Integrated Care Matters
District Nursing Case Management and Buurtzorg Model
Knowledge Tree Branch
District Nursing Case Management Resources

Scotland
Chief Nursing Officer Directorate, Scottish Government (no date) The District Nursing role in integrated community teams [link]
This series of brief papers on the Transforming Roles programme aims to update stakeholders on the professions’ contribution to the wider transformational change agenda in health and social care in Scotland. The third paper outlines how district nursing roles are being developed in NHSScotland.

ihub (Healthcare Improvement Scotland) Frailty and falls assessment and intervention tool [link]
The frailty and falls assessment and interventions tool is designed for use within health, social care and third sector to support assessment and identification of interventions to meet an individual’s needs. It can be used to help signpost individuals to the right care and support within the local community. It is designed to enhance the local assessment and intervention process and documentation. It can also be used as a framework for key worker or clinical assessment, case review or analysis of interventions to support wellbeing.

This paper aims to describe the frequency of four frailty-related risk factors in a cohort of older adults visited by community nurses in Dublin, Ireland. This study results suggest that dependency in activities of daily living (an outcome of frailty) is strongly associated with a decreased likelihood of living alone and increased likelihood of referring oneself to community nursing services. Further research is necessary to examine how frailty screening in the referral process may enhance identification of older adults’ community nursing needs in Dublin, Ireland.

This study examined associations of pre-frailty and frailty states with cognitive and functional health outcomes among community-residing older adults (N = 457) in the Bronx, New York. Results: older adults who met criteria for frailty demonstrated poorer performance in attention, verbal memory, and overall global cognitive functioning compared to healthy controls. Moreover, pre-frail and frail older adults had significantly worse health outcomes including greater perceived difficulty with lower and upper extremity functioning and perceived limitations in completing daily activities, suggesting the need for targeted interventions in the community that may ameliorate age-related health decline.

Acuity and dependency in the community nursing caseload in combination with safe staffing levels are a national issue of concern. Current evidence suggests that there are no clear approaches to determining staff capacity and skill mix in these community settings. As
Community nursing caseloads are large with differing complexities, there is a need to allocate community nursing with the best skill mix to achieve the best patient outcomes. A city-wide service improvement initiative developed a tool to classify and categorise patient demand and this was linked to an electronic patient record system. The aim was to formulate an effective management response to different levels of acuity and dependency within community nursing teams and a consensus approach was used to allow the definition of complexity for twelve packages of care. The tool was piloted by a group of community nurses to assess the validity as a method to achieve a caseload classification. Seventy nurses were trained and applied the tool to 3000 patient referrals. Based on this, standards of care were agreed including expectations of assessment, intervention, visit length and frequency. Community nursing caseloads can now be organised according to acuity and complexity of patient need, which determines allocation of staff and skill mix.

Frailty causes disability and restrictions on older people's ability to engage in leisure activities and for social participation. The objective of this study was to evaluate the effects of a 1-year case management intervention for frail older people living at home in Sweden in terms of social participation and leisure activities. The study was a randomised controlled trial with repeated follow-ups. The sample (n = 153) was consecutively and randomly assigned to intervention (n = 80) or control groups (n = 73). The intervention group received monthly home visits over the course of a year by nurses and physiotherapists working as case managers, using a multifactorial preventive approach. Data collections on social participation, leisure activities and rating of important leisure activities were performed at baseline, 3, 6, 9 and 12 months, with recruitment between October 2006 and April 2011. The results did not show any differences in favour of the intervention on social participation. However, the intervention group performed leisure activities in general, and important physical leisure activities, to a greater extent than the control group at the 3-month follow-up (median 13 vs. 11, P = 0.034 and median 3 vs. 3, P = 0.031 respectively). A statistically significantly greater proportion of participants from the intervention group had an increased or unchanged number of important social leisure activities that they performed for the periods from baseline to 3 months (93.2% vs. 75.4%, OR = 4.48, 95% CI: 1.37–14.58). Even though statistically significant findings in favour of the intervention were found, more research on activity-focused case management interventions is needed to achieve clear effects on social participation and leisure activities.

This paper aims to describe how telephone nurses define a frequent caller and describe their experiences with calls from frequent callers to primary healthcare centres. Interviews were conducted with ten telephone nurses in Sweden in 2015. Qualitative content analysis was conducted. A main theme was established, called ‘Balancing between the experienced and assessed needs’, which described the telephone nurses’ experiences with calls made by frequent callers to primary healthcare centres and was further described in five categories with 15 subcategories. The categories described telephone nurses’ definitions of frequent callers, telephone nurses’ views of the underlying reasons for the calls, challenges related to
frequent callers, experiences with an increased work load and strategies used to manage and help frequent callers. Frequent callers were commonly encountered by telephone nurses’ in this study. Their calls were experienced as complex and demanding to manage. The findings point to needs for guidelines and routines to improve the care of frequent callers. In addition, support and training in communication skills to encounter this group of callers in an optimal and safe way may be required.

The Providing Assistance to Caregivers in Transition (PACT) program offers nursing home discharge planning and case management for individuals in the transitional period following a return to the community. The PACT program targeted individuals newly admitted to nursing homes and worked with a family caregiver to develop and implement a nursing home discharge plan. Design and Method: Reported are the results of a randomized control design evaluating the program’s effectiveness. Those individuals randomly assigned to the intervention group (n = 33) received PACT case management in addition to their usual medical and nursing home care. The individuals in the control group (n = 29) continued their usual care. Result: There were no statistical differences in the discharge rate (84% treatment vs 76% controls) or in the median length of stay (42 days vs 55 days) between the two groups of individuals. Implications: Replications or extensions of a PACT-type intervention might consider a broader mix of nursing homes, working directly with the nursing home’s admission Minimum Data Set coordinator in patient selection, or working with Medicare or Medicaid HMO plans.

The effects of patient advocacy case management on service use and healthcare costs for impaired older people or adults with a chronic somatic disease living in the community were evaluated using a literature review. A literature search was conducted in Medline, CINAHL, and Cochrane databases. Included were English-language randomized controlled trials evaluating service use and costs of the patient advocacy case management model for people with a chronic somatic disease or for impaired older people living in the community. Eight relevant studies were identified and included after evaluation of methodological quality. All studies concerned frail or impaired older people, and one study also included people with a somatic chronic disease. In none of the studies was evidence found for clinically relevant increase of service use and costs, whereas in two studies, it was reported that patient advocacy case management led to decreased service use and to savings in costs.
Buurtzorg Model

This ebook includes a chapter on ‘what the Netherlands can teach the NHS about cutting cost but not quality’. It compares the UK and Netherlands’ institutional settings to identify the implications for implementing the Buurtzorg model in the NHS.

The Knowledge Network (no date) Buurtzorg workshop resources [link]
This page on the Knowledge Network includes presentations, videos and slides from workshops on the Buurtzorg model co-ordinated by Healthcare Improvement Scotland’s improvement hub.

Mitchell, I (2015) The Buurtzorg model: Caring for each other with mutuality at the core. Health and Social Care Integration blog [link]
In this blog post the author discusses his visit to the Netherlands and his own personal experiences shadowing a Buurtzorg Community Nurse.

Moray Council (2016) Testing new models of delivering health and social care in Moray: procurement/tender strategy [link]
This tool is to be used to outline a tender/commodity strategy and highlights the subject headings and the considerations that need to be documented for a procurement project.

NHS (2015) Implementing Buurtzorg principles in the NHS [link]
Slides from an NHS event outlining the Buurtzorg principles

Royal College of Nursing (2016) Briefing: The Buurtzorg Nederland (home care provider) Model [link]
This briefing looks at the successes of the Buurtzorg model, while also identifying some of the challenges which would need to be addressed if the UK were ever to adopt a similar system approach. The content and analysis have been updated to reflect developments taking place across the UK with regards to piloting Buurtzorg, as well as the growth of RCN about how the model works. It identifies challenges to introducing the model to the UK, including limited funding and scope for continuing professional development (CPD).

This opinion piece discusses the Buurtzorg model, evidence of its impact and implications for implementation in the UK.

This report outlines the opportunities that digital technologies offer local authorities. It identifies the Buurtzorg approach’s decentralised and distributed organisational model as an example of a use of a digital platform (Buurtzorgweb) as a mode of advice and evidence sharing that has cost saving potential.
This video and transcript are from the Kings Fund event ‘A new future for social care?’ on 12 July 2016.

Bowen, M (2017) Buurtzorg could work in the UK, but why must it fit into the existing system? BMJ [link]
This letter expresses concerns about the adoption of the Buurtzorg approach in the UK.

This report describes characteristics of the home health care population in the Netherlands, including their needs for care and the amount of care delivered, within the Buurtzorg organisation.

This paper describes the case of Buurtzorg Nederland as a good practice example of integrated care, focusing in particular on the organizational aspects of its innovation.

This study explores the belief system and the entrepreneurial behaviour of Policy Entrepreneurs involved in introducing the Buurtzorg model in Shanghai.

This case study reviews Buurtzorg’s approach and performance thus far and considers how this model of care might be adapted for the United States.

This paper reports the findings of interviews with 17 Buurtzorg nurses in the Netherlands, indentifying four common themes in how the nurses perceived their work and the organisation. The author argues that the model for home care presented by Buurtzorg offers possibilities for the U.S. to lower homecare costs and increase patient and nurse satisfaction.
General Articles on Frailty

There is no single generally accepted clinical definition of frailty. The authors aimed to develop a tool that would be both predictive and easy to use.

This study examined associations of pre-frailty and frailty states with cognitive and functional health outcomes among community-residing older adults (N = 457) in the Bronx, New York. Results: older adults who met criteria for frailty demonstrated poorer performance in attention, verbal memory, and overall global cognitive functioning compared to healthy controls. Moreover, pre-frail and frail older adults had significantly worse health outcomes including greater perceived difficulty with lower and upper extremity functioning and perceived limitations in completing daily activities, suggesting the need for targeted interventions in the community that may ameliorate age-related health decline.

This article provides an overview of the current state of our knowledge about the frailty syndrome: its definitions and pathogenesis, as well as clinical applications and potential preventative and therapeutic interventions.

Frailty is the most problematic expression of population ageing. It is a state of vulnerability to poor resolution of homoeostasis after a stressor event and is a consequence of cumulative decline in many physiological systems during a lifetime. This cumulative decline depletes homoeostatic reserves until minor stressor events trigger disproportionate changes in health status. In landmark studies, investigators have developed valid models of frailty and these models have allowed epidemiological investigations that show the association between frailty and adverse health outcomes. We need to develop more efficient methods to detect frailty and measure its severity in routine clinical practice, especially methods that are useful for primary care. Such progress would greatly inform the appropriate selection of elderly people for invasive procedures or drug treatments and would be the basis for a shift in the care of frail elderly people towards more appropriate goal-directed care.

This systematic review aims to summarise the evidence regarding the effectiveness of integrated care interventions in reducing hospital activity. 50 reviews were included. Interventions focused on case management (n=8), chronic care model (CCM) (n=9), discharge management (n=15), complex interventions (n=3), multidisciplinary teams (MDT)
(n=10) and self-management (n=5). 29 reviews reported statistically significant improvements in at least one outcome. 11/21 reviews reported significantly reduced emergency admissions (15–50%); 11/24 showed significant reductions in all-cause (10–30%) or condition-specific (15–50%) readmissions; 9/16 reported LoS reductions of 1–7 days and 4/9 showed significantly lower A&E use (30–40%). 10/25 reviews reported significant cost reductions but provided little robust evidence. Effective interventions included discharge management with postdischarge support, MDT care with teams that include condition-specific expertise, specialist nurses and/or pharmacists and self-management as an adjunct to broader interventions. Interventions were most effective when targeting single conditions such as heart failure, and when care was provided in patients’ homes. Although all outcomes showed some significant reductions, and a number of potentially effective interventions were found, interventions rarely demonstrated unequivocally positive effects. Despite the centrality of integrated care to current policy, questions remain about whether the magnitude of potentially achievable gains is enough to satisfy national targets for reductions in hospital activity.

This paper provides an overview of measures to increase recruitment and retention of health professionals across Europe. Using a multi-method approach combining an extensive literature review and multiple-case study research, 64 publications and 34 R&R interventions from 20 European countries were analysed. The authors found a consistent lack of evidence about the effectiveness of R&R interventions, and although most interventions were found to not be an explicit part of a coherent package of R&R measures and instead exist in complex configurations, some evidence of the efficacy of the Buurtzorg approach on R&R was identified (p.1523).

Frailty is a clinical syndrome that focuses on loss of reserve, energy and wellbeing. Older people with frailty tend to present late and often in crisis to health and care services so their care may be hospital-based, episodic and unplanned. Frailty should be reframed as a long-term condition that can be managed proactively in primary and community settings by supported self-management and person-centred care. Nurses play a vital role as key workers, care co-ordinators and supporters to patients and their carers at all stages of the frailty trajectory.

This article outlines key actions for the recognition and management of frailty in primary care based on national guidance and existing sources of synthesised and quality-assessed evidence.

British Geriatrics Society (2014) Fit for Frailty. BGS. [link]
This website provides links to various resources including best practice and position papers on the management of specific conditions and audit results.
**Other useful links**

University of the West of Scotland [link]

University of the West of Scotland District Nursing programme [link]

Queen’s Nursing Institute Scotland [link]

Scottish Government (2016) Health and Care Delivery Plan [link]

Public Bodies (Joint Working) (Scotland) Act 2014 [link]

**Scottish Government (2015) National Health and Wellbeing Outcomes [link]**

The framework is for anyone with an interest in health and social care services. In particular, health and social care professionals, including clinicians, GPs, nurses and Allied Health Professionals involved in the planning and delivery of health and social care services, and importantly, people who use services, their carers and their families. This framework will help to inform how services are planned across the whole pathway of care, to ensure a focus on individuals, and also the practice changes within integrated multidisciplinary teams, that will make a difference to the care people receive.