception not standard practice. The care level buffers Case Managers from feeling directly responsible for resource allocation even though that is what they are doing.

Documents define the world through the priorities of those that rule it, not in terms of those whose names are on the documents. The woman who has been assessed "extended care" and must move to an extended care facility is not being served by those documents. It is the LTC program that is gaining by categorizing clients into groups that are admitted to different facilities and which are funded at different rates. More funding for a facility or more homemaker hours can not be requested because Mrs. Smith can walk and therefore is considered intermediate care level. However, even if her case is very time consuming for staff because of her personality disorder, funding remains at the intermediate two level. The same is true for homemaker services or daycare. The care levels are to facilitate administration and funding not, to enhance care for clients.

The production of the documents by the Case Manager is called “assessing the client”, but is it?

Is this an Assessment?

These home visits by Case Managers are called "assessing the client", by everyone in the system. The majority of the information on the form is filled out by asking questions of the client or caregiver. There is little or no effort made to determine if the information is correct. In Social Work or Nursing an assessment usually means that the professional would directly observe the aspect of the client being assessed. For example, a nursing assessment of a patient's skin would involve the nurse actually observing the patient's skin. While doing this LTC Assessment, the Case Manager did not observe anything about the client other than his scrotum. This was done only in response to the wife/caregiver's request. The information obtained from this examination was not documented on the LTC form. The Case Manager did not observe the client walking which was one of the categories to be filled out. What she did do, was fill out the categories on the form, constructing eligibility of the client for the LTC Program from the verbal information given mostly by the wife. Establishing eligibility was the effect of "assessing" the client.

Constructing Eligibility

Eligibility for the LTC Program is based on age, length of residency in British Columbia, Canadian citizenship, chronic medical conditions and financial needs. The work of the Case Manager involves knowing the information required to fill out the five page LTC Application and Assessment form and how to obtain that information from the client or caregiver.

Age

The first criterion of eligibility for a LTC client is age. As the program serves everyone over 19, and the majority of clients are geriatric, there is rarely a dispute about age. Because the question about age is not an issue, the Case Manager simply asks for date and year of birth. No supporting documentation is requested.

Residency

The next criterion for eligibility is residency in British Columbia continuously for the past year. Long Term Care is solely funded by the provincial Government through taxes paid by residents of British Columbia. The provincial government protects the system from use by residents of other Canadian provinces or non-Canadian residents. This is accomplished by enforcing a current one-year in British Columbia admission requirement. This is very strictly enforced when it comes to LTC facility residents. For example, a daughter living in BC could not transfer her father from an Ontario nursing home to one in BC. The father must come to BC and pay for care privately for one year. After a one year wait in B.C., he would qualify for the program. It is possible to appeal the ruling but less than half the appeals are granted. The question of residency was added to the 1994 revision of the first page. As with the question of age, there is no real attempt to obtain documents that corroborate the statement of residency. However, potential clients must produce a Personal Health Care number which is distributed by the B.C. Medical Services Plan. That plan does ask for documentation of three month residency.

Medical Condition

The third criterion involves establishing a chronic medical condition as grounds for care. In the Mission statement of the LTC Program (see Appendix D) it states the program provides care for chronically ill adults. The medical condition is verified by hospital documents if the client has been in hospital, as in our case study. If the client had not been in hospital, there is an expectation that the Case Manager will verify the medical condition with the family Doctor. It is not mandatory the medical condition be independently verified. In this case study, the medical condition is obtained by phone from the Hospital Liaison Nurse during the initial referral to the Case Manager. The Hospital Liaison Nurse would have direct access to hospital documents as part of her work requirement. Also, the Hospice Book which is present in every Hospice client's home contains a medical diagnosis. Thus information is taken from hospital records or from the Hospice Book to establish the chronic medical condition criterion for eligibility is satisfied and documented on the second page of the Application and Assessment form.

Financial Watershed

All residents of British Columbia are eligible for the LTC Program regardless of their financial status. However, the manner in which the financial form is organized makes the program financially undesirable for any client over a certain income. The dividing line or watershed is different for each client depending on their income and the amount of homemaking help required. All the client's income is considered when completing a financial form. In our case study, the Hospital Liaison nurse told the wife/caregiver that the Case Manager had to complete the financial form before the LTC Program would pay for services. The wife had been instructed by the hospital liaison nurse to have the previous year's income tax form available for the Case Manager. The client doesn't receive service from LTC before signing the financial form agreeing to pay for the client portion.

As well, the Case Manager had been told by the Hospital Liaison Nurse that the client was receiving a Veteran's Pension. This income would not have appeared on the federal Income Tax form. After the Second World War, the Federal Government promised veterans with disabilities that their disability pension income would not be taxed. They do not have to pay federal income tax on that money. However, the provincial government did not make a similar promise to veterans. On the LTC Financial form, the

Veteran's pension is considered income. This causes many Veterans great aggravation as they have interpreted the federal government's promise to mean that the money would never be considered income under any circumstance.

The client's financial contribution is based on the same principle as Income Tax. All the income is added up and then certain deductions such as medical premiums can be made. The remainder is divided by 60 to determine the client portion. I do not know why 60 was chosen, nor could I find anyone who could give me a rationale; I assume it is a mathematical formula similar to that of the income tax form. The client portion is the amount the client pays each day for homemaker service in the home. If the client receives the federal Guaranteed Income Supplement (GIS) there is no charge automatically. To be eligible for GIS, the client would be receiving the Old Age Pension exclusively, without any other sources of income. Eligibility of cost coverage of LTC services is treated as pre-established when the client receives GIS. This client had a substantial Veteran's Pension and therefore, like income tax, he would pay a large per diem for LTC services. For this man, the resulting client portion was $54.44. This means he would pay $54.44 each day the LTC homemaker was used. It would be financially better for the client to hire a homemaker privately at a cost of $17.00 per hour, rather than pay $54.44 a day for the LTC funded homemaker. For example, if a client needed a homemaker for two hours a day, it would cost the client $54.44 through the LTC program. But only $34.00 if the homemakers were hired privately. The Case Manager made it sound like a better deal by saying if the client needed a homemaker twenty-four hours a day then this charge would be less than the homemaker's agency would charge privately. This financial form is an example of the way in which LTC documents standardize management of clients.

be less than the homemaker's agency would charge privately. This financial form is an example of the way in which LTC documents standardize management of clients.

Standardization

On the first home visit, the Case Manager must complete the 5 page standardized assessment form (see Appendix A). The very word 'form' immediately conjures up the image of identical pieces of paper with identical boxes and spaces which must be filled out for each person. Each person has a unique identity but must be constructed identically to all the others categorized in the same box. One client who was visited to update papers for placement had to be able to walk twenty feet to be admitted to an intermediate care facility. She was going to be placed in a special ethnic-specific intermediate facility (there is no equivalent ethnic-specific extended care facility). This client did walk twenty feet but she just about fell on the floor, returning to her bed. The Case Manager did not see this. She had seen the client walk the twenty feet; then turned around to talk to the family. The job was done. The client could be classified as intermediate care and could go to the ethnic-specific facility. No matter how confusing or conflicting the evidence, at some point Case Managers must make a decision. The client must be placed in a box. There is an expectation within certain areas of the organization (for example, those concerned with financial accounts for the LTC program) that each person categorized as intermediate care will be expected to be identical and interchangeable with all others assigned that care level.

In the computerization of information process clients are assigned a unique seven digit number when first in contact with the program. That number is never changed or used again for another client, even if the client dies. At first glance this would appear to be a very individualizing aspect of the program. On closer examination it is revealed as further standardization. The most obvious point is that the person is not known by their name but by a number which has exactly the same number of digits as everyone else's number. A client in CRD could have a number such as 6012345. Although the last four numbers (2345) are unique to the client the first three numbers (601) are the health unit's number. All the initial assessments done in CRD are assigned numbers starting with 600 through to 606 so they can be identified as CRD LTC. The first three numbers assigned to people who were initially assessed in B.C. outside of CRD. are different (e.g. 141) and are filed in a separate cabinet called " out of towns." All previously completed assessments are in a folder and filed according to client's number. To access an individual's file, the Case Manager must have the unique LTC number. Computerization of information requires standardization.

Upon completion of the 5 page form, Case Managers must insert clients into one of the five care levels, personal care, intermediate one, intermediate two, intermediate three or extended care. Assessment is not considered complete without designation of care level. Client information can not be entered into the computer system without a care level established. Without official entry into the computerized information system, no LTC benefits can be accessed. Homemaker agencies are paid through the information system, daycare wait lists are compiled on it and facility waiting lists are enumerated on it. The client must be standardized into one of the five care level boxes on the bottom of the form to exist for LTC.

Part of hermeneutic practice in bureaucracies is standardization. Assigning to clients into "care levels" has meaning for members of the organization beyond the definitions of the words themselves. Being assessed as "extended care" not only limits the amount of homemaking the client may receive at home, but also designates the LTC facilities to which the client can be admitted. The division of facilities themselves into care levels such as intermediate and extended care reveals further standardization. The facilities are issued a license by a governmental body. The license specifically restricts their clientele to one care level -- Personal Care, Intermediate Care or Extended Care. Very few facilities are allowed to care for clients of more than one care level . This means that a woman who has lived in the same private room, in an intermediate care facility for over ten years will be forced to a four bed ward in an extended care facility. If she can no longer walk twenty feet, she will be assessed at extended care level. The standardization of facilities into caring for one care level and assessment of clients into care levels, irrationally rationalizes an inhuman act. It is a rational act from the view of the Ministry of Health but irrational from the perspective of a client who must move.

There is the implicit assumption in the functioning of the LTC program that Case Managers too, are interchangeable. The idea that any Case Manager on any given day would assess a client the same way is implicit in the operation of LTC. Results, no matter who assessed the client or the circumstances surrounding the assessment, are all treated alike. Case Managers are considered standardized parts of the program that can be plugged in or removed with no consequence. If Case Managers were truly interchangeable, the results of the study (Beebe, 1994) of the 5,000 files would have revealed correlation between the boxes ticked and the care level assigned to clients. As there was no correlation in the intermediate category, there must be different factors different Case Managers take into consideration when assigning care levels. The LTC program assumes Case Managers are identical.

The fallacy of that assumption is seen when Case Managers try to replace one another for holidays or sick relief. The stress Case Managers experience is far beyond the extra caseload. Trying to 'cover' for someone else's case load is like driving in the dark without headlights. You have the power but you have no idea of the area in which you are operating or where you are heading. Even the few Case Managers who I followed had differences in their approaches to clients and case management work. In spite of LTC operating as though Case Managers are identical, the ones I observed all appeared to function very differently to me. For example, one Case Manager tells obscene jokes on the phone with her fellow workers and the homemaking agencies, while another is so business-like that she could be considered cold. Every Case Manager is unique.

The Ministry of Health has even issued 'standards' for the performance of Case Managers. These standards are supposed to be used to do performance evaluations for Case Managers. In the Oxford dictionary(1979) the definition of standard as a noun is " a thing, quality, or specification by which something may be tested or measured."(p.796). This may serve very well when considering the exact size of a pipe but it does not take into consideration the fascinating variations in human beings or more importantly in this

How can there be 'standards' that are used to judge the performance of Case Managers that cover every possibility that could happen between two people? Again, Case Managers are being judged and standardized in the same way clients are when assigned a care level.

