

A Model Framework for the Implementation of a Case Management Approach

	Process
<p>Step 1: Scoping exercise</p> <ul style="list-style-type: none"> - projecting the expected numbers of patients 	<ul style="list-style-type: none"> ▪ Agree and develop a mechanism with secondary and primary care to scope the existing population to identify the High intensity users ('revolving door; top 4%). The areas to be searched include <ul style="list-style-type: none"> ▪ The first phase, is a diagnostic phase to identify the extent of the problem. Identify the individuals who fall into the high risk of re hospitalisation category ▪ This information will be used to formulate an action plan to implement Case Management effectively and unique to each Trust. ▪ Data originating from secondary care should be simulated to provide information and direction in formulating a Case Management model to meet the needs of the specific population ▪ The volume of targeted patients by locality can be identified using a predictive modelling tool. ▪ Systematic review of current Case Management approaches and their transferability to Northern Ireland. ▪ Map current Case Management approaches/ service approaches within Northern Ireland
<p>Step 2: Agreeing a model for Case Management</p>	<ul style="list-style-type: none"> ▪ Need to streamline approaches and agree a regional best practice/evidence-based model service model for the implementation of Case Management with core elements identified for adoption in local model ▪ There a need to redesign current community and secondary care to provide a range of services from prevention activities to targeted for those people at highest risk ▪ The model should provide a structured and consistent approach to shape the way health and social care deliver integrated long term care locally ▪ Trusts should consider how they will undertake an assessment of competencies for their particular service model
<p>Step 3: Modelling the Workforce</p>	<p>Develop the Workforce Strategy Each trust will be required to develop a robust workforce strategy. This will help to minimise the inherent risks that workforce expansion and modernisation brings from this change</p> <p>Develop a Workforce plan. This should take account of existing services, staff and their competencies and the impact that the Case Management service will have on these, as well as considering issues for new services, teams and staff.</p>

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<p>Workforce Expansion</p> <p>Role Re-Design</p> <p>Recruitment and Retention</p> <p>Learning & Development</p> <p>Resource implications</p>	<p>The plan needs to identify any new or changed roles that are required. There needs to be clarity about workforce expansion (when, where, which staff groups) within this plan.</p> <ul style="list-style-type: none"> ▪ Trusts need to determine if proposed Case Management staffing requirements can be met through re-engineering existing roles and introducing new ways of working (role expansion /redesign/ modernisation) ▪ New interfaces between community and secondary care need to be established as part of the Case Management approach. ▪ Consideration needs to be given in relation to the transfer of patient care from secondary to primary care and how this could impact on staff, carers and patients. <ul style="list-style-type: none"> ▪ Trusts need to identify the required staff (new staff, any workforce growth), new roles and re- engineered roles) and how these will be recruited. ▪ Issues about workforce supply should also be considered. Case Managers could potentially be recruited from existing Trust workforces. ▪ Plans for tackling staff retention will need to be developed in line with potential impact of Agenda for Change. ▪ A plan will be required from each Trust, in respect of recruiting Case Managers and should outline how recruitment will be achieved through re-designing existing jobs and through workforce growth. <ul style="list-style-type: none"> ▪ Trusts need to identify Learning & Development needs across existing roles, proposed re-engineered roles and new roles. ▪ Consideration needs to be given to <ul style="list-style-type: none"> - commissioning existing programmes - redesign of existing programmes to incorporate Case Management competencies - engagement with Higher Education Institutes in the development of new programmes <p>Trusts need to consider the modernisation of existing staff groups to create new roles for</p>
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practitioners through reengineering of current roles, e.g. District nurses, Nurse Practitioners.

Step 4 : Standardising of Case Management core elements

A regional standardised approach to case management should be adopted. The core processes within Case Management should be-

Case finding- The method of finding patients who may benefit from Case Management programmes and the decision making process on whether or not a patient should be included in the Case Management programme.

