InCARE

matia instituto

Case management:

an operational approach

Co-funded by
the European Union

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The aim of this document is to propose a flexible approach to case management in the context of primary care social services, developed within the INCARE pilot project.

The InCARE project (Supporting Inclusive development of communitybased long-term CAREservices through multi-stakeholder participatory approaches), co-funded by the European Union, aims to contribute to the design of a coordinated approach to the development of national long-term care policy and care services at local and regional level by establishing socially innovative and participatory decision-making processes.

The overall objective of InCARE is to improve the well-being and access to appropriate and affordable care for older people with care needs arising from cognitive or functional difficulties and for their informal carers. In this respect, the project aims to generate coordination practices so that carers of people with dementia have their needs covered within a continuum of care. The project proposes to promote the case management methodology in the Social Services as it has been shown to be appropriate for when it comes to facilitating coordination between different systems and services.

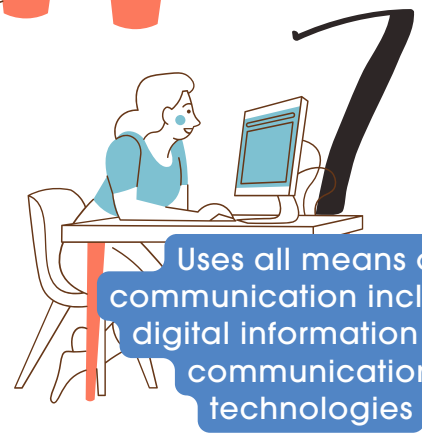
Case management is a concept with multiple definitions that share the professional and informed planning of the provision of supports and services required by people with complex care needs. Case management emerged in the United States in the 1970s to address the fragmentation of social and health care systems, both within each system (Sarabia Sánchez 2007) (primary and specialised care) and between systems, ultimately including the community level.

This approach is gaining relevance in health and social care settings and has been identified as a possible key to support the coordination of care services.

The different meanings of "case management" generally respond to the emphasis on some theoretical and positioning aspects (highlighting, for example, the importance in the term of the person as the main beneficiary) or else raising differences in the practical approach (directiveness of the process).

The case management procedure is broad and in the literature it is usually defined from the characteristics of the professional who develops it. Based on a definition used in Holland and France, according to the Case Management Society of America (CMSA), the International Foundation of Integrated Care (Schrijvers and Somme 2017) states that a case manager is a professional who:

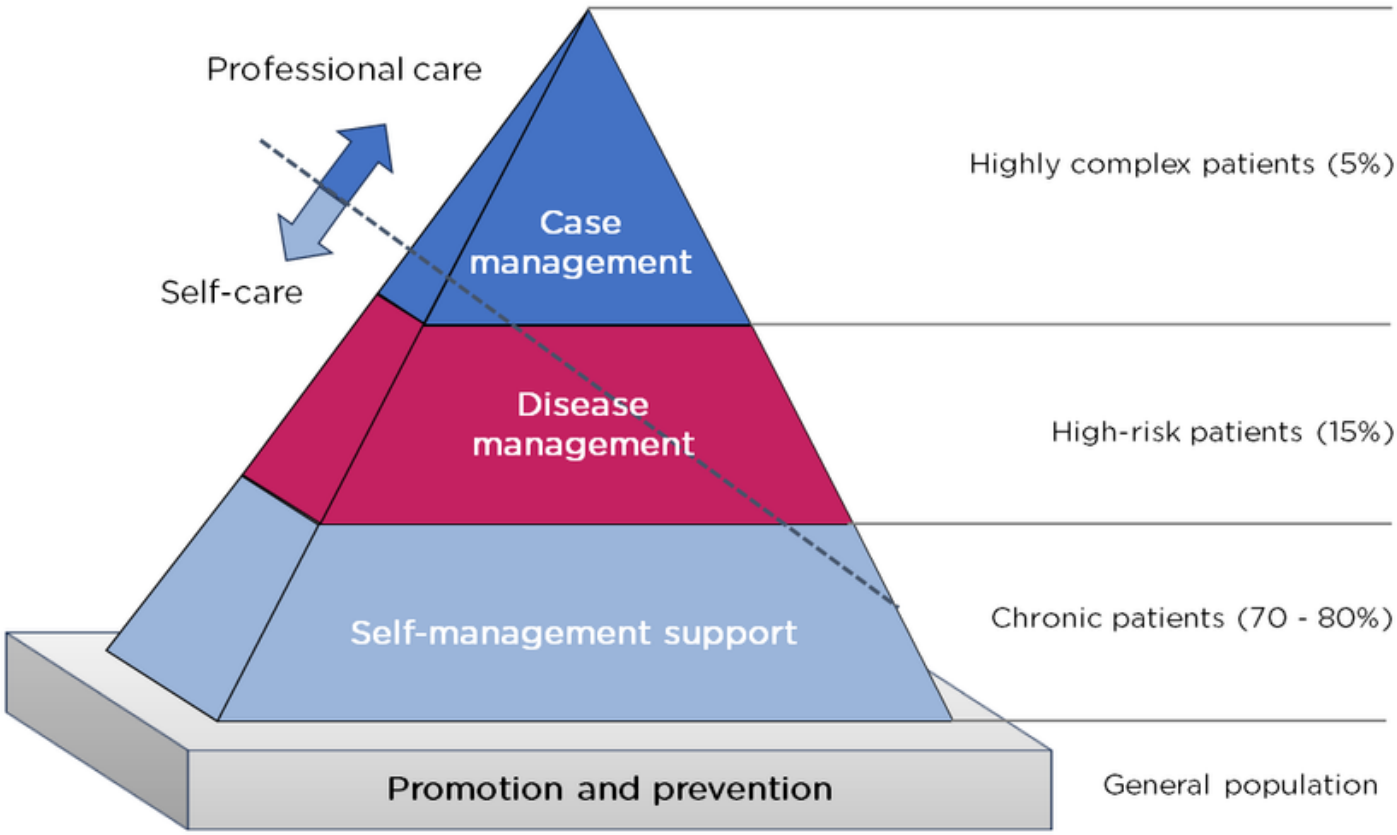
1. Has frequent contact with people in complex situations.
2. Assesses all care and social needs of the person
3. Cooperates with health professionals and other professionals
4. Develops a life/care plan for health and social management.
5. Organizes formal and informal client care
6. Works within a program
7. Uses all means of communication including digital information and communication technologies
8. Works only with people who are unable to organize their care and life plans and do not have a sufficient family network to support them.



Many of the situations described, respond to a situation of complexity, so that in many cases case management is oriented to support people in a state of high complexity. The state of complexity is defined as a care situation with characteristics of instability, unpredictability and intensity.

The private care organization Kaiser Permanent has developed a pyramid model that relates the frequency of cases, the intensity and the type of management they require, considering that at the top of the pyramid are the complex cases: the smallest number of people requiring complex care, which in turn generate the highest health care costs, and case management as the methodology oriented to this complexity as opposed to more preventive and lower intensity interventions.

Extended Kaiser Pyramid

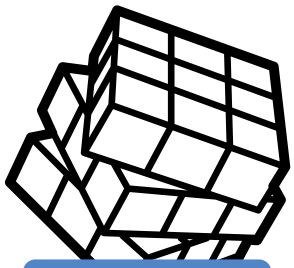


Source: Kaiser Permanente. Adapted

At the national level, case management is developed as a role mainly associated with social and healthcare coordination developed by the nursing professional. This is a specialised role that currently does not have standardised training and is carried out unevenly in different regions, with Andalusia and Catalonia having more experience in this professional development. The competencies of the case manager are:

Knows social and health needs

Ability to promote continuity of care



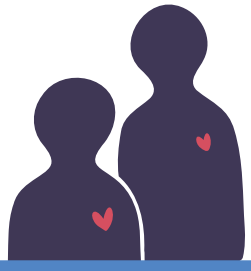
Ability to solve problems and shortcomings with limited resources

Social skills

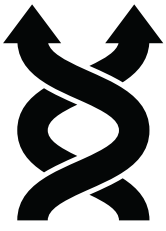
Emotional support. Non-therapeutic

Mediation, negotiation, coordination and integration skills

Perseverance, assertiveness



Builds relationships based on trust



Flexibility and search for solutions that are not exclusively administrative

The case manager usually works with 30 to 40 people from the same target group (people with dementia, cancer patients, complex family problems and social urgency). Furthermore, the limits of case management are often placed according to different definitions on the therapeutic intervention, the duration of the intervention or the executive or administrative attribution to provide services.

In our experience, we have developed approaches to case management from the professional profile of social services with an emphasis on the social domain of long-term care, the ability to prescribe and refer, and the facilitation of community support. In the Etxean Bizi project (Matia Instituto Gerontológico 2020) case management was used as a methodology that has shown benefits for older people and their carers, while at the same time recovering the essence of social work by bringing professionals closer to the home. It is in the homes where people's needs are observed and the necessary support is coordinated to provide a more comprehensive and effective response.

The case management methodology places the person with limited personal autonomy at the centre and provides support for the continuity of her/his life project. This methodology focuses on the person (preferences and life project) and addresses the areas of her/his environment (physical context of the home, building and neighbourhood), social and health coordination, the situation of the caregiving environment (family caregivers, care professionals, internal or temporary), and the list of services that can respond to her/his needs (services by portfolio, private, community and/or voluntary action services in the municipality/county).

The case manager assumes the defence of the rights of the people she cares for; she always responds to the person's needs and seeks the best response to them; she is collaborative, and therefore brings people and groups together to support the person; she builds a culture of care that adapts to the idiosyncrasies of the people, accompanying, not imposing; she serves as emotional support and assumes the role of accompaniment.

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More information on the project's website:

https://incare.euro.centre.org/

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