Case Managers are also standardized and judged through the use of their Case Manager number. I was surprised and somewhat taken aback to have my old assessor number (27) reassigned to me when I returned to LTC after a ten year absence. The number had been standardized with the addition of the zero and updated with the addition of the health unit's three digits. The uneasy feeling I had was due to the fact that through that number, all my work for LTC over a period of eighteen years could be traced. Someone with access to the provincial LTC system could be judging the work I have done without my being aware of it. In my research I did find evidence of Case Managers' numbers being used in that way.

While interviewing one Case Manager, she revealed that she had a negative comment on her last evaluation from her Assistant Manager. "My numbers were down" was the Case Manager's explanation. This failure means that she did not complete enough forms during a specific period of time. This was ascertained by a computer analysis using her assessor number. When I asked if there had been any complaints from clients during that period of time she said, no. Every month Assistant Managers routinely receive computer printouts stating how many assessments each Case Manager has completed, including the care level of the clients assessed. The Assistant Manager focused on these numbers. She wanted to increase staff because Case Managers appeared very stressed.

Unfortunately, the only work acknowledged by the LTC Program in the Ministry of Health, is completion of documents. If there were fewer forms completed, it was interpreted by the Ministry of Health LTC staff that there was not an increase in work. There would be no increase in Ministry of Health funding for staff. By using the computerized information system, it is easy to reduce the complexities of Case Manager work to a few numbers.

The system contains all the locally generated information that the Ministry needs. Not only is the information there but it is instantly accessible without local management or workers being aware of how the information is being used. This information can be used for administration and planning without the decision-makers having to come face to face with the consequences of those decisions. It also can be used for supervision of staff as each Case Manager has a unique number that can be traced throughout the system. Information technology allows the Ministry of Health to have access to the most minute details of the operations of the program without ever having to interact with the live human beings who are workers and clients of LTC. This intense scrutiny of the smallest operational detail of Long Term Care is accomplished through access to information entered into the computerized data base.

Pixel Reality

"Pixel reality" is my term for information from documents entered into a computerized data base. I have named it such because pixel is the name of the smallest square of light on a computer monitor. A pixel is either on or off, there is no 'maybe' or 'sort of'. There is no room for grey tones or for changing realities. This removes ambiguity from computerized information. Even in the documentary reality of the LTC assessment form there are opportunities for some description of the client as a person. Case Managers can mark two characteristics instead of one, if applicable. Or if the options don't really match the situation, there is room to write additional information to qualify the category. In pixel reality all the characteristics that make us unique individuals have been stripped away.

Dorothy Smith (1987) depicts the documentary reality as removing the historical and the local. In pixel reality that desiccation is carried out one step further. The personal and the individual are removed from information about the client. I am defining the 'personal' as the client's behaviour, personality, energy level etc. The 'individual' refers to the physical characteristics such as medical conditions, height and weight. The documentary process resembles the ancient Egyptians methods of preserving the Pharaohs. The blood and guts were removed. The rest of the body remained intact, desiccated and wrapped in paper(papyrus) and/or linen. A mummy is not a whole person, but Egyptologists can deduce an amazing amount of information given the dried out remains in the sarcophagus.

Likewise, from documentary reality a reasonably close approximation of the person could be reconstructed. ‘Pixel reality’ is the equivalent of crushing the dried mummies into dust. The dust can be neatly packaged into uniform boxes labeled with the person’s name. In LTC lingo these boxes are called ‘screens’. A ‘screen’ exactly fits on to a computer monitor. Each person in LTC has a ‘screen’ that contains their name, demographic information and care level last assessed. Given one of these boxes of dust, or ‘screen’ of information, it would be impossible to reconstruct the live human being represented. These desiccated boxes of information are routinely used by the Ministry of Health LTC to make decisions that have significant impact on the lives of clients. Unfortunately, clients are not Egyptian Pharaohs, they live and breathe.

The above metaphor demonstrates how little information there is contained in ‘pixel reality’. Unfortunately, decisions are made using just that computerized information. Decisions that affected the lives of very much alive, LTC residents in care facilities. As I have mentioned, there are three categories in intermediate care, I, II, and III. The funding for intermediate care facilities is based on care levels of residents in facilities. The higher the care level, the more money the Ministry of Health gives to the facility under the auspices of the LTC program. When the LTC program was first launched, Intermediate Care I clients could be admitted to facilities. There was a wide discrepancy between the care needs of residents assessed at the Intermediate Care I level and those assessed at the intermediate care III level. Assessment levels were used as a method of compensating facilities for accepting clients who were assessed at the intermediate II and III care level. These clients required more care. Twice a year the Ministry would do a ‘snapshot’ assessment to determine the facility's budget. On that day, the number of residents at each care level was calculated. Dollar values were assigned to each level. The resulting total determined the facility's budget for the next six months. This process stopped in 1994. The facilities were given the same amount as their previous budget. Clients moved in and out of care facilities but the budgets remained the same. Then in early 1996, without warning, the Ministry of Health LTC carried out another 'snapshot' which resulted in the loss of large amounts of money from facility budgets. Staffing was reduced because clients' care levels were not as high as the previous 'snapshot'. The 'pixel reality of numbers determined facility budgets. The day before the snapshot, Mr. Jones and Mrs. Smith required care in a facility. The day after the snapshot, Mr. Jones and Mrs. Smith still required care in a facility. However, on the day after the snapshot, less facility staff were available because 'pixel reality' said the residents needed less care. It is true that people make decisions, not information systems. However, it is the instantaneous nature of computerized information that allows this arbitrary monitoring and assigning budgets.

Operational Control

The previously mentioned example also demonstrates the ease with which the Ministry of Health can access locally generated information. The 'snapshot' was performed with expediency in mind. The facilities would have requested an update on client assessments if they had been warned. This instantaneous access to statistics, dramatically increases the amount of control exercised by the Ministry of Health central LTC program.

dramatically increases the amount of control exercised by the Ministry of Health central LTC program.

This control and monitoring is accomplished in the LTC program through work of administrative support staff. Cook Street LTC office's administrative support staff are responsible for entering and correcting information into the provincial information system. Case Managers provide this information to update the system. The matching of information from the provincial computerized information system with billing information submitted by care providers (homemaker agencies, daycares and facilities) is crucial. Care providers are not paid if information is imperfectly matched. Local Case Managers authorize monthly homemaking hours allotted to each client. However the agency issues bills to the central LTC program at the Ministry of Health not to the local CRD LTC. Ministry of Health LTC staff compare the computerized information with locally posted information. If inaccuracies appear a list of mismatches, or as the ministry calls them 'invalids', is sent to the local Health unit for correction.. An 'invalid' results in Ministry of Health rejection of a care provider's billing charges. Administrative support checks files or consults Case Managers directly to determine authorization of changes. Changes may have been authorized but not entered into the computer, or were entered incorrectly. Because this process is based on computerized information, the incorrect entering of even one day in the birthday of a client, or one letter difference in the name, will result in an 'invalid'. Information must match precisely. Agencies make errors; a check ensures only services ordered are paid. Case Managers do not consider a call from an administrative support person a priority. Resolution of the conflict in information often takes several calls. Unless the discrepancy is corrected the care provider will not be paid for the work.

The term 'run' is the Ministry of Health computer payment/billing system. Valid invoices of one type of service e.g. homemaking agencies are issued via this system. 'Runs' occur on a weekly basis. Invoices that have been validated by accurately matching computer information are paid. Pressure falls on support staff to correct as many errors as possible before the 'run' occurs. Care providers are paid or not paid depending on administrative support staff's ability to validate information. One clerk told me that in the previous month they had "caught" a homemaking agency billing for hours for a man who had been dead for two months. There is a need for monitoring to ensure that ever decreasing dollars are spent caring for those in real need. The LTC computerized information system itself is in dire need of updating to prelude labour intensive methods presently employed.

In spite of having worked for LTC for over six years, I did not understand the role of administrative support staff in paying care providers. I was aware that there have always been feelings of hostility between the administrative support staff of the central office and Case Managers. One of the administrative support staff told me a Case Manager asked her "Why would you want to go back there and work with them?" This reference was to her applying for a job in the section of administrative support staff where the billings are processed. Interestingly, there are not the same feelings between administrative support staff and Case Managers at other CRD offices. The central CRD LTC office is the only one involved in the billing process and correction of 'invalid' billing forms. I now understand where the conflict arises. Case Managers think administrative support staff are there to support them. In reality, they are there to support provincial Ministry of Health LTC administration. Administrative support staff in the central office monitor and correct the work of Case Managers and care providers. These staff members are not professionally trained but their job is to question and correct Case Managers' work. They also earn approximately half as much as Case Managers. This fact may add another element of tension to the situation. Usually, the person who monitors/supervises a person's work makes more money. All of this adds up to conflict that is organizationally generated. It is not a personality problem between the different groups of workers; that is how the situation has been characterized by Case Managers. This monitoring of billing invoices is the Ministry of Health's way of controlling LTC funds.

Financial Control

Financial control is exerted through the power of money. The provincial Ministry of Health, the federal Ministry of Health and the Capital Regional District all use ruling practices to organize and maintain control in their organizations through financial strategies. Sloan, in his book "My Years with General Motors" (1972), very clearly traces the development of financial control by the central company, General Motors Corporation. This was done to co-ordinate efforts of their divisions such as Buick, who up to that point were fairly autonomous. Sloan very succinctly states " It was on the financial side the last necessary key to decentralization with co-ordinated control was found." (Sloan, 1972, p.158). The provincial Ministry of Health LTC has final authorization over the payment to CRD LTC care providers. Likewise, the federal government has used fiscal control to

CRD LTC care providers. Likewise, the federal government has used fiscal control to coerce the provincial government into following federal policies. This principle of centralized control of finances has been used by all of levels of government to maintain jurisdiction of the use of funds in LTC (see Diagram 2 on the next page). Policy decisions made by the federal and provincial governments can be seen in the day-to-day work of the LTC Case Managers.

