Case management
making a unique contribution to integrated care

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Webinar 27 March
Where does case management fit?

WHO (2015) WHO Global strategy on integrated people-centred health services 2016-2026

**Strategic goals**

1. Empowering & engaging people
2. Strengthening governance & accountability
3. Reorienting the model of care
4. Coordinating services
5. Creating and enabling environment
The Rainbow Model of Integrated Care (RMIC)

**Clinical integration**
- Coordination of care for a complex need at stake in a single process across time, place and discipline.

**Professional integration**
- Inter-professional partnerships based on a shared accountability to deliver care to a defined population.

**Organisational integration**
- Inter-organisational partnerships based on collaborative accountability and shared governance mechanisms, to deliver care to a defined population.

**System integration**
- Coherent set of (informal and formal) political arrangements to facilitate professionals and organisations to deliver a comprehensive continuum of care.

Core dimensions of integrated care

1. Person centred care
2. Clinical integration
3. Professional integration
4. Organisational integration
5. Systemic integration
6. Functional integration
7. Normative integration
### Dimension 2: Clinical Integration

**Clinical Integration**

It refers to how care services are coordinated and/or organised around the needs of service users.

<table>
<thead>
<tr>
<th>2.1 Multidisciplinary assessment and plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care professionals work together to undertake care assessments and planning</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>2.2 Care coordinator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Named care coordinators ensure continuity of care to service users over time</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>2.3 Care transitions management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordination between care professionals enables seamless care transitions for service users across care settings</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>2.4 Case management:</th>
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</thead>
<tbody>
<tr>
<td>Professionals work together to proactively manage the needs of defined service user groups (e.g., case management with precise inclusion criteria)</td>
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<table>
<thead>
<tr>
<th>2.5 Single point of entry:</th>
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<tbody>
<tr>
<td>There is a single point of entry for service users when accessing multiple services from different professionals/providers (centralization of referrals)</td>
</tr>
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<table>
<thead>
<tr>
<th>2.6 Community involvement:</th>
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<tbody>
<tr>
<td>Volunteers and the community are actively involved in coordinating care around people’s needs</td>
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<table>
<thead>
<tr>
<th>2.7 Integrated care pathways:</th>
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<tbody>
<tr>
<td>Partners in care follow defined care pathways to help understand and direct the process of care integration</td>
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Unlike system or service-related care coordination strategies, it is critical that the community-based case manager has an ongoing interpersonal relationship with the individual and is not just a service.

(Meltzer & Davy, 2019)

Therapeutic relationship between the person and one or more providers that spans various healthcare events and results in accumulated knowledge of the person and their needs.

Burge et al (2011)
Integrated care, care coordination and case management

Care coordination – organizational level

- is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organising care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care. (Agency for Healthcare Research and Quality – care coordination Atlas 2010).

- a proactive approach in bringing care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings (WHO 2015)

Case management – relational/personal level

partnership and collaboration (Lukersmith, 2017)
different names

- Community care coordinator
- Care coordinator
- Case manager
- Case monitor
- Clinical case manager
- Coordinator
- Community living facilitator
- Discharge planner
- Local area coordinator
- Planning facilitator
- Support broker
- Support coordinator
- Support facilitator
- Support navigator

currently used
Terminological variance

Confused ????

Apple = or

Mars = or

Seeing = watching, looking, understanding

Address = to speak to/ location

What is the concept behind the term?
Case management – person’s context

International Classification of Functioning, Disability and Health – ICF (WHO 2001)

biopsychosocial perspective of health and functioning
contextual factors

= person-centredness

ICF framework and interactions of components

Health Condition (disorder/disease)

Body functions & structures
(Impairment)

Activities (Limitation)

Participation (Restriction)

Environmental Factors

Personal Factors
The influence of contextual factors on case management?

- Across health conditions
  (ICF personal factor)
  - Chronic health conditions
  - Complex health conditions
- Across age and the life course
  (ICF personal factor)
- Across contexts and systems
  (ICF environmental factors)
  - Health and social systems, education, legal
  - Public, private, NGO
  - Policy and finance systems
- Across time
  - Temporal factors
Scoping and mapping review

Scoping and mapping review
Different definitions
(n=22)

Activity/interventions of case managers (n=69)

Models (n=5)

<table>
<thead>
<tr>
<th>Model</th>
<th>Other terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broker</td>
<td>Service broker</td>
</tr>
<tr>
<td></td>
<td>Managed care</td>
</tr>
<tr>
<td></td>
<td>Medical case management</td>
</tr>
<tr>
<td></td>
<td>Generalist</td>
</tr>
<tr>
<td></td>
<td>Gatekeeper</td>
</tr>
<tr>
<td>Clinical</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Direct care</td>
</tr>
<tr>
<td>Chronic</td>
<td>Long term</td>
</tr>
<tr>
<td></td>
<td>Integrated care</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
</tr>
<tr>
<td>Strengths based</td>
<td>Peer assisted</td>
</tr>
<tr>
<td>Assertive</td>
<td>Intensive case management</td>
</tr>
<tr>
<td></td>
<td>Recovery</td>
</tr>
<tr>
<td></td>
<td>Intensive comprehensive care</td>
</tr>
</tbody>
</table>
Complex intervention Multiple components - interdependent, and dependent

- The Sydney eScholarship Repository, Post graduate theses/Sydney Digital Theses
- (Open Access) [http://hdl.handle.net/2123/17000](http://hdl.handle.net/2123/17000)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Factors influencing variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical model</td>
<td>Strengths based, rehabilitation, broker, clinical, assertive CM, hybrid</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>e.g. Social services, Health (chronic care, stroke, diabetes, mental health), Social insurers (injury systems, NDIS), aged care, Corrective services, Legal......</td>
</tr>
<tr>
<td>Case manager’s discipline</td>
<td>OT, SP, SW, PT, RC, Nurse, Welfare, Attendant care provider, AND whether the case manager assumes a dual role e.g. nurse case manager, OT case manager</td>
</tr>
<tr>
<td>Service context</td>
<td>Interpretation or role and responsibilities Geographical - urban/rural, area service covers Funding No of employees, Acute/non-acute Mobile, Intensity</td>
</tr>
<tr>
<td>Client health domains and context</td>
<td>Health condition Environmental and personal factors</td>
</tr>
<tr>
<td>Temporal factors</td>
<td>Recovery Resuming activities and participation Maintaining health and wellbeing</td>
</tr>
</tbody>
</table>
‘Same same but different’
Reviews and systematic reviews and qualitative research

• lack of information, improved reporting of case management interventions, and more research on case management interventions is needed (Rapp & Goscha, 2004, Lannin et al 2014, Young et al, 2017)

• Numerous issues with methodology and definitions of types of case management have beset research in this field (Smith & Newton, 2007)

• ‘there are many articles on case management but the value of some is compromised by a confusion on the definition of case management (Dellemain & Warburton, 2013)

• and others
Variability
Frail older persons

Effective case management for planning and coordination of health and social support services for **people with a disability, rare health conditions** improves and also positively impacts on the individual’s outcomes, and participation in social and economic life roles

- Castro, R et al 2019 Bridging the gaps between health, social and local services, to improve care for people living with rare and complex conditions: key findings of the EU-funded INNOVCare project and its case management pilot. *International Journal of Integrated Care, 19(S1): A566*, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s3566


We know that case management works

- On the ground it looks like CM is helpful, is a facilitator
- When CM is poorly done – people notice and outcomes can be worse
- When it is absent – outcomes can be very different
Do we need to know more?

What is quality analysis and evaluation used for?
Quality Analysis/evaluation

- What is/what is NOT case management?
- What is good case management?
- What context (client and service)

- Scaling up case management that works
- Implementation or scaling up approach

- Management of case managers
- Resource allocation
- Training and education

- Need for CM
- Cost effectiveness
- Value for money – cost benefit
What we can do:

- Look at case management top down AND bottom up
- Describe the client and service context, temporal factors
- Be clear on the theoretical framework, goals of the service
- Understand concepts and components to reduce variability in how it is described
- Describe the client context and temporal factors
- Adopt a common language to enable comparisons
- Understand what is and what is not case management
- Measure ++ on what is being done by CM
- Measure client and service outcomes
Describe the client context and temporal factors

Client context post acute (Ref: My Plan - icare NSW)

- **Continued recovery**
  - Post discharge, adjusting & settling into community living following serious injury

- **Participation**
  - Resuming life – major areas e.g. self care, domestic, work, interpersonal interactions

- **Maintaining lifestyle & health**
  - Maintain routine and rhythm of life
✓ Describe the service contextual factors
✓ Be clear on the theoretical framework, goals of the service

Models of case management analogy
(even in same context, same ‘condition’,

**Travel agent** sits behind a desk, organises and coordinates

**Travel companion** – accompanies you

**Travel Guide** - has appropriate training experience and expertise (knowledge required) there to do things with you, and show you how to do things for yourself

Understand the components of an intervention/case management activity

WHO International Classification of Health Interventions (ICHI)

Components of a health intervention

Example - Eye assessment with an optometrist (BZZ.AA.AH)

<table>
<thead>
<tr>
<th>Target</th>
<th>the entity on which the Action is carried out</th>
<th>eye and eye functions unspecified (ICF) ..... Standardised assessment for seeing functions (BZZ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>the deed done by an actor to the Target</td>
<td>diagnostic – eye examination (AA)</td>
</tr>
<tr>
<td>Means</td>
<td>the processes and methods by which the Action is carried out</td>
<td>external (AH)</td>
</tr>
</tbody>
</table>
✓ Understand the components of an intervention/case management activity

✓ Adopt a common language to enable comparisons

CMTaxonomy a common language

2. Lukersmith, S. Taylor, J., Salvador-Carulla, L. (under review) Content analysis on the National Disability Insurance Scheme case management role: implementation gaps; Journal of Health and Social Care in the Community
CMTaxonomy – two trees and glossary
Client context post acute
(Ref: My Plan - icare NSW)

**Continued recovery**
Post discharge, adjusting & settling into community living following serious injury

**Participation**
Resuming life – major areas e.g. self care, domestic, work, interpersonal interactions

**Maintaining lifestyle & health**
Maintain routine and rhythm of life
Client context - 5 years post injury

**Continued recovery**
Post discharge, adjusting & settling into community living following serious injury

**Participation**
Resuming life – major areas e.g. self care, domestic, work, interpersonal interactions

**Maintaining lifestyle & health**
Maintain routine and rhythm of life
Extending the service tree

Broker model
- Case management (often nurse) e.g. post operative care
- Discharge planner
* Throughputs = process, CM actions (activities or interventions)
Assessment intervention
Coordination main action
Coordination related actions
**Coordination**

Navigating and facilitating the access, management and cohesion of services and supports for the client.

**Navigating** - Finding the most appropriate pathway through systems, services, resources and supports for the client given their context.

**Facilitating** - Making the process easier, identify gaps, anticipate problems, help remove or negotiate barriers, and promote safe and effective connections to services and appropriate use of resources.

**Advocating** - Mediation or pleading in favour of a client including lobbying to achieve access for the client to existing resources or services.

**Linking** – Linking client with appropriate supports and agencies e.g. referring - the action of sending the client to see another person or place for consultation, review or further action, help or advice. (related action)

Lukersmith, S (2017), A Taxonomy of Case Management: Development, DiCoordination semination, and Impact. The Sydney eScholarship Repository, Post graduate theses/Sydney Digital Theses (Open Access) [http://hdl.handle.net/2123/17000](http://hdl.handle.net/2123/17000)
Emotional and motivational support

Providing the client (family and others as appropriate) with comfort, empathy or motivational support

*Includes*: supportive communication (without using theory based methods) to find strategies to solve or alleviate difficulties arising from their daily demands of life and situation; assisting, encouraging and reinforcing the client (and family as appropriate) to build independence, make decisions, exercise choice and responsibilities, take actions, and support the client’s and family’s adjustment to changed circumstances
Dual responsibilities – using classification system – ICHI

WHO- FIC International Classifications of Health Interventions (ICHI)
### Nursing activity - dressing

<table>
<thead>
<tr>
<th>ICHI code</th>
<th>LZZ.DK.AH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>LZZ - Skin and subcutaneous cell tissue, unspecified</td>
</tr>
<tr>
<td>Action</td>
<td>DK - Application of dressing</td>
</tr>
<tr>
<td>Means</td>
<td>AH - External</td>
</tr>
<tr>
<td>ICHI descriptor</td>
<td>Application of dressing to skin or subcutaneous cell tissue, not elsewhere classified</td>
</tr>
<tr>
<td>Definition</td>
<td>Application of dressing to wound NEC; Change of dressing, NEC; Change of wound packing, NEC; Application of bandage, NEC</td>
</tr>
<tr>
<td>Inclusion Terms</td>
<td>pressure dressing</td>
</tr>
<tr>
<td>Code also</td>
<td></td>
</tr>
<tr>
<td>Excludes Notes</td>
<td>application of pressure garment (UAD.DP.ZZ)</td>
</tr>
</tbody>
</table>
Early Intervention Program (RCT)  
inpatient RTW SCI and TBI

<table>
<thead>
<tr>
<th>Advising</th>
<th>Recommending a course of action to encourage change of functioning, environment, attitude or behaviour</th>
<th>Timeframes – employer, funder, person RTW program Identify strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>Continuous acquisition of information to monitor progress (with client, employer, other parties. Includes phone, email, face to face, worksite).</td>
<td>Discharge phone calls Team meetings, review goals, employer contact Modify plan Monitoring RTW plan</td>
</tr>
<tr>
<td>Travel</td>
<td>All travel related to servicing the client.</td>
<td></td>
</tr>
<tr>
<td>Other VR intervention – AH discipline specific</td>
<td>Discipline specific vocationally related intervention – eg workplace assessment, careers counselling</td>
<td>Normalising RTW Acknowledging worker identity RRTWS Workplace assessment – access and ergonomics Role and identity Job analysis Functional implications Adjustments AT assessment Equipment Career counselling RTW strategies Work simulated tasks Impairment specific strategies (eg memory strategy) vs generic Facilitating peer support RTW program – treatment</td>
</tr>
</tbody>
</table>

Measuring outcomes – client

- Client outcomes relevant to their goals
- Relevant to theoretical framework of CM service
- Standardised outcome measures e.g. functioning and participation, Quality of Life / wellbeing
- Use of supports and services e.g. attendant care, informal supports, emergency attendance

Bridging the gaps between health, social and local services, to improve care for people living with rare and complex conditions: key findings of the EU-funded INNOVCare project and its case management pilot

19th International Conference on Integrated Care, San Sebastian, 01-03 April 2019

Raquel Castro¹, Dorica Dan², Juliet Tschan², Vibeke Sparring³, Irina Vana³, Barbara Glinsner⁴

1: EURORDIS, France;
2: Romanian Prader Willi Association, Romania;
3: Zentrum für Soziale Innovation – ZSI, Austria;
4: Karolinska Institutet, Sweden

Introduction: The EU-funded INNOVCare project aimed at bridging the gaps in the co-ordination between health, social and support services and at developing an innovative care pathway for patients with rare diseases (RD) and other complex conditions. Representatives of RD patients were highly involved in the design and implementation of the project’s activities, services and research.

Short description of practice change implemented: INNOVCare assessed the everyday and care needs of RD patients in Europe, implemented and evaluated a case management pilot, elaborated and shared good practices and training tools, and identified good key issues for the up-scaling of integrated care for RD and other complex conditions in Europe.
✓ Measuring outcomes – service

- FREQUENCY INTENSITY TASK AND TIME (FITT) PER CM/PER CLIENT
- COSTS OF THE SERVICE (EFFICIENCY)
- COSTS TO THE SYSTEM OVER TIME (BENEFITS)
 ✓ Measure ++ on what is being done

Research
- Vocational Intervention program (VIP)
Brain injury NSW
Case management taxonomy YouTube 1

https://www.youtube.com/watch?v=7apR5QX3mwo

Case management taxonomy YouTube 2

https://www.youtube.com/watch?v=POv9WslQxS0

Contacts

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#CMTaxonomy
Case management