Assessment- A standardised method of reviewing a patient's needs – both health and social care using a single assessment process. Need to align to the Regional IT strategy. This should provide comprehensive and specialist assessments for patients with complex needs, and provide tools for on-going monitoring of patients.

A Case Manager should lead the single assessment process.

Trusts will need to clearly define procedures on how many packages of care required through social services can be speedily arranged, following the Case Manager's assessment.

Personalised care plan- Documentation to record information on the treatment and support is required to support the health and social care needs of the patient.

Intervention- An agreement regarding the contacts, support and treatment to be provided by all members of the Case Management team.

Continual review- The monitoring of the improvement or deterioration of the patient, and changes in the level of intervention is required. Additionally, the process to enable the discharging of the patient from the Case Management programme if their condition permits needs to be determined and agreed.

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<p>Step 5: Structure of Case Management services</p>	<p>Best practice indicates that Case Management services should be available 24 hours per day, 7 days per week and this should be inherent within the NI Case Management model</p> <ul style="list-style-type: none"> ▪ The structure and staffing of Case Management services is for local determination. ▪ A number of core roles should be incorporated as a standard into these local models ▪ It is essential that the Case Management provided to patients is robust and comprehensive, and that staff workloads are geared to achieve a high standard service. ▪ When scoping the numbers of patients who will be case managed, sufficient capacity should be reserved for patients who have newly developed needs for case management (e.g. immediately following their second hospital admission in 12 months). These patients will require immediate screening, assessment and intervention.
<p>Step 6: Defining core roles /Functions</p> <p>a. Case Manager</p>	<p>The role of the Case Manager will be a 'proactive generalist' as opposed to the more traditional 'reactive specialist' role- competent generalists that require some specialist knowledge. This shift in emphasis will require significant role re-engineering and not just a change in job title.</p> <ul style="list-style-type: none"> ▪ Each patient will have a Case Manager to ensure on-going co-ordinated care. The needs of individual patients determine the competencies of professionals involved in their care and different models of Case Management should be offered by other professionals, including nurses, AHPs, and social workers to meet different patient needs ▪ Case Managers will require a broad range of competencies. These competencies will need to be developed at a regional level. The Case Manager competencies produced by DOH provide a thorough basis for developments. ▪ Pilots elsewhere have shown that a full time Case Manager can hold a caseload of 50 – patients who may hold a 'active' or retained' status. This can give a rough estimate on the numbers of Case Managers required in each trust. ▪ However, caseload size will be determined by many variables (i.e. competencies of

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<p>b. Case Finder</p>	<p>other team members, team structure, service configuration, related services).</p> <ul style="list-style-type: none"> ▪ The Case Finder requires information identifying patients identified as being at risk. This flow should be established using a predictive modelling tool, initially monthly moving to real time. ▪ Case Finding for Level 3 patients - Patients with highly complex needs will require intensive packages of care. Individualised Patients should be identified through the utilisation of risk stratification tools. The King's Fund (2005) has rolled out on the PARR (patients at risk of re hospitalisation) algorithm to identify high risk patients and this could be used. ▪ Case Finding for Level 2 & 1 patients- as well as patients identified via this initial case finding process, there will be new patients requiring Case Management. ▪ These new patients will require rapid inclusion in the Case Management programme. ▪ There should be no establishment of 'waiting lists' for Case Management services ▪ It may be necessary to restrict or broaden the criteria but it is essential that localities plan how they will allocate their total Case Management capacity.
<p>Step 7: Changing the patient role</p>	<p>Drive the ability of patients and families to manage their chronic condition by providing:</p> <ul style="list-style-type: none"> ▪ Self-management training in the early stages of a condition to help prevent the onset of compounded conditions and further disability. ▪ Healthcare organisation works with voluntary agencies to commission user-led self-management programmes ▪ Encounters with the healthcare system need to facilitate self-management behaviour ▪ Programmes to include information about their chronic condition, including strategies to manage their symptoms and prevent complications, which are reflected within their care plan; ▪ Motivation to self-manage their condition and adhere to treatments; and ▪ Skills, equipment and medication to manage their condition at home

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<p>Step 8: Developing Supporting roles</p>	<p>Although the Case Manager will have responsibility for the Case Management of a patient, in most cases their care plan will include support and treatment by members of a multi-disciplinary team.</p>
<p>a. Pharmacy support</p>	<ul style="list-style-type: none"> ▪ Pharmacy support will be a key feature of an integrated approach to Case Management ▪ This will be further enhanced by the new pharmacy contract and the new roles being taken on by Pharmacists. ▪ The development of a partnership with the secondary/ Community Pharmacist should be established. ▪ This will enable medication reviews and concordant patient partnerships to be facilitated ▪ The medication review should be conducted as soon as a patient enters the Case Management programme, and should be undertaken by a pharmacist.
<p>b. General Practitioner services</p>	<ul style="list-style-type: none"> ▪ The GP will have an essential function in the management of patients receiving Case Managed patients ▪ Support should be given to the development of Local enhanced services agreement through the existing GMS contract.
<p>c. Existing Community Services</p>	<ul style="list-style-type: none"> ▪ The impact of Case Management services on existing community teams (i.e. Health and Social care teams) needs careful consideration. ▪ Trusts will need to determine any necessary function changes and identify any new competencies that will be required to fulfil the requirement of the Case Management role
<p>d. Voluntary and statutory agencies</p>	<ul style="list-style-type: none"> ▪ Enhanced working with voluntary (CHS Association, Diabetes UK etc) and statutory agencies, including the Community Development & Health Network, at a local level needs to be developed ▪ Delivery of the Chronic Condition Management programmes needs to be planned
<p>e. Information support</p>	<ul style="list-style-type: none"> ▪ Information systems are required to record the interventions of Case Management

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Step 9: Supporting the change	<p>Implementing Case Management will require a significant culture shift within health and social care. Consideration should be given within any workforce development strategy to:</p> <ul style="list-style-type: none">• Fairness and equity• Consistent treatment and approach• Development / career frameworks for staff in new / redesigned roles• Collaborative partnership working between organisations
Step 10 : Monitoring & Evaluation	<p>The Case Management approach can achieve reductions in admissions, reductions in length of stay, or a combination of the two and this information needs to be collected through agreed and robust mechanisms.</p> <ul style="list-style-type: none">▪ Trusts need to agree a Performance Management system▪ Monitoring includes both the effectiveness of Case Management and measuring of it's impact on acute services, the later requiring a bridging between the Case Management and the acute databases▪ Key outcome measures include<ul style="list-style-type: none">- case list size of each Case Manager- reduction in emergency admissions- reduction in overall length of stay▪ Key indicators that may be used to measure the success of the Case Management service could include high level indicators such as:<ul style="list-style-type: none">- bed days saved in secondary care by avoiding the hospital admission of people who will be cared for through case management approaches- level of A&E attendances & emergency admissions over time – indicates overall

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	<p style="text-align: center;">demand pressure</p> <p style="text-align: center;">- level of trolley waits (including time waiting profile), medical outliers and cancelled electives over time – indicates how well demand and supply are aligned, expect to decrease as Case Management approaches are implemented</p> <ul style="list-style-type: none"> ▪ Measurement of the specific impact of Case Management will involve sample tracking of patients to verify admission avoidance and identify full intervention activity. ▪ Trusts will need to identify trajectories around the numbers of Case Managers being employed and the numbers of patients identified as receiving care through a Case Management approach. ▪ Measures relating to qualitative indicators of patient Quality of Life, clinical outcomes and satisfaction need to be considered ▪ Benchmarking exercises should be carried out across the various local Case Managements models for levels of efficiency and effectiveness to be determined
<p>Step 11: Cost benefits analysis exercise</p>	<ul style="list-style-type: none"> ▪ Trusts will need to project the full year effect of implementing a single Case Management service. ▪ Trusts will need to map this requirements against existing funding and highlight additionality required ▪ Funding to support this additionality will need to be identified at a regional level