CONTROL OF CASE MANAGERS' WORK

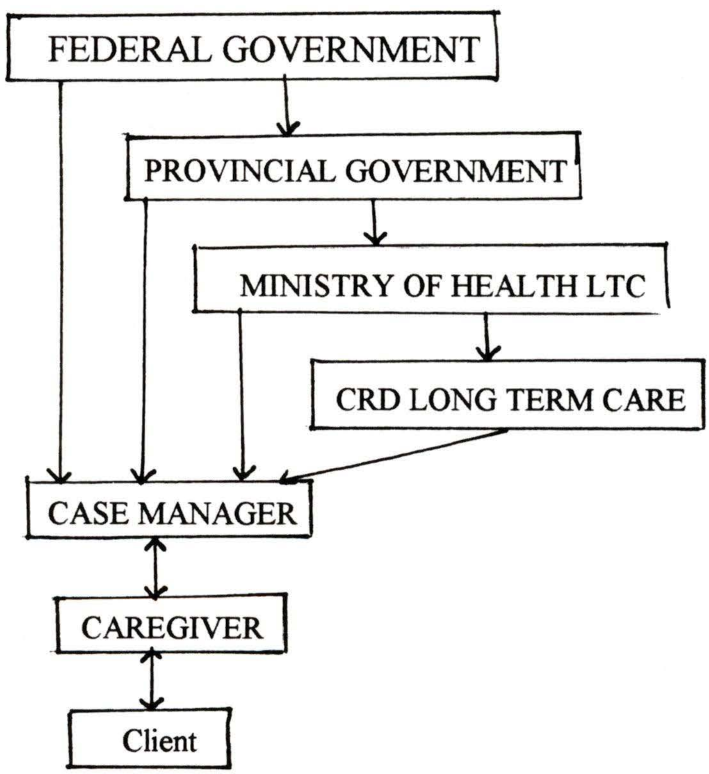


Diagram 2

This control is demonstrated in the work of LTC Case Managers in the discrepancy between waiting periods for out-of-province clients. If the client is assessed as requiring extended care, there is a three month wait. If the client is assessed intermediate care, there is a twelve month wait. This discrepancy is a direct reflection of funding from the federal government for extended care. The federal government insists on a three month portability of health care benefits. In contrast, the wait for intermediate care is twelve months because it is solely funded by the province. The twelve month wait is presumably so the client would have paid taxes at least once in B.C. It also deters families from transferring their elderly family members to B.C. Clients must stay in private-pay facilities in B.C. for twelve months before being assessed and put on a waiting list for a LTC funded facility. The cost of private-pay facilities is approximately $3,000-4,000 per month; an amount beyond the means of most B.C. families. This financial control by the federal and provincial governments is an example of the intersection of LTC and extended social relations.

~~Articulation with the Extended Social~~ Relations

Information gathered by Case Managers to complete documentation on the LTC1 assessment form articulates with other social relations (Smith, 1987) in our society. Information from one set of social relations interweaves with information from other social relations to create a blanket which can cover and conceal the individual as often as it reveals and represents the real person. Examples of these interconnections are so ubiquitous in our society that the crossing of these lines of power are considered logical outcomes of organization in our society. It is at these intersections of ruling relations that outcomes of organization in our society. It is at these intersections of ruling relations that we can illuminate individual threads. By examining the documents, we can see how the lines of power intertwine to organize our everyday lives.

The most commonly used document in LTC is called the assessment form or LTC-1 (See Appendix A). All five pages of this form are filled out during a first time assessment of a client. After the initial assessment, various pages can be used to implement care in other new situations. For example there is a new care provider such as when a client moves to a new care facility, the first three pages must be filled out. However, if the client is just being reassessed as to care level only the first page needs to be completed. Examination of the form demonstrates connections with other organizations, governmental bodies, religious and legal systems (see next page)

Province of British Columbia
Ministry of Health and
Ministry Responsible for Seniors
CONTINUING CARE DIVISION

APPLICATION AND ASSESSMENT FORM

SECTION I
ADMINISTRATIVE AND SUMMARY

1 ☐ NEW ASSESSMENT
2 ☒ REVIEW
3 ☐ RE-ASSESSMENT
4 ☐ APPEAL
5 ☐ CORRECTION

HEALTH DIST. | ASSESSOR
CLIENT NUMBER

A CLIENT'S PERSONAL DATA

1 CLIENT'S FAMILY NAME | FIRST NAME | INIT'S | PHONE (CURRENT)

2 LIST CLIENT'S ADDRESS FOR LAST 12 MONTHS. IF MORE THAN ONE, LIST ADDITIONAL ADDRESSES AND DATES IN PARA. F. SUMMARY. ENSURE PRESENT LOCATION OF CLIENT IS REPORTED IN SPACE PROVIDED.

CURRENT ADDRESS | FROM (DATE)
CITY | POSTAL CODE
CURRENT LOCATION OF CLIENT
☐ AS ABOVE
☐ OTHER

3 MARITAL STATUS
1 ☐ SINGLE
2 ☐ MARRIED
3 ☐ WIDOWED
4 ☐ DIVORCED
5 ☐ SEPARATED
6 ☐ OTHER

SEX ☐ M ☐ F | BIRTHDATE Y Y M M D D | PERSONAL HEALTH NUMBER | VETERAN ☐ YES ☐ NO IF YES | SERVICE NUMBER

B

A "CONTACT PERSON" IS ONE WHO ASSISTS THE CLIENT WITH AN APPLICATION AND/OR A PERSON WHO IS WILLING TO MAINTAIN A CONTINUING INTEREST IN THE CLIENT'S WELFARE WITHOUT IMPLYING RESPONSIBILITY.

CONTACT PERSON'S FAMILY NAME | INIT'S | RELATIONSHIP
STREET ADDRESS
CITY | POSTAL CODE | HOME PHONE | BUSINESS PHONE

C

GIVE DETAILS OF PERSON OR NEXT-OF-KIN WHO SHOULD BE CONTACTED IN AN EMERGENCY. ENTER "CONTACT" IF PERSON IS NAMED IN PARA. B.

NAME | NEXT-OF-KIN: ☐ YES ☐ NO | RELATIONSHIP
ADDRESS | POSTAL CODE

D

GIVE DETAILS OF PHYSICIAN RESPONSIBLE FOR CARE OF CLIENT. IF THERE IS SPECIALIST OR OTHER PHYSICIAN, ENTER IN PARA. F. SUMMARY.

PHYSICIAN'S NAME | OFFICE PHONE
OFFICE ADDRESS | POSTAL CODE

E APPLICATION

I HEREBY APPLY FOR BENEFITS FOR WHICH I/CLIENT MAY BE ELIGIBLE UNDER THE LONG TERM CARE PROGRAM AND CERTIFY THAT THE INFORMATION THAT I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND MAY BE RELEASED TO THE LONG-TERM CARE SERVICE PROVIDER.

CLIENT OR AUTHORIZED SIGNATURE

CLIENT'S PREFERENCE (SEE REVERSE) PREFERRED FACILITIES
1 ☐ CARE AT HOME
2 ☐ FACILITY CARE 1 ____
21 ☐ STANDARD
22 ☐ SEMI-PRIVATE
23 ☐ PRIVATE 2 ____

F ASSESSMENT SUMMARY (TEAM REVIEW IF CARRIED OUT)

DATE CIRCLE APPROPRIATE NUMBER
1. ASSESSMENT DATE
2. REVIEW DATE
3. REASSESSMENT DATE
Y Y M M D D

LOCATION IN WHICH ASSESSMENT DONE:
1 ☐ CLIENT'S HOME
2 ☐ FACILITY
3 ☐ ACUTE HOSPITAL
4 ☐ OTHER

ACTION REQUIRED
1 ☐ TEAM REVIEW
2 ☐ FOLLOW-UP
3 ☐ NA

B F DATE (IF APPLICABLE)

ASSESSOR'S SIGNATURE | B F CODE

G APPROVAL OF SERVICES AND CARE LEVEL (FOR ADMINISTRATOR'S USE ONLY) THE FOLLOWING SERVICES ARE APPROVED:

1 ☐ NOT ELIGIBLE
2 ☐ CARE DECLINED BY CLIENT
3 ☐ CARE AT HOME
4 ☐ CARE AT HOME; MENTAL HEALTH SUPPORT
5 ☐ FACILITY CARE
6 ☐ DAY CARE

1 ☐ PERSONAL CARE
2 ☐ INTERMEDIATE CARE 1
3 ☐ INTERMEDIATE CARE 2
4 ☐ INTERMEDIATE CARE 3
5 ☐ EXTENDED CARE

EFFECTIVE DATE ____
AGENCY ____
SECOND PROVIDER ____
C.P. $___ GIS ___ Y ___ N ___
TOTAL HRS. ____
S ___ C ___ E ___ N/C ____

PREFERRED FACILITY		ALTERNATE FACILITY	
FACILITY CODE	DATE ON LIST Y Y M M D D	FACILITY CODE	DATE ON LIST Y Y M M D D

LTC ADMINISTRATOR'S SIGNATURE | DATE SIGNED

On the previous page is a copy of page one of the Long Term Care Application and Assessment form. At the top on the left hand side of the form is the crest of British Columbia and the words *Province of British Columbia.* There can be no mistaking that this is a provincially funded program. The next are the words *Ministry of Health and Ministry Responsible for Seniors.* Immediately beneath are the words *Continuing Care Program.* The designation of the Ministry and the Program further delineates the invisible line of power that controls the LTC program. In the middle, in large block letters is the title *Application and Assessment Form.* The word application denotes a voluntary aspect. People who go into placement against their will because families insist are not *applying* for placement; they are being forced into it. Likewise the word assessment is misleading. As previously discussed, Case Managers do not really assess; they establish eligibility for the LTC program.

Beside the title are five boxes, one of which is to be ticked. The boxes are numbered and read as follows, *New Assessment, Review, Reassessment, Appeal,* and *Correction.* Computer information is entered according to these indicators. If the wrong code is marked in the boxes the computer will not allow information to be posted. If for example, the assessment is marked as a new assessment and the person has been assessed before, the computer will not allow the information to be typed in. The code must be changed to the *Review* or *Reassessment* category. The review category is used if the person has been seen but the care level has not been changed. Until I examined these categories for this research, I was not consciously aware that there was an *Appeal* category. I was aware that appeals were possible and they do happen. However, I did not know that they had a separate entry designation.

On the top right hand side of the page there are squares to be filled in with numbers: the *Assessor's* number, the health unit's number and the client's number. It is interesting that in spite of using the word Case Manager in policies and memos, the Ministry forms still refer to Case Managers as "assessors". This may be because in some areas social workers in the acute care hospitals do assessments. It is worth noting that these numbers are to be filled immediately following the 5 boxes. These are the most easily accessed information when reading an assessment form. The numbers can be traced through the whole LTC system. As previously discussed, the numbers standardizes Case Managers as well as clients.

Section 1 - Administrative and Summary appears directly below the headings. This is followed by *Personal Data.* The client's last name is written first. Last names are acquired through our patriarchal society. It is either the name of your father, or your husband. Women often keep their original names when they marry but this is not the case in the cohort of LTC clients. The name links you with your father or husband is first. To the right is the client's first name. This is the name that your father and mother gave you at birth. More importantly for LTC it is the one on the birth certificate. If the client happens to use a name, other than her legal first name, it usually has quotation marks around it, to denote its informal status. There is a space for initials.

Beside this, on the top line on the very right hand side is the phone number. The most commonly used information about a LTC client is at the top of the page, the client's number, name and phone number. Two out of three are numbers. The Case Manager's number is also in the easily accessed area. Case Managers fill in their number on the form but they never use it for any purpose. It follows that the number is assigned for management purposes, to keep track of productivity levels.

The person's *Address* is directly under the name. This is used in many ways. Besides the most obvious one such as directing the homemaker to the residence, it serves other functions. The address also indicates geographic area. Contracts for homemaker services are often limited to designated areas. Certain high-rise buildings have designated homemaker agencies. If the client lives in a designated building then the designated agency will be contracted. In LTC the address is also used to delineate the Case Manager's district. Case Managers are assigned according to geographical area. The client does not always have a choice of Case Manager or homemaker agency.

