

Canadian Core Competency Profile for Case Management Providers

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National Case Management Network
Réseau National des gestionnaire de cas
— *du/of Canada* —

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I. INTRODUCTION AND BACKGROUND

This first generation of the Canadian Core Competency Profile for Case Management Providers (hereinafter referred to as the *Profile*) is a foundational document that describes the core competencies (i.e., the knowledge, skills and abilities) required by those working in Case Management in Canada at the beginning and throughout their practice. It was developed by the National Case Management Network of Canada (NCMN) as a companion to the Canadian Standards of Practice for Case Management developed in 2009. Case Management is described as both a process and a role. The Standards focus on the process of Case Management and the Core Competencies focus on the role of Case Management Providers.

The *Profile* aims to provide concrete and actionable competencies while remaining broad enough to encompass the diversity of professional backgrounds and working environments that fall under the Case Management umbrella. The *Profile* was created to reflect the diversity of Case Management practice and to help support the evolution of Case Management in relation to the changing nature of the Canadian health care system. The document will be of value to a wide variety of stakeholders but was created primarily to guide Case Management Providers and employers while providing the public with information about the role and competencies associated with the provision of Case Management in Canada.

II. DEVELOPMENT OF THE *PROFILE*

The *Profile* was developed through the completion of a seven-phase project that involved consultation with a wide variety of Case Management Providers across Canada as well as input from the NCMN Competency Steering Committee, Core Competency Work Group, and Advisors Council (see Appendix A for details about the project development methodology).

The framework for the *Profile* was adapted from the CanMEDS competency framework developed and used by the Royal College of Physicians and Surgeons of Canada (Frank, 2005). The CanMEDS framework describes core competencies essential to effective medical practice and is organized thematically around seven meta-competencies or roles: *Expert* (the central integrative role), *Communicator*, *Collaborator*, *Manager*, *Health Advocate*, *Scholar* and *Professional*. The decision to adapt the framework for Case Management was based on several factors. The CanMEDS framework is supported by a substantial amount of research conducted over the past 15 years. Further, it uses a language that is shared across healthcare professions that supports interprofessional collaboration and initiatives (Verma, Patterson and Medves, 2006).

The original CanMEDS framework has been adapted to represent Case Management practice. With this Case Management-specific model, the seven roles developed for Case Management Providers include the central role of *Expert*, which integrates the roles of *Communicator*, *Collaborator*, *Navigator*, *Manager*, *Advocate* and *Professional*. While these roles are represented in the *Profile* as discrete entities, it is recognized that the roles often overlap in actual practice and that in order to demonstrate competent practice, all seven roles must be exhibited in an integrated manner.

III. CONTEXT OF PRACTICE

Description of Case Management Practice

Case Management is often described in the literature as a strategy, a process, and a role. Health care and social service agencies view Case Management as a potential means for improving client care and support. Those who provide Case Management use a collaborative, client-driven process for the provision of quality health and support services promoting the effective and efficient use of resources. Case Management Providers support the clients' achievement of safe, realistic, and reasonable goals within a complex health, social and fiscal environment (NCMN, 2009).

Case Management Providers

It is recognized that those who provide Case Management are from a variety of educational and professional backgrounds, regulated and unregulated. For example, they may be physicians, nurses, occupational therapists, social workers or paraprofessionals such as addiction counselors. Case Management Providers may be known within their working environment under different titles such as case manager or discharge planner or care coordinator. They may also be known by a professional discipline such as nurse or social worker. Regardless of the professional title or regulatory status, there are common roles that Case Management Providers are required to perform in order to maximize client outcomes.

Client

Clients who require Case Management often are experiencing acute or chronic health and/or social issues that necessitate a wide variety of resources and services to address them. The relationship between the client and the Case Management Provider may be short term or long term.

Contexts of Practice

The context of practice for Case Management Providers is varied. The types of clients, the areas of practice, the practice settings and the funding models may be different. Sectors in which Case Management Providers work may include acute care, long term care, primary care, community support agencies, disability management, home and community care, mental health and addictions, academia and education, private insurance, regional health authorities, rehabilitation, research, therapy services, First Nations and Inuit Health, Canadian Forces, Veterans Affairs Canada, and Workplace Safety and Insurance Boards. These different contexts of practice influence the roles and the competencies that individual Case Management Providers require to work effectively. Regardless of the context, Case Management is always client-focused.