Next to the address is the question regarding *Marital Status*. There is something for everyone in this selection because there is a choice of *single, married, widowed, divorced, separated* and *other*. I have no idea what *other* may be; perhaps to delineate the possible presence of a potential caregiver. These categories intersect with the religious and legal system in our society and with the Canadian Pension Plan. According to Canada Pension policy, a married couple collect less pension than a two single people.

Under the address there are two boxes that have to be ticked. Usually, these ones are answered. The category is *Current location of the client*, the choices are *As above* or *Other*. There is space to write the exact location beside the word *other*, providing a context in which the person was seen. However, it is most often used to locate the client in hospital if placement is necessary.

The next section down is the usual tick box for *Sex*. The choices are *M* or *F*. I am not aware of a case in which the sexual identity of a client was a question. Is the designation based on chromosomes, sexual orientation or dress preference? This is not an issue in single room facilities but it becomes an issue in facilities with four bed wards where segregation according to the sexes is usually practiced.

The next information required is less controversial. *Birth Date* is requested by *year, month , day*. When these forms first came out in 1978 there was no space for the first two digits of the year of birth. The assumption was that the reader could figure it out. If the year read 94, it would have been assumed that the year was 1894. However when the forms were changed in 1990, the full year was required. The Ministry must be anticipating nineteen year olds and one hundred and nineteen year olds receiving LTC in the future.

These birth dates are necessary for two reasons. The first is the age eligibility of the program. This is not an issue really because the funding for the under nineteen year olds is much better than through LTC. Or perhaps, to quote Foucault (1980) "it is impossible to govern a state without knowing its population."(p.124). Even as far back as the Romans there was an awareness of the importance of counting the population. Biblical accounts claim that Jesus was born in Bethlehem because Mary and Joseph had to return to the paternal city of origin for Roman census. In today's society all births and deaths must be legally registered. To the ruling apparatus it is important to know who is being ruled.

Adjacent to the birth date is the space for *Personal Health Number*. This number is issued by the Medical Services Plan of B.C. (MSP) and is ostensibly to pay for medical care services. This number must be presented when receiving treatment from a doctor or being admitted to hospital. In addition, coverage under the Plan is required for admittance to a LTC facility and drugs dispensed in the facility are paid for by Pharmcare, a division of MSP. The client's personal health number is used for billing.

The personal health number also validates financial information when a client is applying for placement in LTC. There is a sliding scale based on income that determines how much the client will pay per day when admitted to a LTC facility. This information is verified by using the client's personal health number to access computerized income information retained by Medical Services Plan (MSP). To apply for subsidy the potential client must supply income information to MSP. This same information supplied is used by LTC to determine the daily rate for facility care. In April of 1996 a new form was issued. In lieu of financial information, the client's social insurance number and a written consent is required. The consent allows LTC access the client's income tax information directly from Revenue Canada. If the client refuses to grant permission, the maximum rate daily for facility care is automatically charged.

Veteran Service category is next on the right. There is a square to tick for *no* however no one bothers if it's irrelevant. There is space for the Case Manager to fill in the service number. The service number was assigned to the person on joining the military.

This number is unique to the holder. The numbers of First World War veterans are short, never filling the ten spaces allocated for more recently assigned numbers. Information required by Department of Veteran Affairs (DVA) workers is very similar to that collected by Case Managers. If the client signs the consent, the LTC assessment form can be Faxed over to DVA. LTC information is issued for DVA files. Interestingly, the flow of official information is never reversed. LTC does not rely on DVA documented information. In the case study of the dying man, the Case Manager was constructing the LTC assessment as though his war disability was the primary factor necessitating homemaker help. He would receive free homemaker service from DVA if his war disability was the reason he needed help. If the assessment had been written up stating his cancer as the reason, he would have had to pay some of the cost As he was receiving such a large veteran's pension, homemaker service through LTC would have been too expensive.

There follows a large section requiring *contacts* information. Space is provided for two contacts. My criticism of this section is that it only supplies the demographics of contacts disregarding the information required by Case Managers. Case Managers need information as to who is the caregiver/s. The word *contact* is neutral. It is difficult to determine if the person is involved with the client on a day-to-day basis, or if this is a 'Christmas and Mother's Day' relationship. Case Managers must rely on their memories as to the involvement of contacts.

One of the changes made to the new edition of this page is the addition of a small box labeled *research code*. This is to be used to flag the information for research purposes. In the past, research has been done using the assessment forms only, with <u>no</u> client permission. The permission statement on the front of the form only states that information would be released to a care provider(e.g. homemaker agency). Clients are not informed information may be used for research purposes. I am aware of two research projects funded by the Ministry of Health LTC , in which clients' files were used without permission.

On the left side of the form provides a space for the *Physician's name, office phone number address and postal code.* A client can not be admitted to a LTC facility without a doctor assuming medical responsibility. This requirement links LTC with the medical profession and the monopoly it has over health care. As there is no remuneration, it is difficult to compel family doctors to provide a medical history informing care facilities of new clients' medical conditions. There is so much resistance from the doctors that the LTC facilities will not admit a client without having a copy of the medical history. If the client cannot be admitted without the medical history, families put pressure on family doctors to dictate the medical history. Again the families must do the work which should lie within the jurisdiction of the LTC program. This coercion has evolved because clients would have been admitted to the care facility without medical histories. Six months later the history would still not have arrived. The Quality Assurance program of LTC monitors facility documentation. The facilities are required to have a medical history on the client's chart. Once the client is admitted, facilities have no leverage to demand the medical history. CRD LTC has even funded a special telephone dictation line that physicians can phone to dictate medical histories 24 hours a day, 7 days a week. The history is typed and faxed to the LTC placement department. From there it is faxed to the appropriate facility and a copy placed in the client's file.

Below the Physician's section there is a statement in large print. A signature from the client or authorized other is required. This statement is a combination of an application for LTC services and certification that the information given was correct. The client's signature is straightforward however the authorized signature poses difficulty. At this time, there are no guidelines as to whose signature is acceptable. The Case Manager simply assumes that if someone signs, they must have the right to do so. This may become more of an issue when/if the new guardianship legislation becomes law. That legislation more clearly states who can sign on behalf of the client. At the moment, it is ambiguous.

The next section is not ambiguous but is misnamed. *Client's preference* is the title. The first box under the title, *Care at Home* would be the choice of most clients. However as I have previously discussed, it is often not the client's preference that is being requested, but that of the family. In the example of the woman being placed in a care facility by her family, she was adamant that this was not her choice. In the same section the requests for *Standard, Semi-Private and Private* are meaningless 90% of the time. Intermediate and extended care facilities were built to the Ministry of Health's specifications. The client has no choice as to the type of accommodation. Intermediate care facilities were designed with private rooms and extended care facilities with four-bed wards. Also, because of the waitlists client requests are irrelevant if space is not available.

The Assessment Summary is an eight line paragraph in which the Case Manager writes out in long hand the most relevant information regarding the client. Although this could be an opportunity to provide a quick descriptive sketch of the person behind the client, what is written usually amounts to a synopsis of the next four pages that cover the medical and functional abilities of the client. When completing these forms, in my position as a Facility Co-ordinator, I attempt to describe the person physically and psychologically. From this brief documentation, I hope that the client is recognizable to the next care provider. This, however, is not standard practice. Other client summaries have often given me no mental picture of the client; only the restating of the client's medical diagnosis. Again, this diagnosis links the client with the medical profession. This section continues to reconnect the client with external social relations.

Summary

Analysis of the form completed by Case Managers illuminates connections with external relations in our society. A LTC client's identity with other government agencies and systems such as medical care is more salient on the form than the client's identity as an individual. One set of information interweaves with another until the individual is concealed beneath the blanket of connecting external social relations. More and more in our society we are known for our connections with external social relations.

Chapter 9

Third Layer - Case Managers Making It Work

I observed several examples of Case Managers organizing and compensating for deficiencies in the LTC system as it attempts to care for chronically-ill people. As the human link that joins the two discrete areas in LTC, the organization and the caregivers, Case Managers are necessary to do whatever needs to be done. Those tasks are as varied as compensating for inadequate information systems to acting as a paramedic when the need arises. The organization with its policies and regulations never meets and never will meet every need of the caregivers/clients. Case Managers as human beings have the unique ability to get the job done creatively. It is Case Managers who help convince caregivers to do the caring and who utilize the LTC resources in a unique way to help caregivers.

Information is carefully selected as in the previously mentioned case where the grandmother was being placed against her wishes. In that instance, the woman had to be able to walk 20 feet to be admitted to the intermediate care facility where one of her daughters worked. The client barely walked the necessary distance but the Case Manager recorded that the client could walk 20 feet. As a result the client could go to the desired facility. However, the client almost fell when trying to return to bed. The Case Manager's attention was elsewhere and she did not observe the incident. However, the Case Manager could record the client was 'intermediate care'. The woman clearly stated she did not want to be placed. However, if she was, the one where her daughter worked was the best choice.

Sometimes it is keeping track of clients that helps make the LTC program work. In 1978, the first year of the program, a co-worker and I instituted a time saving device for when clients call. It is a small rolodex with basic client information on each card. Each Case Manager in CRD has a rolodex containing information on her clients alone. These cards are filed alphabetically to be easily accessible when on the phone. Even the stamp we devised is still in use. The stamp has categories for all important client information.. When we designed this system, Case Managers did not have access to LTC computerized information. However, even though there are now two terminals for Case Managers, they have a rolodex and a card on each client. Even if everyone had desktop computers, I think there would still be the rolodexes for those times when the system 'goes down'. These cards are also used by management and administrative support staff when there is an office move or a change in boundaries. The only collective record of Case Managers' clients is the little rolodex cards. The current computer program is not capable of providing local LTC management with Case Managers' district information. The program was designed only to meet the needs of the central Ministry of Health LTC management.

Another interesting process that I observed during my research, was the workers constructing, modifying, and correcting information to correlate with the billing information submitted to the central LTC organization by service providers. Action Memos are designed to monitor the billing received from services agencies. These forms are completed by Case Managers if there has been a start, a change or an end in homemaker hours etc. This information is entered into the computerized information system to alert the central Ministry of Health LTC. Agencies are only paid for services authorized by Case Managers. That is how the system is designed to work. However, authorized by Case Managers. That is how the system is designed to work. However, what I saw was a Case Manager filling out the Action Memo according to what the clerk told her the agency had billed. This occurs because the large caseloads prevent Case Managers completing the paperwork on one crisis before going on to the next one. Instead of monitoring service providers as intended, the Action Memos become simply more paperwork. The Case Manager did get the job done -- the agency was paid and the paperwork was done satisfying LTC policies.

Sometimes what Case Managers do to 'make it work' is not related to the formal LTC program. One Case Manager told me she had taken a woman to the Emergency department in the CRD car because the client was threatening to burn down her apartment building. CRD management would have instructed the Case Manager to call an ambulance. This would not have worked because the woman was extremely paranoid about men. The ambulance attendants, most of whom are male, would not have been able to put her into the ambulance, short of rendering her unconscious. The Case Manager did what needed to be done. This was the ethically correct thing but was directly against CRD policy. There is a strict policy saying CRD vehicles cannot be used to transport anyone other than a CRD employee, even in the event of an emergency.

All of these are examples of workers picked up selected pieces of information, made them accessible or shaped them into a useable form. This requires skill and experience. Case Managers are the essential human link connecting documentary and pixel realities to the everyday lived experiences of clients/caregivers.

Summary

Case Managers are actively engaged in 'disciplining' caregivers into particular caregiving roles. Support for these caregivers is limited to the parameters of the LTC program. Case Managers, at the moment, do have some discretionary power to tailor the services offered by LTC to meet the needs of the caregiver. Offering the caregiver some, albeit limited, options to exercise discretion. In the following chapter I will present an overview of the findings and discuss the policy and practice implications.

Chapter 10

Conclusion

In 1993, the price of caregiving for twenty CRD LTC caregivers was death or hospitalization. These caregivers probably had pre-existing conditions that led to these serious consequences. However, why were those people with such fragile health giving care? These people were giving care to clients requiring intense 24 hour per-day-care. The clients required so much care that placement was the only alternative when the caregiver was no longer available. These caregivers paid a high price for giving care.

If the price is so high what are the rewards? The rewards of caregiving were not evident on the home visits; however, that was not what I was focused upon. I was also not focused on the costs of caregiving but I saw them. The costs were visible but not the rewards. No one showed any signs of satisfaction for being effective or respected as a reward for their work. In fact, one client was relieved her husband had died. According to her, this man had been difficult for their entire marriage. She talked about his miserliness and controlling ways. He wouldn't let their son finish drywalling and painting the kitchen walls for his mother. There she sat looking at smoke-yellowed walls with the nails still showing. There were no happy times remembered by that caregiver. Caregiving did not give her any satisfaction.

The caregiving that I observed appeared to be hard work, done mostly by women. This was at great physical and emotional cost. The satisfaction of doing a good job was not visible during my home visits. It could be argued that caregivers wanted to appear exhausted to receive more help. However, during our home visits, not one caregiver asked for more help. Caregiving is a difficult job with few rewards and little recognition.

Caregivers require assistance to continue doing this job. Case Managers are one source of help for caregivers. All the work of the LTC Case Manager is essential for accomplishing the Mission of the LTC Program. There are two discrete and different aspects to Case Managers' work. One is the highly visible work of completing the documents that takes precedence over all other concerns on a home visit. This is also the only segment of the LTC Case Managers' work that is recognized by the Long Term Care Ministry of Health. The other, unrecognized work, is supporting the caregiver so they can continue to give the majority of care to chronically ill clients. This invisible work is vital to the LTC Program as it supports the unpaid caregiver, even if only in extremely limited ways. That "support" of the unpaid caregiver is essential to attaining the goals of the LTC Program.

Policy and Practice Implications

This research has focused on the work of LTC Case Managers. These professionally educated women are the human link between caregivers/clients and the Long Term Care system. The documents Case Managers produce meet the needs of the organization to account for resource allocation decisions. Equally important, but invisible to the organization, is Case Managers' support of unpaid informal caregivers. To continue effectively in the support role, Case Managers must have flexibility to meet the needs of caregivers in an effective creative manner. The less hindered by rules and regulations, the more creative and effective their support for caregivers can be.

Information technology currently used by LTC is antiquated and exclusively meets the needs of the Ministry of Health Long Term Care. The trend towards wider use of information technology will continue. This change can not be reversed. However, as well as replacing some of the tedious paperwork, the latest technology could be programmed to accommodate the supportive work of Case Managers.

Case Managers are women who have university degrees in nursing or social work. This education has prepared them to work with people in a professional manner. Application of their knowledge and experience in their work is called professional discretion. This is used in case management work to adapt the LTC program to fit the needs of caregivers/clients. Without this adaptation, the LTC program's efficacy would be greatly decreased. Just as all humans are unique, the situations in which they live and give/require care are unique. One solution is not applicable to everyone. Each caregiver/client requires a unique adaptation of LTC services. For example, some caregivers need a day a week off whereas others can survive if two weeks a year are available for respite.

The concern that I mentioned at the beginning of this thesis is that LTC will become increasingly computerized. With such increases come, in most instances, a reduction in descretionary power. If they are not carefully designed, information technology could severely limit the professional discretionary power of Case Managers. For example, if forms are computerized and the care level automatically assigned, Case Managers will be prevented from considering the needs of the caregiver when assigning the care level, something that frequently occurs now. At the moment, there is no correlation between boxes ticked and level of intermediate care assigned (Beebe, 1994). I believe Case Managers circumvent policy to take caregivers' needs, as well as the client's functioning into consideration when assigning client care levels. At present, there is no documentary consideration given to caregivers' needs. Only Case Managers' community experience allows caregivers' needs to be factored into the situation. If that process were to be automated, even limited capacity to differentially support caregivers could disappear. As informal caregivers are giving 80-85% of the care, they do need to be considered. If they are not considered, the likelihood of caregiver breakdown increases. This will lead to more formal care which would be funded by Long Term Care.

Like the answer to many complex problems, it is the process that needs to be examined rather than seeking one definitive solution. The path to success is to incorporate an allowance for different approaches for each individual client/caregiver dyad; Case Managers will tailor LTC services to design a unique solution for every situation.

In the future, society will be have to accommodate an increasing number of elderly in the population. As the generation of baby boomers age, they will be demanding more and varied assistance. Due to increased expectations, they are not satisfied with the old three ice cream flavours of vanilla, chocolate and strawberry. They now demand 31 flavours. Likewise, when they require care, Baby Boomers will want 31 options in Long Term Care assistance, not just homemakers, daycare or placement. Maintaining flexibility in the system will allow creative options to meet the aging population's needs.

Today's information technology systems have exponentially increased capabilities that could accommodate Case Managers professional discretion. The present LTC and individuality could be accommodated with the current improvements in information technology. Any decrease in flexibility and professional discretion of Case Managers will erode their support for caregivers. Campbell's (1992) study showed how social workers' ability to help clients would be impeded by computerization. Likewise, LTC Case Managers may be hobbled, if there is further standardization through the use of information technology.

Unpaid caregivers are the bedrock of the Long Term Care system. Without their caregiving, the LTC system would be overloaded trying to cope with care needs of the chronically ill. It is not for job satisfaction of Case Managers, or emotional health of caregivers, that support for caregivers is so vital. Support for caregivers is necessary for the very survival of the LTC system as an economically manageable system.

This research provides support for Case Managers who may wish to advocate for for more discretionary judgment in the work of LTC resource allocation. It must be recognized that any attempts in this direction are confronting central financial control functions of government departments. However, the research offers many instances where financial accountability clearly takes precedence over individual citizen's welfare. To the extent that politicians and bureaucrats can be held accountable for individual citizen's concerns, the research offers a platform from which such a debate could be ignited.

Epilogue -- Personal reflections

What I learned about LTC

The most obvious answer to this question is the role of the caregiver in the functioning of LTC. It is hard to believe I had been so blind to their contribution. However, it just further emphasizes the essence of my argument; caregivers and their caregiving are invisible to the LTC organization. Although there is token acknowledgment of their work, there is no documentation of the vital role of caregivers. Documentation dictates how workers will do their jobs, and this is certainly true in the LTC system.

Another revelation to me was the functioning of administrative support staff in Long Term Care. I did not realize their role in the Ministry of Health billing process. When I discovered what tasks they were executing, the reason for the perpetual conflict between them and Case Managers became clear. One person had been in one of the jobs for several years. The conflict had been attributed to a personality problem. This puzzled me because I had a good relationship with her. Now I see that it is an organizationally generated conflict, not a personal problem. Also, Case Managers mistakenly think administrative support staff are there to support Case Managers. In reality, the central office. administrative support staff are there to support the central Ministry of Health LTC. In the outer offices, there is no conflict between Case Managers and administrative support workers, but there is perpetual friction in the Cook St. office. This is where billing is corrected. It may be beneficial to have open discussion about this issue, given this new perspective to enable greater understanding on both sides. It is no longer a person's problem but rather how the organization constructs the work.

The impact of control by various levels of government was a new concept to me. While doing the job, it was never stated why there were various anomalies in the system. We just accommodated them. Different waiting periods for out-of-province clients in extended care and intermediate care was never clearly explained. In the first two years of the program, we were too overworked to have the energy to wonder about anything other than how to get through the next hour; or in the first six months, whether there would be enough forms to take on that afternoon's home visits.

It was fascinating to stand back and look at the Long Term Care organization and examine it from a different point of view. Having worked there was a distinct advantage. The access was easy as all the Case Managers knew me. I had no problems obtaining Case Manager volunteers for my research project. As I was familiar to them, it was easier for them to continue to work as usual while I observed them. Once or twice when I looked back at my transcripts, I did feel that I should have asked more definitive questions. Because of my own understanding of the situation, I accepted what was said and did not probe further. On the other hand, I did understand the program and did not miss important points that have plagued other studies. One study examined over 5,000 files (Beebe, 1994). He correlated care levels and answers to the various questions on the Long Term Care Assessment and Application form. The missed opportunity was not recording the dollar amount of the client portion. This would have been an indicator of socioeconomic status. Several studies that have found the higher the socioeconomic level, the longer people live. It would have been interesting to see if that correlation held for Long Term Care clients in British Columbia.

Methodology

I enjoyed the methodology because it truly does fit my world view. It was unsettling before I actually started data collection. I had no idea if it would work. What I found was not completely what I expected, necessitating a rewrite of my literature review to include a section on caregiving. It was a revelation to me that caregivers do some functions of case management.

Application to my present position

This research changed my perspective on the LTC organization. As a worker, I now know what I can do and what I cannot do. Also, enlightenment on the source of some conflicts has helped me to have a broader perspective on work issues. The perspective I've learned promotes less person blaming and more general analysis on how these conflicts are frequently organizationally constructed.

My clients have benefited too. Now I am more likely to fit the LTC system to the person instead of making the person fit the LTC system. For example, I am very lenient with alert intermediate care clients when assessing them for extended care. If assessed extended care, they would be forced to move to a four-bed ward in an extended care unit. I would like to leave all clients in their original facility. This is not possible due to facility environments, staffing, and funding of intermediate care. However, for a minority of clients who are mentally healthy but physically frail, I leave them assessed as intermediate care for as long as possible. As these clients are usually favoured by facility staff, usually, the facilities co-operate. In this way, I am using documentary reality to work for the client instead of against them.

Intellectual Challenge

Intellectually, I enjoyed exploring how parallel 'development' attributed to the Industrial Revolution have extended through history to be found in LTC 1 form supporting the bureaucratic work of Long Term Care. Even though that concept has probably been explored before, it was fun discovering it for myself. Also, working with the text of Michel Foucault was a challenge. I'm sure his work will be studied well into the next century. His writings were easier (but not easy) for me to understand because we had studied Dorothy Smith extensively during our class work. When I first read Dorothy Smith, I instantly recognized LTC as an exemplary model for analysis. Smith and Foucault are both viewing society from the same side of the fence, even though it may be from different positions.