Assumptions

A number of overarching assumptions apply to all competencies described in the *Profile*.

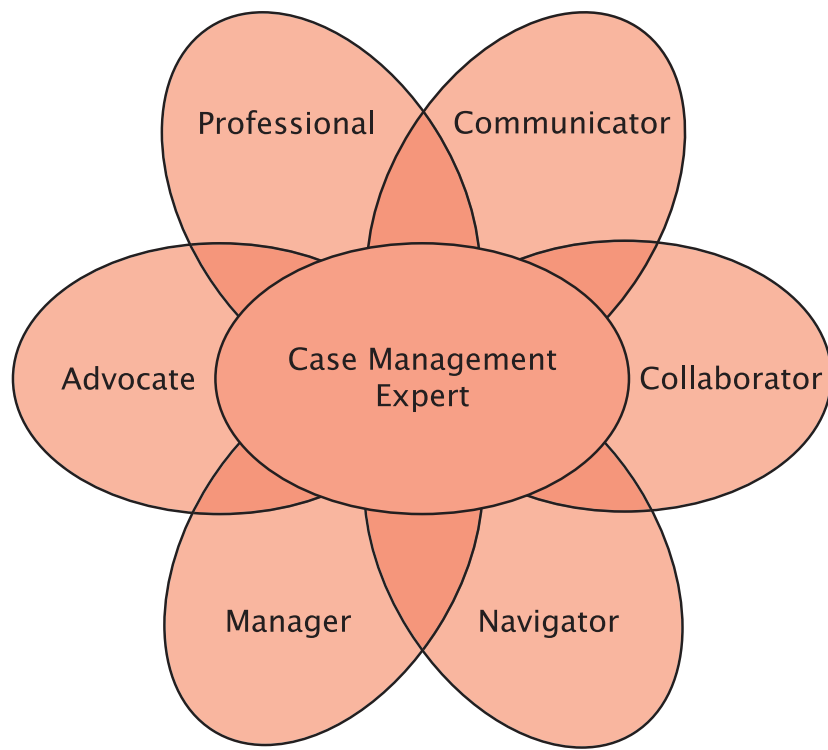
Case Management Providers:

1. Work in partnership with clients and their social network.
2. Support client rights.
3. Focus on the quality and continuity of care.
4. Work in an interprofessional and interorganizational environment.
5. Integrate a holistic perspective to client goals.
6. Demonstrate compassion, empathy and caring in dealing with client and social network.
7. Are accountable.

IV. CASE MANAGEMENT PROVIDER ROLES

There are seven roles used to represent Case Management within the *Profile*. These are represented on the opposite page as a diagram to illustrate the interconnected nature of the Case Management Provider roles in actual practice (Adapted from CanMEDS, 2005).





THE
CANMEDS
 CASE MANAGEMENT
 ROLES FRAMEWORK

Case Management Expert: Case Management Providers demonstrate expertise in complex health and social needs planning. As leaders in coordination and facilitation, Case Management Providers integrate all Case Management roles to promote and optimize the health and well-being of targeted client populations.

Communicator: Case Management Providers use effective communication to develop and enrich the client’s health and social networks, to build partnerships and to address barriers at the client and system level using a variety of different communication strategies/methods/techniques.

Collaborator: Case Management Providers facilitate the achievement of optimal client and system outcomes by working with the broad health and social networks. Case Management Providers skilfully engage individuals and groups to reach consensus by providing direct or indirect assistance, guidance or supervision along the continuum of care.

Navigator: Case Management Providers help clients navigate health and social systems by working with their networks to identify and address disparities and barriers.

Manager: Case Management Providers are integral participants in making decisions about time, resources and priorities that affect the Case Management plan and contribute to the effectiveness of clients’ healthcare plan, social networks and the organizational systems.

Advocate: Case Management Providers use their expertise and influence to speak on behalf of their clients, community or population to advance their health and well-being.

Professional: Case Management Providers demonstrate professional behaviour in the best interests of clients and society by adhering to the Canadian Standards of Practice for Case Management and through ethical and evidence-informed practice.

V. COMPETENCIES

1. Case Management Expert

Definition:

Case Management Providers demonstrate expertise in complex health and social needs planning. As leaders in coordination and facilitation, Case Management Providers integrate all Case Management roles to promote and optimize the health and well-being of targeted client populations.

Key Competencies

Case Management Providers are able to:

- 1.1 Screen clients for eligibility.
- 1.2 Perform a comprehensive assessment.
- 1.3 Develop a collaborative Case Management plan.
- 1.4 Facilitate coordination, communication and collaboration with clients and stakeholders to maximize their outcomes.
- 1.5 Evaluate the outcomes of the Case Management plan.
- 1.6 Facilitate the transition process.

Enabling Competencies

Case Management Providers are able to:

1.1 Screen clients for eligibility

- 1.1.1 Collect and review information relevant to the clients' situations including the health and social factors that may impact their needs.
- 1.1.2 Demonstrate knowledge of health, social and community-based resources required to provide Case Management services.
- 1.1.3 Identify priorities and clients' needs that Case Management can address.
- 1.1.4 Explain the Case Management process to clients and their social networks, including the processes of screening, assessing, planning, implementing, evaluating and transitioning.
- 1.1.5 Ensure that clients understand the role of the Case Management Provider.
- 1.1.6 Inform clients of their rights to privacy and confidentiality, and explain to them the complaint and/or appeal process.

1.2 Perform a comprehensive assessment

- 1.2.1 Assess clients' physical, psychosocial, emotional, spiritual and cultural factors (i.e. body, mind and spirit).
- 1.2.2 Integrate subjective and objective information from multiple sources including clients, social networks and the various stakeholders.
- 1.2.3 Prioritize service needs with clients' input and explain to them the assessment results.
- 1.2.4 Determine the expertise required and engage stakeholders.
- 1.2.5 Identify short- and long-term goals in collaboration with clients and their social networks.
- 1.2.6 Determine the reassessment timeframe.
- 1.2.7 Document clients' assessment results.

1.3 Develop a collaborative Case Management plan

- 1.3.1 Critically appraise clients' needs in relation to the required resources.
- 1.3.2 Seek information from clients and other sources to assist in shared decision-making.
- 1.3.3 Set short- and long-term goals in collaboration with clients and their social networks.
- 1.3.4 Co-create strategies to address clients' goals.
- 1.3.5 Promote clients' self-management options.
- 1.3.6 Assist clients to select options.
- 1.3.7 Communicate the agreed-upon Case Management plan to the identified stakeholders.
- 1.3.8 Document the Case Management plan.

1.4 Facilitate coordination, communication and collaboration with clients and stakeholders to maximize their outcomes

- 1.4.1 Maintain the oversight of clients' Case Management plan.
- 1.4.2 Motivate stakeholders to sustain and maintain support for clients' goals.
- 1.4.3 Collect and provide feedback on services provided by stakeholders involved in the clients' plan.
- 1.4.4 Help clients navigate the health and social systems.

1.5 Evaluate outcomes of the Case Management plan

- 1.5.1 Monitor progress on clients' goals and the Case Management plan.
- 1.5.2 Identify gaps and barriers to enhance outcomes for current and future cases.
- 1.5.3 Advocate on behalf of clients to achieve the best outcomes possible.
- 1.5.4 Reassess the clients' needs and the Case Management plan periodically.
- 1.5.5 Modify the Case Management plan and the use of service providers as necessary.

1.6 Facilitate the transition process

- 1.6.1 Engage clients and stakeholders in creating a transition plan for movement from one service provider and/or setting to another.
- 1.6.2 Communicate pertinent information to clients and receiving providers to ensure continuity of service.

2. Communicator

Definition:

Case Management Providers use effective communication to develop and enrich clients' health and social networks, to build partnerships and to address barriers at the client and system level using a variety of different communication strategies/methods/techniques.

Key Competencies

Case Management Providers are able to:

- 2.1 Develop rapport, trust and ethical relationships with clients and stakeholders.
- 2.2 Elicit and synthesize relevant information and perspectives from clients, social networks and stakeholders where applicable.
- 2.3 Employ effective means of communication (e.g. verbal, non-verbal, written, electronic and social media communications.)

Enabling Competencies

Case Management Providers are able to:

2.1 Develop rapport, trust and ethical relationships with clients and stakeholders

- 2.1.1 Demonstrate sensitivity to the individuality of clients and stakeholders.
- 2.1.2 Listen effectively and facilitate discussion to ensure an exchange of information from multiple perspectives.
- 2.1.3 Adapt communication to the audience while considering social and cultural diversity, and special needs.
- 2.1.4 Provide information and respond to questions in a sensitive, timely, empathetic and truthful manner.
- 2.1.5 Respect clients' confidentiality, privacy and autonomy in all verbal and written communications.

2.2 Elicit and synthesize relevant information and perspectives from clients, social networks and stakeholders where applicable

- 2.2.1 Demonstrate effective interview skills.
- 2.2.2 Demonstrate openness and flexibility when dealing with other points of view.
- 2.2.3 Synthesize all relevant information to develop the Case Management plan.

2.3 Employ effective means of communication (e.g. verbal, non-verbal, written, electronic and social media communications)

- 2.3.1 Determine the best means or strategy for communication.
- 2.3.2 Maintain legible and accurate records.
- 2.3.3 Employ effective verbal or written etiquette for the medium used.
- 2.3.4 Present clear verbal or written information about clients' Case Management plan to stakeholders.

3. Collaborator

Definition:

Case Management Providers facilitate the achievement of optimal client and system outcomes by working with the broad health and social networks. Case Management Providers skillfully engage individuals and groups to reach consensus by providing direct or indirect assistance, guidance or supervision along the continuum of care.

Key Competencies

Case Management Providers are able to:

- 3.1 Establish and maintain team relationships that foster continuity and client-centered collaboration.
- 3.2 Collaborate with stakeholders to prevent, manage and resolve conflict.
- 3.3 Build networks of resources.

Enabling Competencies

Case Management Providers are able to:

3.1 Establish and maintain team relationships that foster continuity and client-centered collaboration

- 3.1.1 Demonstrate an understanding of the responsibilities and perspectives of other stakeholders.
- 3.1.2 Share relevant information with clients and stakeholders in a timely manner.
- 3.1.3 Orient stakeholders to the roles and responsibilities of the Case Management Provider.
- 3.1.4 Promote collaborative, active and informed shared decision-making.

3.2 Collaborate with stakeholders to prevent, manage and resolve conflict

- 3.2.1 Maintain open and honest dialogue with stakeholders to promote a client-centered approach to client care.
- 3.2.2 Recognize actual or potential conflict situations.
- 3.2.3 Employ effective conflict resolution and reconciliation approaches and techniques.
- 3.2.4 Negotiate with others to mitigate barriers to optimize outcomes.

3.3 Build networks of resources

- 3.3.1 Establish and maintain formal and informal networks to support the provision of clients' services.
- 3.3.2 Use effective strategies for connecting with stakeholders.

4. Navigator

Definition:

Case Management Providers help clients navigate health and social systems by working with their networks to identify and address disparities and barriers.

Key Competencies

Case Management Providers are able to:

- 4.1 Anticipate, identify and help remove barriers to holistic care.
- 4.2 Facilitate safe and effective connections to services across settings.

Enabling Competencies

Case Management Providers are able to:

4.1 Anticipate, identify and help remove barriers to holistic care

- 4.1.1 Demonstrate knowledge and understanding of the needs of the target populations.
- 4.1.2 Coach clients and their social networks to self-navigate the health and social systems.
- 4.1.3 Participate in the creation of new or innovative opportunities to satisfy clients' unmet needs.

4.2 Facilitate safe and effective connections to services across settings

- 4.2.1 Identify situations where clients are not receiving optimal care.
- 4.2.2 Connect clients to required health and social services.
- 4.2.3 Accompany clients along the continuum of services as needed.
- 4.2.4 Address behaviours, practices and policies that may adversely affect client services.
- 4.2.5 Negotiate respectful access to the continuum of services.

5. Manager

Definition:

Case Management Providers are integral participants in making decisions about time, resources and priorities that affect the Case Management plan and contribute to the effectiveness of clients' healthcare plan, social networks and the organizational systems.

Key Competencies

Case Management Providers are able to:

- 5.1 Manage decision-making around the Case Management plan.
- 5.2 Manage unplanned changes that impact the Case Management plan.
- 5.3 Manage personal and organizational relationships.
- 5.4 Manage information in a timely manner according to agency and legislative requirements.

Enabling Competencies

Case Management Providers are able to:

5.1 Manage decision-making around the Case Management plan

- 5.1.1 Understand the structure, relevant legislation, funding and function of the health and social system as it relates to the target population served.
- 5.1.2 Identify risks and set priorities in collaboration with clients.
- 5.1.3 Balance clients' needs and expectations within the limits of the system finite human, physical and financial resources.
- 5.1.4 Make timely decisions when required.

5.2 Manage unplanned changes that impact the Case Management plan

- 5.2.1 Determine the impact of unplanned changes on clients' services.
- 5.2.2 Deal effectively with unplanned events.
- 5.2.3 Modify plans and renegotiate commitments and deadlines as circumstances dictate.

5.3 Manage personal and organizational relationships

- 5.3.1 Establish effective relationships with stakeholders within and beyond the immediate agency.
- 5.3.2 Direct and guide stakeholders to maximize client outcomes (e.g. assign tasks and monitor other personnel as required).
- 5.3.3 Determine the lead for the Case Management plan and assume it when needed.
- 5.3.4 Set priorities and manage time effectively.

5.4 Manage information in a timely manner according to agency and legislative requirements.

- 5.4.1 Gather and document information.
- 5.4.2 Keep records secure, accessible and up to date.
- 5.4.3 Share information and coordinate its flow among all stakeholders.
- 5.4.4 Accurately report information verbally and/or in writing.
- 5.4.5 Follow up on information with stakeholders as required.

6. Advocate

Definition:

Case Management Providers use their expertise and influence to speak on behalf of their clients, community or population to advance their health and well-being.

Key Competencies

Case Management Providers are able to:

- 6.1 Identify and act on service gaps and overlaps at the client, community and population levels.
- 6.2 Assist clients to become autonomous and informed decision-makers.

Enabling Competencies

Case Management Providers are able to:

6.1 Identify and act on service gaps and overlaps at the client, community and population levels

- 6.1.1 Identify and challenge unclear or unsupported decisions that may negatively impact the Case Management plan.
- 6.1.2 Use tact and diplomacy to foster and sustain positive relationships with the various stakeholders.
- 6.1.3 Identify and balance competing interests.
- 6.1.4 Participate in activities to reduce service disparities and improve service outcomes.

6.2 Assist clients to become autonomous and informed decision-makers

- 6.2.1 Educate and support clients in self-advocacy and assertiveness.
- 6.2.2 Encourage and support clients to exercise their rights and responsibilities.

7. Professional

Definition:

Case Management Providers demonstrate professional behaviour in the best interests of clients and society by adhering to the Canadian Standards of Practice for Case Management and through ethical and evidence-informed practice.

Key Competencies

Case Management Providers are able to:

- 7.1 Comply with all relevant policies, standards and laws.
- 7.2 Demonstrate respect for clients' individuality and autonomy.
- 7.3 Contribute to the development of the Case Management body of knowledge.
- 7.4 Use self-reflective practice to enhance professional development.
- 7.5 Care for self.

Enabling Competencies

Case Management Providers are able to:

7.1 Comply with all relevant policies, standards and laws

- 7.1.1 Demonstrate knowledge of policies and standards related to their role, and of the applicable legislations.
- 7.1.2 Adhere to a model of ethical decision-making.
- 7.1.3 Document and report instances of unethical or improper conduct.
- 7.1.4 Refrain from exploitation of clients for personal or professional gain.

7.2 Demonstrate respect for clients' individuality and autonomy

- 7.2.1 Balance clients' autonomy with professional accountability.

7.3 Contribute to the development of the Case Management body of knowledge

- 7.3.1 Keep up to date with current research, literature and other developments relevant to the field and apply learning toward their practice.
- 7.3.2 Engage in activities that support the development of Case Management practice.
- 7.3.3 Support research initiatives where applicable.

7.4 Use self-reflective practice to enhance professional development

- 7.4.1 Acknowledge their values, attitudes, beliefs, emotions and past experiences, and their impact on their practice.
- 7.4.2 Pursue opportunities or educational development to enhance their practice.
- 7.4.3 Elicit feedback from clients, peers and supervisors to continuously improve their practice.
- 7.4.4 Identify professional limitations and seek guidance from others.

7.5 Care for self

- 7.5.1 Take responsibility for their personal, professional, mental and physical health.
- 7.5.2 Balance personal and professional priorities to ensure personal health and a sustainable practice.

VI. GLOSSARY

Client: A client is the recipient of service. Clients may be individuals, families, or communities (CNO).

Continuum of care: Interrelated and connected range of services including acute care, home and community care, long term care, respite care, public health, mental health, palliative care, addiction services, children, youth and family services, and housing services (Canadian Healthcare Association, <http://cha.ca/index.php/continuumofcare>).

Core Competencies: The repertoire of measurable skills, knowledge and abilities required by Case Management Providers throughout their career (Adapted from the Canadian Alliance of Physiotherapy Regulators, 2009).

Enabling Competencies: The sub-elements or key ingredients to achieving the key competencies (Frank, 2005).

Health and social networks: A group of health care and social providers who work together to co-ordinate and deliver services to clients involved in Case Management.

Holistic Care: A system of comprehensive or total client care that considers the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs.

Informed Consent: The process of giving permission or making choices about care. It is based on both a legal doctrine and ethical principle that respects a client's right to sufficient information when making decisions about care (CNA, 2008).

Key Competencies: The important outcome objectives (i.e. what is to be achieved or performed).

Social networks: The people that support the client involved in Case Management. This network may be comprised of family members, friends or persons hired by clients or their families.

Stakeholders: A person, group, organization providing services to clients involved in Case Management, for example, health and social providers, meals on wheels, day centers, community centers, etc.

Transition plan: Agreement between the Case Management Provider and the receiving stakeholder that details the steps for the movement of clients from one service provider and/or setting to another.

VII. REFERENCES AND RESOURCE DOCUMENTS

The following documents were consulted in the development of the Canadian Core Competencies for Case Management Providers.

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APPENDIX A

PROFILE DEVELOPMENT

The Canadian Core Competency *Profile* for Case Management Providers is a culmination of hundreds of hours of time and effort by over 150 stakeholders over a two-year period. The process used to create, review and validate the competency *profile* followed a best-practice approach to competency development and strongly relied on the content expertise of a diverse group of Case Management Providers and stakeholders. The *profile* was designed to be meaningful to practitioners as well as those who want to learn more about the role of Case Management. There were seven key phases to the development of the *profile*; (1) literature review and recommendation to NCMN; (2) bi-monthly meetings of the Core Competency Work Group; (3) three-day competency development workshop with a sub group of the Core Competency Work Group; (4) three focus groups with members of the Core Competency Work Group and the Advisors Council to provide feedback on the draft competency document; (5) public validation of the competency *profile*; (6) review of the draft competency document by attendees of the annual NCMN Conference and Expo; and (7) finalization and additional review of the *profile* with the NCMN Competency Steering Committee.

Phase I of the project involved conducting a scan of the current practice in Case Management as well as other health care fields. Based on this review, a report was produced and recommendations were provided to the NCMN Competency Steering Committee, which reviewed the information and approved a general framework for the competencies.

Phase II comprised of a series of bi-monthly meetings conducted by the NCMN Steering Committee with its Core Competency Work Group to start developing the competency framework roles and competencies.

Phase III of the project involved a 3-day workshop where a sub-group of the Core Competency Work Group created the complete competency *profile* after receiving training in competency development practice. The final product was presented to the NCMN Steering Committee for review before the validation process (i.e., focus groups).

Phase IV comprised a series of focus groups with members of the Core Competency Work Group and those of the Advisors Council to provide feedback on the complete draft competency *profile* document. The focus group participants were asked about the applicability of the current competencies and whether competencies were duplicated or omitted. The NCMN Competency Steering Committee reconvened to make a decision about modifying or deleting competencies based on the validation survey outcome report. In total, three competencies and sub-competencies were added while eight competencies and sub-competencies were deleted (Note that some of the content from many of these competencies were merged with other competency or assumption statements). Minor revisions were made to 27 competencies to increase concept clarity.

During **Phase V**, the competency *profile* was disseminated for a public 40-day review using an online validation survey. The survey was developed in order to enable a broader group of stakeholders to review the competencies. The competency validation questions used for the short survey were similar to those posed at the focus groups.

During **Phase VI**, the competency *profile* was presented at the 6th annual NCMN Conference. The goal was to solicit additional feedback from stakeholders to ensure that the competency *profile* reflected the practice of Case Management Providers. A set of questions similar to the focus groups questions was posed to approximately 125 NCMN Conference attendees.

In **Phase VII**, this feedback was taken under advisement by the NCMN Competency Steering Committee and integrated into the document for validation. The Canadian Core Competency *Profile* for Case Management Providers was finalized on November 2012.

APPENDIX B

ACKNOWLEDGMENTS

The development of the Canadian Core Competency *Profile* for Case Management Providers was made possible through the hard work and devotion of many groups and individuals.

Thanks are extended to members of the Core Competency Work Group and Advisors Council that included Case Management Providers from across the country, representing the many sectors of Case Management practice. Those who contributed content expertise include:

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Core Competency Working Group:
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Advisors Council:
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NOTES