I would like to finish with a quote from Foucault (1980) which to me encompasses the functioning of the LTC program.

> Truth is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements.
> 'Truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it, A 'regime' of truth'.
>
> (p. 133)

The work of Case Managers is to create the "regime of truth" for the documentary and pixel realities of the LTC program while supporting the unpaid, informal caregivers in their everyday lived experience of caring for clients.

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APPENDIX A

Alternative Criteria for Personal Care Level in the Residential Services Program, Mental Health Services

The applicant for this level of care may or may not have the characteristics described in the above criteria.

The applicant:

- may have a chronic mental illness and require a protective environment but will be a minimal management problem
- may require care/supervision and housing because lack of motivation or long institutional care makes further rehabilitation unrealistic
- may need reminders regarding personal grooming and self care
- will require a simple activational and recreational program with the goal of achieving and maintaining an optimal level of function

<u>Intermediate Care Level</u>

The three Intermediate Care levels build on the Personal Care level and recognize a need for care planning and supervision under the direction of a health care professional by introducing a combination of professional and non-professional (lay) supervision. This professional supervision is required on a daily rather than a twenty-four hour basis. An individual at the Intermediate Care levels is independently mobile, with or without mechanical aids.

- Intermediate Care I

  This level of care recognizes the person who is independently mobile with or without mechanical aids, requires moderate assistance with the activities of daily living, and requires daily professional care and/or supervision.

  The following criteria shall be used to determine eligibility for Intermediate Care Level I:

  Communication

  The applicant:

  - may have difficulty expressing needs (e.g., dysphasia)
  - may be unable to adapt to sensory loss

Personal Functions

The applicant:

- will be independently mobile with or without mechanical aids
- may need specialized aids for transferring independently
- may need a moderate amount of assistance with bathing, dressing and grooming
- may require reminder or routine toileting to avoid frequent incontinence
- may require assistance with toileting to maintain cleanliness
- may need some supervision in eating
- may need directional assistance
- may need occasional enemas

Mental Functions

The applicant:

- may be mildly depressed or agitated
- may have moderately impaired comprehension (e.g., has the ability to understand simple instructions, simple number and time concepts)
- may be unable to express some needs
- may demonstrate difficulty in orientation as to day, time, place
- may have varying degrees of mental defects and deterioration

Medical Problems

The applicant:

- will require daily supervision by professional health staff

- may require nursing procedures such as:

  supervision of medications, or

  change of surgical dressing, or

  supervision of catheter and ostomy apparatus.

- may require supervision for visits to doctor, dentist, eye specialist, etc.
- may require therapeutic dietary supports (e.g., diabetic and other special therapeutic diets)
- will require regular review by a physician
- may require specialist services from time to time (e.g., physiotherapist, occupational therapist, speech therapist)
- may require therapeutic services for a psychiatric problem

Social Functions

The applicant:

- will require a program of activities to maximize potential in the activities of daily living
- will require programs for social and recreational activities
- may be attending a workshop, educational course or equivalent

Alternative Criteria for Intermediate Care Level I in the Residential Services Program, Mental Health Services

The applicant for this level of care may or may not have the characteristics described in the above criteria.

The applicant:

- may be physically as well as psychiatrically handicapped but does not present serious management problems
- may require supervision by professional staff as appropriate
- depending on the nature of physical disability, may require some professional nursing overview
- may require considerable motivation towards self-care

- Intermediate Care II

  This level of care recognizes heavier care and/or supervision requiring additional care time.

  The basic characteristics of this level of care are the same as for Intermediate Care Level I.

  The following criteria shall be used to determine eligibility for Intermediate Care Level II:

  As for Intermediate Care Level I plus

  - may need considerable directional assistance, supervision of activities, etc.
  - may present management problems due to wandering
  - will present staff difficulties or require extra staff time due to impaired comprehension
  - may occasionally misappropriate the property of others
  - may have multiple disabilities/medical problems
  - may have need of more variety and/or extensive professional services
  - may be incontinent of bladder and/or bowel
  - may have severe disability/medical problem
  - may have an indwelling catheter
  - may need assistance with eating
  - may require daily professional supervision of catheters, surgical dressing, colostomy, oxygen therapy, etc.

  Alternative Criteria for Intermediate Care Level II in the Residential Services Program, Mental Health Services

  The applicant for this level of care may or may not have the problems described in the above criteria.

  The applicant:

  - may be a chronically psychiatrically disabled person who requires training for independent living
  - may have marked behavioural problems requiring considerable staff intervention and management
  - will require daily supervision by professional personnel as appropriate

- Intermediate Care III

This level of care recognizes the psychogeriatric person who has severe behavioural problems on a continuing basis. However, this level of care may also be used for persons requiring a heavier level of care involving considerably more staff time than at the Intermediate Care II Level but who are not eligible for Extended Care.

The basic characteristics of this level of care are the same as for Intermediate Care Level II.

The following criteria shall be used to determine eligibility for Intermediate Care Level III:

As for Intermediate Care Level II plus

- may disturb others with such anti-social habits as spitting, voiding and/or defecating in public, indecent exposure, etc.
- may exhibit destructive, aggressive or violent behaviour (e.g., shouting and screaming)
- may continually wander away
- may endanger own life

Alternative Criteria for Intermediate Care Level III in the Residential Services Program, Mental Health Services

The applicant for this level of care may or may not have the problems described in the above criteria.

The applicant:

- may be psychiatrically handicapped with one or more severe behavioural problems which make the person unacceptable in the usual residential resources in the community
- may require a behaviour modification program on a time-limited or highly structured basis
- may be a younger adult who functions adequately in the activities of daily living, but who requires considerable supervision, training and care; this person is likely to be able to return to an independent lifestyle if given an appropriately intensive counselling and a therapeutic program

This person will almost always require placement in a facility that is staffed with professional personnel.

Placement in a facility that is operated by a lay person will be considered, whether a professionally executed program exists or not, when the lay operator is a person who has demonstrated the ability to accept very difficult placement problems. Usually, a maximum of one or two persons will be placed in these facilities, depending on the size of the facility.

Extended Care Level

This level of care recognizes the person with a severe chronic disability which has usually produced a functional deficit which requires twenty-four (24) hour a day professional nursing services and continuing medical supervision, but does not require all the resources of an acute care hospital. Most persons at this level of care have a limited potential for rehabilitation and often require institutional care on a permanent basis.

The following criteria shall be used to determine eligibility for Extended Care Level:

Communication

The applicant:

- may have difficulty expressing needs or be unable to express needs
- may be unable to adapt to visual or auditory losses (e.g., a blind person who is also confused)

Personal Functions

The applicant:

- may require a varying amount of assistance with dressing, washing, grooming and bathing

Mental Functions

The applicant:

- may or may not be mildly depressed or agitated
- may or may not have moderately impaired comprehension (e.g., ability to understand only simple instruction, short retention span)
- may or may not demonstrate varying degrees of difficulty in orientation as to time, place and persons

Medical Problems

The applicant:

- will require monthly or more frequent visits by a physician
- may require a therapeutic diet

- may require brief periods of individual Physiotherapy or Occupational Therapy
- may require professional monitoring and judgement on a continuing basis for a psychiatric problem
- may be mobile without human assistance but exhibit gross fecal or urinary incontinence

Social Functions

The applicant:

- will require a home-like environment
- will require programs for social and recreational activities
- may be attending social or educational facilities outside of an Extended Care Unit (including vocational training)

Admission to Public Extended Care Unit

A person is considered medically eligible for extended care who:

- does not require the services of any other type of hospital, acute, rehabilitation or psychiatric
- is unable to transfer* without the physical assistance of another person. This means move from one article of furniture to another or on and off the toilet without the physical assistance of another person. If the person requires mechanical aids such as grab bars or trapeze bars, he is still considered independent so long as no physical help from another person is required
- is unable to walk without the physical assistance of another person over a distance of approximately 10 to 15 feet of clear space without holding on to furniture. If the applicant requires a cane, walker, crutches, or a brace, he is still considered independent so long as no physical help from another person is required
- is unable to use a wheelchair independently without the physical assistance of another person, except to place the wheelchair where it can be reached. An applicant is considered to be independent in wheelchair use when he can safely transfer in and out, apply brakes, raise and lower foot rests and propel the chair without the physical assistance of another person
- requires for medical reasons a program continuously and professionally supervised over each twenty-four hour period, which cannot be provided in a lesser type of care.

  *In testing ability to transfer, attention is drawn to the physical features of the furniture. A satisfactory rating cannot be established if the bed is very low or too high, or if the chair is low, heavily upholstered, or with a seat that slants down at the back. Use of a straight-backed chair with arms and with a seat height of at least 17 inches can provide a valid rating.

An Extended Care Unit or Hospital provides:

- around-the-clock supervision by a graduate nurse as well as supervision by various other professional health workers such as Pharmacist, Dietitian, Occupational Therapist, Physiotherapist, and Social Worker
- regular medical supervision
- simple nursing procedures once or more a day, such as application of surgical dressing, administration of injectable medications, oxygen therapy (low-concentration, low-flow), catheter care
- fulfilment of social needs
- a home-like environment
- a program to assist each resident to retain or improve functional ability
- skilled assistance with activities of daily living, such as dressing, washing, grooming and bathing

Eligibility Exclusions

Registered Indians

Registered (status) Indians and non-Indians living on the reserve (with the exception of non-Indians occupying commercial rental units) do not qualify for designated continuing care services. Detailed policies outlining the Division's relationship with Indian and Northern Affairs Canada (INAC) are included in Section 2.F - Indian and Northern Affairs Canada.

Queries regarding the status of an applicant should be directed to the nearest office of Indian and Northern Affairs Canada or referred to:

Regional Director
Medical Services Branch
Health & Welfare Canada
Ste. 540 - 757 West Hastings
Vancouver, B.C.
V6C 3E6
Telephone: 666-3235

APPENDIX B

Province of British Columbia

Ministry of Health and Ministry Responsible for Seniors
CONTINUING CARE PROGRAM

APPLICATION AND ASSESSMENT FORM

1 NEW ASSESSMENT
2 REVIEW
3 REASSESSMENT
4 APPEAL
5 CORRECTION

RESPONSIBLE ASSESSOR

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1

HEALTH DIST. | CLIENT NUMBER

ECTION 1 - ADMINISTRATIVE AND SUMMARY

CLIENT'S PERSONAL DATA

CLIENT'S FAMILY NAME | FIRST NAME | INIT'S. | PHONE (CURRENT)

CURRENT ADDRESS | FROM (DATE)

3. MARITAL STATUS
1 SINGLE
2 MARRIED
3 WIDOWED
4 DIVORCED
5 SEPARATED
6 OTHER

VETERAN SERVICE CATEGORY
☐ N
If Yes A B C
U *(Unknown)*

CITY | POSTAL CODE

SERVICE NUMBER

CURRENT LOCATION OF CLIENT
☐ AS ABOVE
☐ OTHER

SEX ☐ M ☐ F | BIRTHDATE Y Y Y Y M M D D | PERSONAL HEALTH NUMBER | SPOUSE'S CLIENT NUMBER | SPOUSE'S PERSONAL HEALTH NUMBER

CONTACT PERSON'S FAMILY NAME | INIT'S. | RELATIONSHIP

STREET ADDRESS

CITY | POSTAL CODE | HOME PHONE | BUSINESS PHONE

NAME | NEXT OF KIN ☐ Y ☐ N | RELATIONSHIP | RESEARCH CODES

ADDRESS | POSTAL CODE

PHYSICIAN'S NAME | OFFICE PHONE

OFFICE ADDRESS | POSTAL CODE

LOCATION OF ASSESSMENT
1 HOME
2 FACILITY
3 HOSPITAL
4 OTHER

ACTION REQUIRED
1 ☐ TEAM REVIEW
2 ☐ FOLLOW-UP
3 ☐ NA

APPROVED SERVICES
1 NOT ELIGIBLE
2 CARE DECLINED BY CLIENT
3 CARE AT HOME
4 CARE AT HOME WITH MENTAL HEALTH SUPPORT
5 FACILITY CARE
6. DAY CARE

APPLICATION

hereby apply for benefits for which I / Client may be eligible under the Continuing Care program and certify that the information I have provided is correct to the best of my knowledge and may be released to the Continuing Care provider.

Client or authorized signature

CANADIAN CITIZEN ☐ YES ☐ NO

B.C. RESIDENT YY MM DD

APPROVED CARE LEVEL
1 PC
2 IC 1
3 IC 2
4 IC 3
5 EC

LIVES WITH CARE GIVER ? YES NO

ASSESSMENT SUMMARY

Y Y M M D D

CASE MANAGER'S SIGNATURE: X

SERVICE AUTHORIZATION

PROVIDER ID | ASSESSOR | SA - ID

AUTHORIZATION DATE YY MM DD | 1 PAID 2 UNPAID | ORG. | SERVICE | TYPE

☐ START | CARE LEVEL | CLIENT CONTRIBUTION $ | APPROVED HRS./DAYS

☐ CHANGE | 1 BEGIN PAID ABSENCE A VACATION B ILLNESS 2 RETURN

☐ END | 2 DEATH 5 UNPAID TEMP ABSENCE

☐ CORRECT | DELETE SA - ID

AUTHORIZING SIGNATURE: | DATE:

H CLIENT'S PREFERENCE *(see reverse)*

1 ☐ AT HOME
2 ☐ FACILITY
21 ☐ STANDARD
22 ☐ SEMI-PRIVATE
23 ☐ PRIVATE

PREFERRED FACILITY

FACILITY CODE | DATE ON LIST YY MM DD

ALTERNATE FACILITY

FACILITY CODE | DATE ON LIST YY MM DD

BF CODE | BF DATE YY MM DD

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2

IG TERM CARE ESSMENT | SECTION II | HEALTH PROFILE | DATE YY MM DD | CLIENT FAMILY NAME | CLIENT NUMBER

MEDICAL BACKGROUND 1 MAJOR MEDICAL PROBLEMS INCL. PSYCHIATRIC DIAGNOSIS — INFO PROVIDED OR VERIFIED BY PHYSICIAN ☐ YES ☐ NO

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE	PRESCRIBED BY

TREATMENTS/SPECIAL PROCEDURES

CLIENT SMOKES ☐ YES ☐ NO
DEGREE OF PROBLEM
☐ NONE ☐ MODERATE ☐ MAJOR

5. CLIENT DRINKS ☐ YES ☐ NO
DEGREE OF PROBLEM
☐ NONE ☐ MODERATE ☐ MAJOR

6. ALLERGIES ____________________

URRENT DIET

EATING HABITS

HEIGHT: __________
WEIGHT: __________

MENTAL HEALTH INDICATE WHICH OF THE FOLLOWING STATES ARE APPLICABLE FROM YOUR INTERVIEW TODAY: BASE ASSESSMENT ON WHAT YOU HAVE SEEN TODAY AND USE COLLABORATIVE INFORMATION AS REQUIRED

ATTITUDE	☐ COOPERATIVE ☐ INDIFFERENT ☐ RESISTIVE ☐ DEMANDING ☐ SUSPICIOUS ☐ HOSTILE
APPEARANCE	☐ WELL GROOMED ☐ ADEQUATE ☐ DISHEVELLED ☐ INAPPROPRIATELY DRESSED ☐ ILL - NOT DRESSED
SELF DIRECTION	☐ INDEPENDENT ☐ NEEDS MOTIVATION ☐ NEEDS DIRECTION ☐ DEPENDENT
BEHAVIORS	☐ NORMAL ☐ WANDERING ☐ SUNDOWNING ☐ WITHDRAWN ☐ SEXUALLY INAPPROPRIATE AGGRESSIVE ☐ VERBAL ☐ RESTLESS ☐ ELOPING ☐ SELF DESTRUCTIVE ☐ FIRE HAZARD ☐ OTHER (SPECIFY BELOW) ☐ PHYSICAL
AFFECT	☐ APPROPRIATE ☐ ANXIOUS ☐ EUPHORIC ☐ LABILE ☐ HISTORY OF MOOD SWINGS ☐ INAPPROPRIATE ☐ BLUNTED ☐ DEPRESSED ☐ ANGRY
THOUGHT CONTENT	☐ NORMAL DELUSIONS: ☐ PERSECUTORY ☐ GUILT ☐ OTHER ☐ OBSESSIONS ☐ PHOBIAS ☐ PREOCCUPATION ☐ NOT ABLE TO ASSESS
PERCEPTIONS	☐ NORMAL HALLUCINATIONS: ☐ AUDITORY ☐ VISUAL ☐ OTHER __________
COGNITION	☐ NORMAL IMPAIRMENT: ☐ MILD ☐ MODERATE ☐ SEVERE MINI MENTAL STATUS SCORE ☐ EXPLAIN REASON FOR NOT COMPLETING
INSIGHT	☐ GOOD ☐ PARTIAL ☐ NONE
JUDGEMENT	☐ GOOD ☐ ADEQUATE ☐ POOR

ADDITIONAL COMMENTS

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3

NG TERM CARE SESSMENT | SECTION II CONTINUED | HEALTH PROFILE | DATE YY MM DD | CLIENT FAMILY NAME | CLIENT NUMBER

DENTAL CARE

DOES CLIENT CURRENTLY HAVE DENTAL PROBLEMS? ☐ YES ☐ NO	3 DENTAL STATE 1 ☐ NO DENTURES 2 ☐ FULL UPPER 3 ☐ FULL LOWER 4 ☐ PARTIAL DENTURE 5 ☐ DAMAGED DENTURE 6 ☐ NO DENTURES, NO TEETH 7 ☐ DENTURES NOT WORN	4 IS CLIENT ABLE TO CHEW FOOD EFFICIENTLY? ☐ YES ☐ NO
IS CLIENT UNDER CARE OF DENTIST? ☐ YES ☐ NO		5 DENTIST'S NAME

COMMUNICATION

1 ☐ WEARS GLASSES 2 ☐ USES HEARING AID

LANGUAGES USED: 1 ☐ ENGLISH 2 ☐ FRENCH 3 ☐ CHINESE 4 ☐ ITALIAN 5 ☐ RUSSIAN 6 ☐

	1	2	3	4	5
VISION	☐ UNIMPAIRED	☐ ADEQUATE FOR PERSONAL SAFETY	☐ DISTINGUISHES ONLY LIGHT OR DARK	☐ BLIND-SAFE IN FAMILIAR LOCALE	☐ BLIND-REQUIRES ASSISTANCE
HEARING	☐ UNIMPAIRED	☐ MILD IMPAIRMENT	☐ MODERATE IMPAIRMENT BUT ADEQUATE FOR SAFETY	☐ IMPAIRED — INADEQUATE FOR SAFETY	☐ TOTALLY DEAF
SPEECH	☐ UNIMPAIRED	☐ SIMPLE PHRASES INTELLIGIBLE ONLY	☐ SIMPLE PHRASES PARTIALLY INTELLIGIBLE ONLY	☐ ISOLATED WORDS INTELLIGIBLE ONLY	☐ NO SPEECH OR SPEECH NOT UNDERSTANDABLE OR NO SENSE MADE
UNDERSTANDING	☐ UNIMPAIRED	☐ UNDERSTANDS SIMPLE PHRASES ONLY	☐ UNDERSTANDS KEY WORDS ONLY	☐ UNDERSTANDING UNKNOWN	☐ NOT RESPONSIVE
IF CLIENT CANNOT SPEAK INDICATE MEANS AND DEGREE OR EFFECTIVENESS OF METHOD	☐ EFFECTIVE	☐ MODERATELY EFFECTIVE	☐ PARTIALLY EFFECTIVE	☐ NOT EFFECTIVE	

ADDITIONAL COMMENTS ON COMMUNICATION

ACTIVITIES OF DAILY LIVING

1 ☐ USES CANE 2 ☐ USES WALKER 3 ☐ USES CRUTCHES 4 ☐ USES WHEELCHAIR 5 ☐ OTHER PROSTHESIS OR AID

	1	2	3	4	5
AMBULATION	☐ INDEPENDENT IN NORMAL ENVIRONMENTS	☐ INDEPENDENT ONLY IN ENVIRONMENT SPECIFIED BELOW	☐ REQUIRES SUPERVISION	☐ REQUIRES OCCASIONAL OR MINOR ASSISTANCE	☐ REQUIRES SIGNIFICANT OR CONTINUED ASSISTANCE

LIMITATIONS:

	1	2	3	4	5
TRANSFER	☐ INDEPENDENT	☐ SUPERVISION FOR: ☐ BED ☐ CHAIR ☐ TOILET	☐ INTERMITTENT ASSIST. ☐ BED ☐ CHAIR ☐ TOILET	☐ CONTINUED ASSIST. ☐ BED ☐ CHAIR ☐ TOILET	☐ COMPLETELY DEPENDENT FOR ALL MOVEMENT
BATHING	☐ INDEPENDENT IN BATH OR SHOWER	☐ INDEPENDENT WITH MECHANICAL AIDS	☐ REQUIRES MINOR ASSISTANCE OR SUPERVISION	☐ REQUIRES CONTINUED ASSISTANCE	☐ RESISTS
DRESSING	☐ INDEPENDENT	☐ SUPERVISION AND/OR CHOOSING OF CLOTHING	☐ PERIODIC OR DAILY PARTIAL HELP	☐ MUST BE DRESSED	☐ RESISTS
GROOMING/HYGIENE	☐ INDEPENDENT	☐ REQUIRES REMINDER MOTIVATION AND/OR DIRECTION	☐ REQUIRES ASSIST. WITH SOME ITEMS	☐ REQUIRES TOTAL ASSISTANCE	☐ RESISTS
EATING	☐ INDEPENDENT	☐ INDEPENDENT WITH SPECIAL PROVISION FOR DISABILITY	☐ REQUIRES INTERMITTENT HELP	☐ MUST BE FED	☐ RESISTS
BLADDER CONTROL	☐ TOTALLY CONTINENT	☐ ROUTINE TOILETING OR REMINDER	☐ INCONTINENCE DUE TO IDENTIFIABLE FACTORS	☐ INCONTINENT— LESS THAN ONCE PER DAY	☐ INCONTINENT— MORE THAN ONCE PER DAY
BOWEL CONTROL	☐ TOTALLY CONTINENT	☐ ROUTINE TOILETTING OR REMINDER	☐ INCONTINENCE DUE TO IDENTIFIABLE FACTORS	☐ INCONTINENT— LESS THAN ONCE PER DAY	☐ INCONTINENT— MORE THAN ONCE PER DAY

ADDITIONAL REMARKS ON A.D.L. NOTE FREQUENCY OF GROSS PROBLEMS. COMMENT ON SIGNIFICANT SLEEP PATTERNS.

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LONG TERM CARE ASSESSMENT SECTION III SOCIAL PROFILE

DATE YY MM DD	CLIENT FAMILY NAME	CLIENT NUMBER

4

A HOUSING AND SOCIAL CONTEXT

1 HOUSING

MODE

1 ☐ HOUSE
2 ☐ APARTMENT
3 ☐ ROOM
4 ☐ FACILITY
5 ☐ OTHER

1 ☐ RENTAL 2 ☐ SELF-OWNED

APPROPRIATENESS

1 ☐ CURRENT 2 ☐ PROPOSED

2 HOUSEHOLD COMPOSITION

COMPANIONS

1 ☐ LIVES ALONE
2 ☐ SPOUSE
3 ☐ OTHER ADULT MALE(S)
4 ☐ OTHER ADULT FEMALE(S)
5 ☐ CHILDREN
GIVE AGES

DESCRIBE RELATIONSHIPS

PRINCIPAL HELPER:

SUPPORTIVE RELATIONSHIPS (SEE GUIDE ON REVERSE OF THIS PAGE)

4 RELEVANT CULTURAL AND RELIGIOUS FACTORS

SELF CARE INDICATE CLIENT'S CAPABILITY ON MOST DAYS

FOOD PREPARATION 1 ☐ INDEPENDENT	2 ☐ ADEQUATE IF INGREDIENTS SUPPLIED	3 ☐ CAN MAKE OR BUY MEALS BUT DIET INADEQUATE	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ NO OPPORTUNITY OR DOES NOT PARTICIPATE BY CHOICE
HOUSEKEEPING 1 ☐ INDEPENDENT WITH HELP FOR HEAVY TASKS	2 ☐ CAN PERFORM ONLY LIGHT TASKS ADEQUATELY	3 ☐ PERFORMS LIGHT TASKS BUT NOT ADEQUATELY	4 ☐ NEEDS REGULAR HELP AND SUPERVISION	5 ☐ NO OPPORTUNITY OR DOES NOT PARTICIPATE BY CHOICE
SHOPPING 1 ☐ INDEPENDENT	2 ☐ INDEPENDENT ONLY FOR SMALL ITEMS	3 ☐ MUST BE ACCOMPANIED	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ NO OPPORTUNITY OR DOES NOT PARTICIPATE BY CHOICE
TRAVELLING 1 ☐ INDEPENDENT	2 ☐ NO PUBLIC TRANSPORT USES PRIVATE VEHICLE OR TAXI	3 ☐ CAN TRAVEL ONLY IF ACCOMPANIED	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ REQUIRES AMBULANCE FACILITIES
TELEPHONE 1 ☐ INDEPENDENT	2 ☐ DIALS WELL KNOWN NUMBERS	3 ☐ ANSWERS TELEPHONE ONLY	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ NO OPPORTUNITY OR DOES NOT USE PHONE
MEDICATIONS AND TREATMENTS 1 ☐ COMPLETELY RESPONSIBLE FOR SELF	2 ☐ REQUIRES REMINDER OR ASSISTANCE	3 ☐ RESPONSIBLE IF MEDICATIONS PRE— PARED IN ADVANCE	4 ☐ PHYSICALLY OR MENTALLY UNABLE	5 ☐ RESISTS

COMMENTS ON SELF CARE

SERVICE INVENTORY · SEE GUIDE ON INSTRUCTION PAGE

CODE	HEALTH SERVICES	Y/N	CODE	HOME SUPPORT SERVICES	N/Y	CODE	COMMUNITY SERVICES	N/Y
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	
	☐			☐			☐	

ONG TERM CARE SSESSMENT | SECTION IV 5 ☐ CORRECTION | FINANCIAL PROFILE SERVICE RECOMMENDATIONS | DATE | CLIENT'S FAMILY NAME | CLIENT NUMBER 161 | 5

A FINANCIAL AFFAIRS

1 DOES CLIENT RECEIVE "GAIN FOR SENIORS" OR "GAIN" FOR HANDICAPPED"?
1 ☐ YES
2 ☐ NO
IF YES

IF CLIENT IS 65 YEARS OF AGE OR OLDER, RECORD THE 9 DIGIT NUMBER WHICH APPEARS TO THE RIGHT OF THE PAYEE'S NAME ON THE "GAIN" CHEQUE.

IF THE CLIENT IS UNDER 65 YEARS OF AGE, RECORD ALSO ANY ALPHABETIC SUFFIX AFTER THE 9 DIGIT NUMBER.
IF NUMBER IS LESS THAN 9 DIGITS, ZERO-FILL FROM LEFT.

START 9 DIGIT NO. HERE

PLACE ANY ALPHABETIC SUFFIX HERE

2 IS THE CLIENT IN RECEIPT OF THE GUARANTEED INCOME SUPPLEMENT?
1 ☐ YES
2 ☐ NO

3 IS THE CLIENT IN RECEIPT OF WAR VETERANS ALLOWANCE?
1 ☐ YES
2 ☐ NO

4 IF ANSWER TO 1, 2, 3 IS "NO", IS THERE AN INDICATION OF FINANCIAL NEED FOR FACILITY PER DIEM AND PERSONAL NEEDS?
1 ☐ YES
2 ☐ NO

5 IS THE CLIENT IN RECEIPT OF THE OLD AGE SECURITY PENSION?
1. ☐ YES
2. ☐ NO

6 IF ANSWER TO 5 IS "YES" AND THE CLIENT IS MARRIED, WILL CLIENT BE ELIGIBLE FOR A SINGLE PERSON'S OAS PENSION RATE ON FACILITY ADMISSION?
1. ☐ YES
2. ☐ NO
3. ☐ N/A

7 IF ANSWER TO 6 IS "YES" AND FACILITY ADMISSION IS RECOMMENDED, HAS CLIENT BEEN ADVISED TO APPLY FOR THE SINGLE OAS PENSION RATE?
1. ☐ YES
2. ☐ NO
3. ☐ N/A

8 MANAGEMENT
1 ☐ INDEPENDENT IN ALL AFFAIRS
2 ☐ INDEPENDENT IF TRANSPORTED
3 ☐ NEEDS ADVICE WITH BANKING OR MAJOR PURCHASES
4 ☐ CAPABILITY OF COMPREHENSION DOUBTFUL
5 ☐ AFFAIRS MANAGED BY PUBLIC TRUSTEE, COMMITEE OR POWER OF ATTORNEY

9 WHO MANAGES AFFAIRS?
1 ☐ SELF
2 ☐ CONTACT
3 ☐ OTHER (STATE)

10 IS ARRANGEMENT IN PARA. 9 APPROPRIATE?
1 ☐ YES
2 ☐ NO

11 RESPONSIBILITY FOR COMFORTS.
1 ☐ SELF
2 ☐ CONTACT PERSON
3 ☐ OTHER: GIVE DETAILS BELOW

12 ADDITIONAL INFORMATION

B ASSESSOR'S COMMENTS AND RECOMMENDATIONS

COMMENTS ON CLIENT'S CURRENT SITUATION AND RECOMMENDATIONS FOR CARE OF CLIENT.

IF THE RESPONSE IN PARA. 2 BELOW IS CODE 5, MENTAL HEALTH ORIENTATION OF PROVIDER, DESCRIBE NATURE OF SPECIFIC PROBLEM.

RECOMMENDED OUTCOME
1 ☐ NOT ELIGIBLE
2 ☐ HOME MAKER
3 ☐ CARE IN FACILITY
4 ☐ HOME CARE PROGRAM
5 ☐ MENTAL HEALTH ORIENTATION OF PROVIDER
6 ☐ DAY CARE

1 ☐ PERSONAL CARE
2 ☐ INTERMEDIATE CARE 1
3 ☐ INTERMEDIATE CARE 2
4 ☐ INTERMEDIATE CARE 3
5 ☐ EXTENDED CARE

RECOMMENDED PROVIDER

RECOMMENDED HOURS OR SERVICES

APPENDIX C

CRD LTC PROGRAM : ESQUIMALT TEAM

Mission Statement - DRAFT

The mission of LTC is to provide an effective compassionate and affordable continuum of community health care support services to individuals who have chronic disabilities, while respecting the dignity and independence of the clients and their families.

APPENDIX D

Province of British Columbia | Ministry of Health and Ministry Responsible for Seniors | CONTINUING CARE DIVISION

APPLICATION FOR HOME SUPPORT SERVICES

Applicant's Name:	Client #	Spouse's Name:	Client #

CALCULATION OF DAILY CHARGE

	Applicant		Spouse			
Earned Income	______	+	______	=	______	(A
Unearned Income						
1. Old Age Security	______		______			
2. Canada Pension	______		______			
3. Disabled Veterans' Pension	______		______			
4. Other Pensions or Superannuation	______		______			
5. Investment Income (Interest from stocks, bonds, bank accounts, etc.)	______		______			
6. Other: ______	______		______			
______	______		______			
Total Unearned	______	+	______	=	______	(B
Subtotal (Earned + Unearned)			(A) + (B)	=	______	(C
Less: Income Tax Paid ______ + Medical Premiums	______			=	______	(D
NET MONTHLY INCOME			(C) - (D)	=	______	(E
	(divide (E) by 12 if calculated annually)				______	(F
Deductions						
1. Determine basic income level from table	______					
2. $125 for each disabled or aged person	______					
3. $100 if working adults in family unit	______					
4. Spousal Earned Income for handicapped designation	______					
Total Deductions	______				______	(G
AVAILABLE MONTHLY INCOME			(F) - (G)	=	______	
Calculation of Daily Charge : Divide Available Monthly Income by 2					______	
DAILY CHARGE (divide by 30 days)					______	

Application Agreement: I declare the above information is correct. I agree to pay the designated home support agency the amount calculated for each day I receive homemaker service. **Refusal to provide financial information or to sign the form is refusal of service.**

______ Signature of Applicant

______ Signature of Second Applicant or Spouse

______ Date

______ Assessor / Case Manager

______ Continuing Care Manager or Designate

VITA

Surname: Goodwyn | Given Names: Sherry Elizabeth

Place of Birth: Vernon, British Columbia, Canada

Educational Institutions Attended:

Royal Jubilee Hospital School of Nursing	1967 to 1971
University of Victoria	1976 to 1978

Degrees Awarded:

B. S. N.	University of Victoria	1978

Honours and Awards:

Publications: