National Council on Ageing and Older People

Care and Case Management for Older People in Ireland

An outline of current status and a best practice model for service development

Sarah Delaney, Rebecca Garavan, Hannah McGee and Aodán Tynan
Health Services Research Centre
Department of Psychology, Royal College of Surgeons in Ireland

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Care and Case Management for Older People in Ireland
As Chairperson of the National Council on Ageing and Older People, it gives me great pleasure to present this study of Care and Case Management for Older People in Ireland.

The National Council on Ageing and Older People has recommended the implementation of Care Management as a framework for the co-ordinated planning and delivery of health and social services for older people in various reports since 1992. The Council believes that its introduction will produce health and social gain for older people by enhancing the quality of care that they receive and ultimately by enabling more of them to remain living in the community for as long as is possible or practicable.

This study provides, for the first time, a systematic review of how health and social services are currently being delivered to older people with the purpose of identifying models of best practice within a Care Management framework. The research allows the voices of a wide range of health and social service providers to comment individually about how care is currently delivered in Ireland. In addition, the research provides them with an opportunity to express how they feel about Care and Case Management as a model for the planning, co-ordination and delivery of services and its feasibility in an Irish context.

The research also allows older people and their carers to voice their opinions about how health and social care services are currently being delivered to them. In addition, older people are consulted for their views on Care and Case Management as a potential strategy for their health and social care. This research again demonstrates that older people strongly assert their preference to remain living in their own homes within their own communities. Older people believe that the implementation of Care and Case Management, as a model of care delivery, will ensure that their preference for remaining in their own homes will become a reality.

The challenge for health and social service providers is to ensure that the prerequisites for the effective implementation of Care and Case Management as described in the report are met. The systemic and attitudinal changes that are required to ensure that these prerequisites are met are by no means trivial and the scale of adaptation required must not be underestimated. However, there is strong evidence, based on the findings of this report, of a concerted organisational shift throughout health and social services and a growing recognition of the need to integrate services and to adopt a person-centred approach to the delivery of care for older people. This is the essence of Care and Case Management. The National Council on Ageing and Older People hopes that this
report will act as a source of guidance, support and encouragement for all those who seek to promote the health and social well-being of older people through the provision of health and social services.

On behalf of the Council, I would like to thank the authors, Ms Sarah Delaney, Ms Rebecca Garavan, Professor Hannah McGee and Mr Aodán Tynan, for their hard work and dedication in producing an excellent report. I would also like to thank Professor Faith Gibson who chaired the Council Consultative Committee that advised on the progress of the research and oversaw the preparation of the report. Thanks are also due to the members of this Committee: Mr John Brennan, Ms Janet Convery, Mr John A. Cooney, Mr Jim Cousins, Ms Marie Dooley, Dr John Gibbon, Ms Ann Judge, Sr Stanislaus Kennedy, Mr Eddie Matthews, Ms Mary McDermott and Mr Maurice O'Connell.

Finally, the Council would like to thank its Director Mr Bob Carroll, Research Assistant Ms Sinead Quill and former Research Officer Ms Catherine Conlon who steered the project on the Council's behalf. Thanks are also due to Mr Eamonn Quinn who prepared the report for publication and to the Council's administrative staff for their assistance throughout the course of the project.

Dr Michael Loftus
Chairperson
This report on Care and Case Management in Ireland was commissioned by the National Council on Ageing and Older People (NCAOP). The Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland, conducted the study. The study team comprised Ms Rebecca Garavan (study co-ordinator), Ms Sarah Delaney (researcher), Mr Aodán Tynan (health economist) and Professor Hannah McGee (centre director). The study aimed to provide a first systematic national review of health and social service delivery practices in the care of older people for the purpose of identifying models of best practice within a Care Management framework in the Republic of Ireland. The study also examined and outlined the prerequisites for the development of effective Care and Case Management in Ireland.

We acknowledge the support and assistance of many individuals in completing the report. We acknowledge the advice of Professor David Challis (Professor and Site Director, Personal Social Services Research Unit, University of Manchester, UK), Dr Michael Donnelly (Reader, Epidemiology and Public Health, The Queen’s University of Belfast, Northern Ireland) and Ms Brigit Smith (Area Co-ordinator of Services for Older People, North Western Health Board, Sligo). We also particularly note the roles of the Project Consultative Committee in the consultation process: Professor Faith Gibson (Chair – Consultative Committee), Mr John Brennan (Senior Social Worker, Tallaght Hospital), Ms Mary McDermott (Regional Co-ordinator of Services for Older People, Western Health Board), Ms Janet Convery (Director of Services for Older People, East Coast Area Health Board), Dr John Gibbon (Retired Consultant Physician in Geriatric Medicine), Mr John Cooney (Chief Executive Officer, South Eastern Health Board), Mr Maurice O’Connell (Chief Executive Officer, Alzheimer Society of Ireland), Councillor Jim Cousins (Dundalk Urban District Council), Ms Ann Judge (Management Development Specialist, Office for Health Management), S. Stanislaus Kennedy (President, Focus Ireland), Ms Marie Dooley (Director of Public Health Nursing, North Eastern Health Board) and Mr Eddie Matthews (Director of Services for Older People, Northern Area Health Board). We also thank the NCAOP staff for their support in numerous ways over the lifetime of the project.

Health and social service professionals from both the statutory and voluntary sectors across the health boards in Ireland participated in study interviews. Two focus groups were also held with older people in Dublin and Roscommon. We especially thank all of the service providers and service users who participated in the study and gave of their time and expertise. We trust that their contributions will enable progress in the challenging task of developing Care and Case Management in this country.

Rebecca Garavan, Sarah Delaney, Aodán Tynan, Hannah M. McGee
Health Services Research Centre, Department of Psychology,
Royal College of Surgeons in Ireland
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Council Comments and Recommendations

Summary Of Council Recommendations

1. The Council recommends that future national, regional and local policies on health and social care service provision for older people be developed to embrace a Care Management approach to service co-ordination and planning at a management level, and Case Management as the means by which health and social care services are tailored and delivered to vulnerable older people who are on the margin between living at home and living in long-term care.

2. The Council recommends that the task of developing a coherent and consistent terminology for Care and Case Management in Ireland be made a priority.

3. The Council recommends that the principles of best practice identified in this report be adopted to inform the development of Care and Case Management nationally and locally in Ireland. The principles of Care and Case Management are that planning, co-ordination and delivery of health and social services to older people should:
   - promote an anti-ageist philosophy
   - be integrated
   - be needs focussed
   - be person focussed
   - be holistic
   - be flexible
   - build self-respect and self-esteem
   - facilitate choice
   - facilitate empowerment of both care recipients and informal carers
   - promote partnership
   - aim to maximise the health and well-being for all with minimal disturbance to the older person/client.
4. The Council recommends that, consistent with the person-centred philosophy of Care and Case Management, the older person/client and his/her family/carer should be placed at the heart of health and social service planning and delivery in this country. Health and social care professionals should build an awareness of the individual patient into their care practices and try to involve people in their own care by informing them, listening to their point of view and involving them in decisions about their own care.

5. The Council also recommends that the needs of informal carers be listened to and supported throughout the Care and Case Management process.

6. The Council strongly recommends that the Advisory Committees on services for older people that were recommended by *The Years Ahead* (1988) should be reviewed and given an extended remit to incorporate the function of consulting with older people. A range of research strategies including surveys of users and focus groups should be employed by health boards to hear older people’s views on services. Measures to promote and enhance service quality such as those proposed in *Shaping a Healthier Future* (1994) should be developed (*HeSSOP*, 2001).

7. The Council welcomes the forthcoming National Health Information Strategy. It is recommended that health information systems be developed to meet the information management requirements of Care and Case Management. These systems must facilitate service co-ordination and evaluation. Within this National Health Information Strategy it is also recommended that the health information requirements of older people should be provided for so that they can be empowered to make informed choices about their own health. Using the forthcoming National Health Information Strategy as a foundation, a Health and Social Care Information Strategy for Older People should also be developed. Such a strategy would acknowledge the fact that older people are a heterogeneous group with diverse abilities and needs.

8. The Council recommends that a variety of measures be implemented to foster the development of a mix of health and social services for older people in Ireland. Increased financial support for the community, voluntary and statutory sectors involved in the provision of services for older people should be prioritised as should measures to encourage recruitment and retention of staff in these sectors.
9. The Council has recommended in past reports (Ruddle et al, 1997) that the social care services that assist older people to carry out the activities of daily living should be designated as core services underpinned by legislation and appropriate statutory funding. To date, these measures have not been introduced and so the recommendation is reiterated.

10. The Council recommends that budgetary control be devolved to an appropriate level. Case Managers authorised to purchase services would thereby be enabled to customise health and social care service delivery in each instance to meet the particular needs of the individual older client. Ultimately this would lead to the maximisation of health and social gain of the client through the provision of the appropriate services at the appropriate time.

11. In the past, the Council has recommended that a national framework for the multi-disciplinary assessment of older people in acute and community care settings should be developed. To date, this measure has not been introduced and so this recommendation too must be reiterated.

12. Care Management should be situated in a flexible continuum of care that represents different levels of care (self-care, informally assisted care and Care Management) that an individual can move between according to his or her changing needs or circumstances. Because a person’s needs change over a period of time, the Council recommends that ongoing assessment and review are carried out to ensure that Care Management remains the most appropriate form of care for them.

13. In order to facilitate the effective targeting of those who may be potential recipients of Care and Case Management, the Council recommends that measures should be put in place to facilitate a continual monitoring of all older people above a certain age, 65 years for example. These measures should be complemented by the development of a nationally agreed list of life events (e.g. hospital discharge, loss of a carer, loss of mobility) that would automatically trigger the interest of a Care Manager in that older person. It is also recommended that Care and Case Management for people with specific needs be designed in consultation with care teams that would have training and experience in working with such groups of people.

14. The Council recommends that service managers conduct an audit of skills and competencies of staff, and, more importantly, those skills which need to be developed to ensure effective implementation of Care and Case Management. In addition, the Council recommends that the role of a Case Manager be clearly defined and reflected in the job description.
15. The Council recommends that measures be taken to develop the skills and competencies needed to be a Care Manager or a Case Manager (for example, Personal Development Plans might be introduced for Care Managers and Case Managers). In particular, the focus should be on interpersonal skills such as listening, engaging, empathising, questioning, joint problem-solving, conflict resolution, teamwork, managing change and uncertainty, and working across disciplines. The Council also recommends that any training programmes that are designed for Care or Case Managers should be based on an actively anti-ageist ethos.

16. The Council recommends that those who are interested in becoming Care and Case Managers, irrespective of professional background, be given the opportunity to do so through the provision of appropriate specialist training programmes. The Council proposes that any training programmes should create a pool of Care and Case Managers who are dedicated to the aims, philosophy and principles of Care and Case Management and who will work to deliver health and social services within such a structure.

17. The Council reasserts its recommendation for the establishment of multidisciplinary teams and proposes that, at the very least, the establishment of such teams should facilitate the process of fostering inter-agency collaboration. The Council also recommends that existing reporting relationships be carefully studied and that consultation and negotiation be carried out before Care or Case Management is implemented on a larger scale. In addition, it is strongly recommended that administration and information technology resources available to service providers be developed to a level capable of sustaining service development and inter-agency collaboration.

18. The Council recommends that an evaluation programme be developed to focus on quality of life outcomes for the client, among other things. In addition, this programme must focus on how well the needs of the client are met through Care and Case Management, and service users must be consulted during the development and planning of those aspects of the evaluation. This evaluation programme must also include costing information on any system alterations required to implement a Care and Case Management Framework for the planning and delivery of health and social services. The development of this programme must be complemented by the active training and engagement of service providers both in choosing key indicators for evaluation and in conducting these evaluations.
19. The Council also recommends that Care and Case Management programmes have access to adequate personnel, funding, time and information technology systems with which they can plan, review and evaluate their programmes.

20. The Council further recommends that a National Older Persons’ Care and Case Management Monitoring and Development Group be established with the support of the Department of Health and Children and with the following terms of reference:

i. to develop a coherent and consistent terminology for Care and Case Management in Ireland

ii. to promote the development of Care and Case Management through

- the identification of further policy initiatives
- the promotion of training in Care and Case Management
- the revision and updating of implementation and evaluation frameworks
- the development and refinement of best practice guidelines
- the provision of advice as required by health boards to ensure ongoing monitoring and targeted attention in areas of most need

iii. to advise on the development of models of Care and Case Management, service plans based on Care and Case Management, generic job descriptions for different Care and Case Management roles and accompanying competency specifications

iv. to seek to develop a working plan for a programme of evaluation; in particular to develop a common set of outcome criteria, a methodology and a procedure that can be used across similar programmes

v. to collect and disseminate information on Care and Case Management as it is being implemented.
Council Comments And Recommendations

1. Background To The Study

The National Council on Ageing and Older People has recommended the implementation of Care Management as the basis for a co-ordinated health and social care delivery structure in a number of reports since 1992 (Browne, 1992; Ruddle et al, 1997; O’Shea and O’Reilly, 1999; O’Shea, 2000; Garavan, Winder and McGee, 2001). Care and Case Management is a system for the planning, co-ordination and delivery of services for vulnerable older people at local level and is marked by its ability to tailor care plans through a process of consultation between older people themselves and their carers, general practitioners and other health and social service professionals.

2. Defining Care Management And Case Management

Care Management is the process of service co-ordination and planning at management level. Case Management is defined as the development of individually tailored care plans, with a person-centred and multi-disciplinary focus delivered through a Case Manager or a team. Care and Case Management operate according to a coherent philosophical framework and set of underlying principles. The core principles underlying Care and Case Management are that the planning and delivery of a package of care for an older person should be integrated, needs focussed, person focussed, holistic and flexible. In addition, this planning and delivery should facilitate choice and empowerment, promote the self-respect and self-esteem of the older person, promote partnership and an anti-ageist philosophy and it should aim to maximise the health and well-being for all with minimal disturbance to the older person who will be the recipient of the package of care.

The National Council on Ageing and Older People believes that the introduction of Care and Case Management should produce health and social gain for older people by enhancing the quality of care and quality of life for older people and enabling more older people to remain in the community. This is consistent with one important principle and objective of the The Years Ahead: A Policy for the Elderly (Working Party on Services for the Elderly, 1988) which is to enable older people to live in their own homes in dignity and independence for as long as is possible and practicable. This was also endorsed by the HeSSOP study (2001) in which older people...
‘expressed clearly that they want to remain living in their own homes, that they wish their family or friends to be the principal caregivers and that the role of health and social services should be to provide support to help them and their families realise this aspiration’.

(Garavan et al., 2001. Health and Social Services for Older People, p.29)

The principle of Care and Case Management is now gaining support among health and social care professionals. Some are pursuing practices of care delivery that come close to Care Management or are undertaking pilot projects in Care and Case Management themselves. The Council wishes to act as a source of expertise, support and encouragement for these (both current and planned) projects. It has been the aim of the study, ‘Care and Case Management for Older People in Ireland: An Outline of Current Status and a Best Practice Model for Service Development’, to increase knowledge and understanding of Care and Case Management and to identify models of care delivered by health and social care professionals which come close to Care and Case Management. The findings of the study, have also been used as one of the bases for the design of two models of ‘best practice’ for Care and Case Management and for the investigation of ways in which Care and Case Management projects can be monitored and evaluated.

3. Models Of ‘Best Practice’

In this study, two models of ‘best practice’ of Care and Case Management were presented to a number of interested individuals and agencies working with older people in order to ascertain the feasibility of each in the context of the Irish health and social care system. Model A proposed the appointment of a dedicated Case Manager who would report to a Care Manager or the Co-ordinator of Services for Older People. The Case Manager would have the responsibility for preparing a care plan for the client, in consultation with the older person and informal carers, and would be backed up by a multi-disciplinary team.

Model B proposed that on referral to the Co-ordinator of Services for Older People, the needs and wishes of the older person and appropriate informal carers would be assessed by a multi-disciplinary team. Subsequently a key worker who was the most appropriate person to tend to the specific needs of the older person at that time would be appointed. For example, if the most immediate need was for physiotherapy, a physiotherapist might be appointed as the key worker.
In this study, Model A emerged as the preferred model for the majority of respondents working within the health and social services. In addition, a strong preference for the presence of one dedicated key worker who could act as a contact point during the care planning and implementation process was expressed in the focus groups with older people and carers. It should also be noted that this Model A is similar to the model proposed in *An Action Plan for Dementia* (O’Shea and O’Reilly) published by the Council in 1999.

This research has demonstrated that structures that approximate to Care and Case Management planning, co-ordination and delivery structures that are currently in place in Ireland are similar to Model B. However, based on international literature and consultations with service providers and older people, Model A is the model preferred. In this context, it is important to note that the Council does not wish to discourage those who are currently operating a model of service provision similar to Model B. The Council is concerned to support all Care and Case Management projects currently in operation while at the same time supporting the development and adoption of best practice models within an Irish context. At some time in the near future, it is hoped that a decision can be made in relation to which model should be promoted as being the most appropriate and effective in the Irish context of health and social service planning, co-ordination and delivery.

This study suggests that effective implementation of either model will be hampered unless certain prerequisites for implementation are met. The Council urges that the fulfilment of these prerequisites be addressed with urgency. The following sections detail recommendations for the successful implementation of Care and Case Management in Ireland based on the prerequisites for effective implementation that are detailed in the study.

4. **Policy Development To Embrace Care And Case Management In Ireland**

The findings of the study provide strong evidence of a concerted organisational shift throughout the health services, and a growing recognition of the need to integrate services and adopt a person-centred approach to the delivery of care for older people. The Council therefore recommends that future national, regional and local policies on health and social care services for older people be developed to embrace a Care Management approach to service co-ordination and planning at a management level, and Case Management as the means by which health and social care services can be
tailored and delivered to the target population of older people. Based on consultations with both service providers and service users, the study clearly indicates that this philosophy and organisational approach to care delivery should be adopted in the preparation and development of future strategies of health and social care and service delivery to vulnerable older people. This should be carried out within a policy framework that promotes positive, preventative approaches to healthy, active ageing.

5 Development Of A Coherent And Consistent Terminology

The Council is aware of the divergence in understanding of Care and Case Management that currently exists among health and social service providers in Ireland. For the purposes of this report Care Management is defined as the process of service co-ordination and planning at management level while Case Management is defined as the delivery of individually tailored care plans, with a person-centred and multi-disciplinary focus delivered through a Case Manager or a team. However, the issues of defining Care and Case Management and the development of a suitable terminology have not been resolved at a national, regional or local level. The Council recommends that the task of developing a coherent and consistent terminology for Care and Case Management in Ireland be made a priority. (See no. 15 below).

6. Adoption Of A Coherent Set Of Principles

The Council recommends that the principles of best practice identified in this report be adopted to inform the development of Care and Case Management nationally, regionally and locally in Ireland. The principles of Care and Case Management are that planning, co-ordination and delivery of health and social services to older people should:

- promote an anti-ageist philosophy
- be integrated
- be needs focussed
- be person focussed
- be holistic
- be flexible
- build self-respect and self-esteem
facilitate choice

facilitate empowerment of both care recipients and informal carers

promote partnership

aim to maximise the health and well-being for all with minimal disturbance to the older person/client.

The Council also recommends that these principles of Care and Case Management be the basis and act as a reference point for the delivery of all health and social services to vulnerable older people.

7. The Role Of The Service User And His/Her Family

The Council recommends that, consistent with the person-centred philosophy of Care and Case Management, the older person/client and his/her family/carer should be placed at the heart of health and social service planning and delivery in this country. Health and social care professionals should build an awareness of the individual patient into their care practices and try to involve people in their own care by informing them, listening to their point of view and involving them in decisions about their own care. This automatically implies that consultation is a prerequisite for effective Care and Case Management planning and implementation. When the Council commissioned *A Review of the Implementation of the Recommendations of The Years Ahead* (see Ruddle et al, 1997), it highlighted the absence of any reference to the need to consult with older people about services that most affect them. The HeSSOP report (2001) noted that the principle of consumer-oriented services was adopted in the 1994 Health Strategy document *Shaping a Healthier Future*. The HeSSOP report (2001) noted that this adoption has remained mostly aspirational since then.

The HeSSOP report (2001) described how democratic strategies for consultation, in which users take an active role in the decision-making process, including how services are developed structured and provided, were empowering and capable of strengthening people’s commitment to a better health and social system. These strategies also facilitated an individual’s perception of an increased sense of control over their lives. The Council endorses this view. The present report again highlights that there still are no formal guidelines in place for consulting older people and their carers. In the past, the Council has proposed various mechanisms for consulting older people as users of health and social services at the various levels (macro and micro) at which decisions are taken and policy is formulated that impact on the quality of older people’s lives.
The Council strongly recommends that the Advisory Committees on services for older people that were recommended by *The Years Ahead* (1988) should be reviewed and given an extended remit to incorporate the function of consulting with older people. Older people should be represented on such committees. A range of research strategies, including surveys of users and focus groups, should be employed by health boards to hear older people’s views on services. Measures to promote and enhance service quality such as those proposed in *Shaping a Healthier Future* (1994) should be developed (HeSSOP, 2001).

The Council also recommends that the needs of informal carers be listened to and supported throughout the Care and Case Management process. The Council considers the role of carers as being vital both to the fulfilment of the aim of maintaining older people in dignity and independence in their own homes for as long as is possible or practicable and critical to the success of Care and Case Management in Ireland. A recent report by O’Shea (2000) stated that 97,000 households in Ireland contain a carer looking after an older person aged 65 or over who either lives with them or in another house. The Council urges that ways be developed in which these family caregivers are facilitated, encouraged and supported to continue in their role of caring for older people at home.

### 8. Information Dissemination And Information Quality

Increasingly in recent years, policy documents have emphasised the importance of information provision to the attainment of quality services that are oriented towards the clients of the services. *Shaping a Healthier Future* (1994) described a reorientation of services towards the consumer ‘to ensure that detailed and accurate information is available on services, entitlements, eligibility criteria and assessment procedures’. The importance of information for older people was also highlighted in *The Review of the Implementation of the Recommendations of The Years Ahead Report* (1997). In this review, ‘inaccessibility of services due to lack of information’ was identified as a major deficit in the care of older people.

The *HeSSOP* report (2001) concluded that lack of information is a significant barrier to older people needing to access health and social services. GPs were cited as a preferred source of information, and they are in a unique position to provide this information (given their status, their frequency of contact and numbers of people with whom they come in contact). However, this report also recommended that other avenues of information dissemination needed to be explored, as the GP may not be the most appropriate person to provide the large range of information required due to lack of time and limited knowledge of non-health matters.
Based on consultations with service providers and users, the present study again confirms that most staff at all levels and older people themselves recognise that information is hard to access, sometimes not available at all and certainly not disseminated proactively. However, the provision of information is key to empowering older people to make fully informed choices about their future. Consequently, information on Care and Case Management is essential if older people and their carers are to be aware of it and able to access it. Information provision will ultimately ensure that Care and Case Management is a truly inclusive and person-centred approach to the planning, co-ordination and delivery of health and social care services. The Council acknowledges that it is important to orientate services towards the consumer by providing comprehensive information on services available. The main challenges in developing a truly client-centred information strategy relevant to older people are to determine what information the older person really wants and needs, by what means should this information be provided and where may this information be accessed most usefully.

The Council welcomes the forthcoming National Health Information Strategy. The Council recommends that health information systems be developed to meet the information management requirements of Care and Case Management. These systems must facilitate service co-ordination and evaluation. In addition, within this National Health Information Strategy it is recommended that the information requirements of older people should be satisfied so that they can be empowered to make informed choices about their own health. Because older people are more vulnerable to illness, they will need to be able to access information about health related issues quickly and easily. Using the forthcoming National Health Information Strategy as a foundation, a Health and Social Care Information Strategy for Older People should also be developed. Such a strategy would acknowledge the fact that older people are a heterogeneous group with diverse abilities and needs.

This strategy should build on the valuable work that has been done by the various health boards in relation to information provision and should ensure that relevant information is disseminated in a proactive and accessible fashion. This strategy must be built on the basis of a democratic approach to consumerism, whereby consultation with the service user is vital, and be paralleled by an active implementation framework to ensure that the problems that beset current information policies are effectively tackled.
9. Increased Resources – Service Availability And Staffing

The availability of a range of health and social services is one very important prerequisite for effective Care and Case Management implementation. A tailored package of care cannot be delivered if options are limited to one or two services. As has been already indicated in the report ‘A Framework for Quality in Long-Term Residential Care for Older People in Ireland’ (2000), the National Council on Ageing and Older People believes that it is imperative that significant, real-term increases in financial resources are made available to health and social services for older people each year for the next five years. This is to ensure that older people have access to a variety of statutory, community and voluntary services at levels appropriate to their needs and that these services are of a sufficiently high standard to deliver the benefits that they were set up to achieve. Only in this way will the stated objectives of public policy in regard to health and welfare services for older people be realised.

The Council recommends that a variety of measures be implemented to foster the development of a mix of health and social services for older people in Ireland. Increased financial support for the community, voluntary and statutory sectors, should be prioritised as should measures to encourage recruitment and retention of staff in these sectors. According to the HeSSOP report (2001), in addition to the recruitment difficulties currently being experienced in the health sector, ‘a central problem has been that home and community care services have never been established on an equitable basis’ (Garavan et al, 2001). These are the social care services that assist older people to carry out activities of daily living. In Ireland, there is no statutory entitlement to either assessment of social care needs or financial assistance to pay for social care services. The development and allocation of social care services is discretionary. This means that health boards are not obliged to provide them and older people have no right to expect them even if they have been assessed as being in need of them (Convery, 2001).

Hospital, home and community-based health and social care services are essential to the realisation of older people’s aspirations to remain at home. The low level of use of home and community care services as evidenced in the HeSSOP (2001) study is indicative of their limited availability. For example, this study reported that ‘a significant number of people (thirty-seven percent) found to be severely impaired in carrying out activities of daily living had not received any home services in the past year’ (p.29). This study also found that for seven of the fifteen home and community-based services studied, there were more people who did not receive the service but would have liked to than people who did receive it. This confirms the view that health and social care services in this country are extremely limited and fragmented (HeSSOP, 2001). This has been highlighted by Council research in the past (Ruddle et al, 1997) and now has been confirmed by older people themselves.
The discretionary nature of key services central to the support of frail elderly at home in their own communities has led to a situation where older people in different areas of the country experienced considerable variations in the extent, scope and nature of services provided and in eligibility criteria. The Council has recommended in past reports (Ruddle et al., 1997) that these services should be designated as core services underpinned by legislation and appropriate statutory funding. To date, these measures have not been introduced and so the recommendation is reiterated.

10. Devolved Budgets

Currently, health and social services are delivered out of a ‘mixed economy of care’ – some services (in particular those provided privately or by the voluntary sector) have to be bought, others are provided free of charge on a statutory basis. In order that the principles of Care and Case Management such as partnership, flexibility and responsiveness are operationalised, the Care or Case Manager must be in a position to provide or purchase appropriate services for his/her client. The Council recommends that budgetary control be devolved to an appropriate level. Case Managers authorised to purchase services would thereby be enabled to customise health and social care service delivery in each instance to meet the particular needs of the individual older client. Ultimately this would lead to the maximisation of health and social gain to the client through the provision of the appropriate services at the appropriate time.

11. Assessment

In order to develop a care plan that will effectively address the needs of an older person, a structured assessment is necessary both to identify a person’s difficulties or problem areas and to identify their strengths and supports. This report highlights the need for a generic assessment tool. The concern in relation to the multiplicity of assessment tools currently being used by the different disciplines is confirmed by the number of interviewees who referred to their own attempts to develop assessment tools that could be used within a health and social care service context. This is supported by the findings of the HeSSOP report (Garavan et al., 2001) which illustrated the need for a better system of identifying older people’s needs to ensure that services are delivered on an equitable basis. In addition, health needs have been historically defined in mainly medical terms with emphasis on diagnosis and treatment of illness rather than on rehabilitation and activation of older people (Convery, 2001). Any assessment tool must address needs that are broader than medical ones to facilitate the holistic approach to care that Care and Case Management implies.
In the HeSSOP report (2001) the Council recommended that a national framework for the multi-disciplinary assessment of older people in acute and community care settings should be developed. To date, this measure has not been introduced and so this recommendation too must be reiterated. By standardising assessment procedures, comparisons across projects and health boards will be facilitated. A standardised assessment procedure would also facilitate the execution of more efficient, effective and targeted project evaluations.

Care and Case Management are set in the context of a larger continuum of care. This continuum progresses from ‘self care’ where the older person is able to look after him/herself without any direct intervention to ‘informally assisted care’ where the older person is able to look after him/herself with the help of the family or informal carer to ‘Care and Case Management’ where there is more direct involvement by a Case Manager to allow the older person to remain at home. Because a person’s needs change over time and he/she will move between points along this continuum, the Council recommends that ongoing assessment and review are carried out to ensure that Care Management remains the most appropriate form of care for them. In order to facilitate the effective targeting of those who may be potential recipients of Care and Case Management, the Council recommends that measures should be put in place to facilitate a continual monitoring of all older people above a certain age, 65 years for example. These measures should be complemented by the development of a nationally agreed list of life events (e.g. hospital discharge, loss of a carer, loss of mobility) that would automatically trigger the interest of a Care Manager in that older person. For people with specific needs, a package of care should be tailored in consultation with specialised care teams and the Case Manager should have specific training and experience working with such groups.

12. Competencies And Core Skills Of A Care Or Case Manager

This report indicates that the community and statutory sectors are under severe strain due to lack of resources and serious difficulties with staff recruitment and retention. In the face of such difficulties it is clear that a Care or Case Manager will need to possess special skills to ensure that resources are optimised and that health and social gains are achieved for older people. Both the international literature and consultations with service providers and older people suggest that there are two categories of core skills that all Care and Case Managers should possess – organisational and interpersonal.

While Care and Case Managers should possess organisational and interpersonal skills, some of these skills are more appropriate to the Care Manager than the Case Manager and vice versa. For example, a Care Manager should have to have excellent
organisational skills to be able to effectively plan and co-ordinate services at a macro level. The Case Manager, who would operate at a micro level and in direct liaison with service providers and with older people, should possess very strong interpersonal skills.

Organisational skills include administrative ability, or having an understanding of existing organisational structures and reporting relationships and management (including financial management) skills. Personal skills include negotiation and conflict resolution, counselling skills, communication skills, health and welfare assessment skills, political skills, the ability to understand work and organisational sensitivities, and the ability to understand and work with the local community. Finally, the experience of working in ‘human care’ services and with older people should be a prerequisite. The Council recommends that service managers conduct an audit of skills and competencies of staff, and, more importantly, those skills that need to be developed to ensure effective implementation of Care and Case Management. In addition, the Council recommends that the role of a Case Manager be clearly defined and reflected in the job description.

The need for certain core skills and competencies implies that specialist education and training is vital to the successful implementation of Care and Case Management as a model to co-ordinate, plan and deliver services for older people and is an important requirement for all service providers involved. The principles and core skills of Care and Case Management should be the basis of any training provided to Care and Case Managers. They should also inform the continuing professional development of all workers within health and social care settings. Consultations with service providers and older people have found that the focus of education and training should be on managerial aspects, counselling, interpersonal skills, conflict resolution etc.

The Council recommends that measures be taken to develop the skills and competencies needed to be a Care Manager or a Case Manager (for example, Personal Development Plans might be introduced for Care Managers and Case Managers). In particular, the focus should be on interpersonal skills such as listening, engaging, empathising, questioning, joint problem-solving, conflict resolution, teamwork, managing change and uncertainty and working across disciplines. The Council also recommends that any training programmes that are designed should be based on an anti-ageist ethos. In addition, Care and Case Management should be seen as a new speciality with relevant training courses open to all those with a qualification in a health or social care discipline and who have relevant work experience. The Council recommends that those who are interested in becoming Case Managers, irrespective of professional background, be given the opportunity to do so through the provision of appropriate specialist training programmes. The Council proposes that any training
programmes should create a pool of Care and Case Managers who are dedicated to the aims, philosophy and principles of Care and Case Management and who will work to deliver health and social services within such a framework.

13. Inter-Agency Collaboration And Multi-Disciplinary Team Working

The division of the responsibility for services between different health boards and different sectors in Ireland has led to the fragmentation and uneven distribution of services and poor communication between service sectors and individual providers. Mechanisms for co-ordinating the work carried out by different agencies have been limited. Furthermore there are no frameworks within which to carry out joint assessments of need, joint service planning or development at area or regional level (Convery, 2001).

This present study also reports that links between the health and social services are under-developed and, according to service providers, they should be strengthened, if a holistic approach to health and social care is to be achieved and service duplication avoided. Service providers interviewed also felt that this problem is further compounded by the presence of separate reporting structures and professional boundaries. It was thought that there may be difficulties due to tensions and communication gaps between the health, psychological and social services. In the HeSSOP report (2001), the Council recommended that multi-disciplinary teams providing intensive domiciliary care for older people in all health boards be established at district level. The services of these teams could be provided to those at risk of or on discharge from hospitalisation. The Council reasserts this recommendation and proposes that, at the very least, the establishment of such teams should facilitate the process of fostering inter-agency collaboration.

The Council also recommends that existing reporting relationships be carefully studied and that consultation and negotiation be carried out before Care or Case Management is implemented on a larger scale. In addition, it is strongly recommended that administration and information technology resources available to service providers be developed to a level capable of sustaining service development and inter-agency collaboration.

14. Evaluation

Generally, consultations with service providers who took part in this study revealed that there were no formal guidelines for monitoring and evaluation of Care Management projects in place. In those circumstances where evaluation did take place, it was felt that there was too much emphasis on admission statistics and the cost of the service
rather than qualitative outcomes for the older people themselves. The Council recommends that an evaluation programme be developed to focus on quality of life outcomes for the client, among other things. In addition, this programme must focus on how well the needs of the client are met through Care and Case Management and service users must be consulted during the development and planning of those aspects of the evaluation. This evaluation programme must also include costing information on any system alterations required to implement a Care and Case Management Framework for the planning and delivery of health and social services. The development of this programme must be complemented by the active training and engagement of service providers both in choosing key indicators for evaluation and in conducting these evaluations. The development of a generic assessment tool would greatly facilitate this evaluation process and enable comparisons to be made across health boards or projects. The Council also recommends that Care and Case Management programmes have access to adequate personnel, funding, time and information technology systems with which they can plan, review and evaluate their programmes.

15. National Older Persons’ Care And Case Management Monitoring And Development Group

The Council further recommends that a National Older Persons’ Care and Case Management Monitoring and Development Group be established with the support of the Department of Health and Children and with the following terms of reference:

i. to develop a coherent and consistent terminology for Care and Case Management in Ireland.

ii. to promote the development of Care and Case Management through

- the identification of further policy initiatives
- the promotion of training in Care and Case Management
- the revision and updating of implementation and evaluation frameworks
- the development and refinement of best practice guidelines
- the provision of advice as required by health boards to ensure ongoing monitoring and targeted attention in areas of most need.
iii. to advise on the development of models of Care and Case Management, service plans based on Care and Case Management, generic job descriptions for different Care and Case Management roles and accompanying competency specifications.

iv. to seek to develop a working plan for a programme of evaluation; in particular to develop a common set of outcome criteria, a methodology and a procedure that can be used across similar programmes.

v. to collect and disseminate information on Care and Case Management as it is being implemented.

REFERENCES


Executive Summary
Executive Summary

Study Background

Care and Case Management as an approach to care for older people was developed in response to: a) increasing fragmentation of services with a consequent need for co-ordination, b) a need to reduce the growth of the residential and nursing home sector, c) an increasing trend towards shifting the focus away from in-patient care to care at home or in the community.

There has been little consensus as to the key differentiating features of Care and Case Management, and varying definitions of Care and Case Management are found throughout the literature. However, for the purposes of this study the term Care Management will be used to mean the process of service co-ordination and planning at management level, and Case Management to refer to the delivery of individually tailored care plans, with a person-centred and multi-disciplinary focus delivered through a Case Manager or team.

A wide variety of models of Care and Case Management have been piloted and implemented as policy internationally. Studies of these initiatives have shown that a significant proportion of individuals can avoid unnecessary admission to long-term care (Challis et al, 1998; Bernabei et al, 1998). Although there is some evidence for reduced cost, cost-effectiveness is not the primary motivating factor for the introduction of Care Management or Case Management and as such should not be treated as a criterion for success.

Aim Of The Study

The study on Care and Case Management was commissioned by the National Council on Ageing and Older People (NCAOP). The aim of the study was to provide a first, systematic review of health and social service delivery practices in the care of older people for the purpose of identifying models of best practice within a Care Management framework.

Objectives Of The Study

- To review and summarise the literature on Care and Case Management models and their application within a range of settings and target groups.
To identify and document current care delivery practices which approximate models of Care and Case Management among the health boards in Ireland.

To develop one or more ‘best practice’ model(s) of Care and Case Management suitable to the Irish context.

To develop a system of evaluation which is appropriate and valid for ongoing quantitative and qualitative review of the Care and Case Management Pilot Project(s).

Methods

The main research strategy in the Care and Case Management study was a qualitative exercise in the form of semi-structured interviews, with designated professionals and others representing services for older people in the health board areas, voluntary groups and consumers. Two phases of interviews were carried out; the first phase aimed to investigate current service provision in Ireland, and to identify any emerging systems which approximated to Care and Case Management. Based on information from this stage, two working models of best practice in a Care and Case Management project for the Irish setting were designed. The second research phase involved obtaining appraisals of the feasibility and efficiency of the models from specific professionals working with older people. Two groups of older people, one representing an urban and the other a rural perspective, were also consulted for their views on Care and Case Management as a potential strategy for their health and social care.

Key Findings

Phase One Interviews

Ten main themes were identified through the analysis of Phase One interviews.

Aim and philosophy of service

Findings from the research indicate a clear ethos of enabling older people to stay in their own homes for as long as they wish, or as long as is possible. Two interviewees, however, felt that current care provision did not have a coherent philosophy informing it.

Social and cultural factors in the delivery of care

Several interviewees discussed the role of the medical model of health and personal care in Ireland, feeling it to be unduly dominant with consequent under-development of social services. Another issue that arose was the rapid change in family systems and
structures in Ireland. Emphasis was placed on the fact that families are now more widely dispersed, and the concept of the extended family is much less important than it once was. Finally, the need to increase awareness of ageist practices within the health boards was also referred to.

- Services available for older people in the community

The main services available for older people in the community were identified as public health nursing, community mental health nursing, general nursing, home help, meals-on-wheels, physiotherapy, occupational therapy, social work, speech and language therapy, dietetics and chiropody. All these services were described as severely under-resourced and under-staffed. Speech and language therapy, dietetics and chiropody were seen as especially under-resourced. Interviewees also expressed concern about the lack of administrative and IT support available. This was regarded as placing severe strain on the ability of service providers to function effectively.

- The process of delivering care

Referral pathways: a variety of referral pathways were described by interviewees, including self-referral, referral via social workers and consultants, or by word-of-mouth. However, public health nurses, general practitioners and consultant geriatricians emerged as key referral agents.

Eligibility: two main criteria emerged as key factors in deciding whether someone was eligible for public services or not. The first criterion was whether an individual was eligible for the ‘medical card’. The second criterion was the level of assessed need. However, there was a degree of flexibility on the part of interviewees in determining eligibility.

Assessment: a variety of assessment tools were identified as currently in use in community service provision. These included the BARTHEL, Roper-Tierney and Winchester instruments. Some interviewees also referred to a number of initiatives whereby generic assessment tools are being developed and piloted.

Monitoring and evaluation: in the main, formal guidelines for monitoring and evaluation were not viewed as being in place, although interviewees from two health board areas did refer to plans to develop monitoring and evaluation guidelines and procedures.

Feedback and complaints: two routes for receiving feedback and complaints were identified. The first is via informal communication networks (with the public health nurse regarded as the main contact). The second is via formal complaints and grievance procedures set up by the health boards.
Service flexibility: interviewees felt that current service provision, being so under-resourced, cannot easily adapt to the changing circumstances and needs of older people.

Information dissemination: information was regarded as being of key importance in empowering older people to make fully informed choices about their care. Information is mainly disseminated through information booklets and leaflets.

- Management structure and reporting relationships

In the main, health boards use a line-management arrangement alongside inter-professional management (such as multi-disciplinary teams). Services therefore tend to have discrete reporting relationships which connect only at certain points through multi-disciplinary arrangements. Control over budgets generally rests with middle or senior management, although some moves towards increased devolution have taken place. The public health nurse and the general practitioner were identified as key service providers in the community.

- Communication

Communication between service providers was seen as playing an important role in current service provision. Communication was also described as operating on an informal basis. However, some formal arrangements, such as hospital-community liaison meetings and multi-disciplinary teams, were described as an improvement. At planning and administration level, care groups and service planning groups were also mentioned as measures to improve inter-professional communication.

The role of the service user: although there was a general recognition that the dignity and rights of older people and their carers should be central to care planning, in general there were no formal guidelines identified for consulting them. However, services and carers have consequently established strong informal links with older people.

The relationship between health and social services and the voluntary sector: there was a general consensus that links between health and social services were under-developed. Health boards were described as being very dependent on the voluntary sector which provided services that the statutory sector could not.

- Care and Case Management

Interviewees discussed some of the key areas of potential difficulty that could arise with the introduction of Care and Case Management. There was concern that it could be difficult to negotiate the existing reporting relationships and yet maintain the
acceptability of Case Managers. Another key issue that arose was the preferred professional background of Case Managers. There were a wide variety of opinions – some felt that Case Managers should have a nursing background, while others felt that the key skills of Case Management were not specific to a medical background.

● Pilot projects

Thirteen pilot projects were identified which aim to improve care provision for older people. Nine of these were considered to be ‘near’ Care Management, with the appointment of an individual to act as service co-ordinator, key contact for older people and their carers, and a designer of care plans (see Table 4.9).

● The state of care in Ireland

Interviewees were asked to undertake a SWOT (strengths, weaknesses, opportunities and threats) analysis of current care provision in Ireland. The voluntary sector, the public health nursing service and the home help service were cited as key strengths. Three main weaknesses emerged from the research: lack of resources and staff; lack of transport (especially in rural areas) and the gathering and dissemination of information. Only a few interviewees identified opportunities for service development and threats to service improvement. The opportunities cited included improving transport facilities; investing in community and home-based care; recruiting more registered general nurses to support public health nurses; reviewing the role of the public health nurse; up-skilling staff such as care attendants to take over personal care tasks, and increasing the flexibility of existing services. Threats identified (other than staffing and recruitment) were poorly organised referral pathways; a reluctance to identify older people, especially those with dementia, as a priority; communication and inter-professional collaboration difficulties, and high demands placed on informal carers. Staffing and recruitment problems throughout all sectors of health and social care were viewed as the single biggest obstacle to service development.

● Staffing and recruitment

It became clear during the research that problems to do with recruiting and retaining staff were viewed as the single biggest obstacle to service development by those who took part in the first phase of fieldwork. It was evident that these staffing problems run through all aspects of care – in hospitals and in the community.
Focus Groups With Older People

Two focus groups were carried out with older people in two areas, Roscommon (rural) and Dublin (urban). The aim was to obtain their views on Care and Case Management as a potential strategy for the delivery of their health and social care. The Care Management concept was presented to both groups and feedback was invited. The groups were also asked to identify the key issues of importance to them in planning and receiving care.

Both groups clearly voiced the desire to remain in their homes. However, they felt that changes in family structures, lack of public transport, the lack of community services and the cost of having to pay for private domiciliary services were obstacles to achieving this goal. In addition, both groups believed that general practitioners were severely over-stretched and so could not give them the time in consultations that they needed.

Both groups reacted very positively to the idea of Care and Case Management. The presence of a Case Manager was very important to them, especially in terms of being able to form a meaningful relationship with someone who could smooth the transition between different health care settings, and who could act on their behalf when necessary. The importance of patience, discretion and inter-personal skills on the part of the Case Manager were stressed as being of key importance.

Developing ‘Best Practice’ Models Of Care And Case Management

The consultations with health and social service professionals in Phase One, and with older people in the focus groups, revealed that while Care and Case Management were generally seen as a ‘good idea’, a number of external constraints upon current service provision posed considerable difficulties for the implementation of a pilot Care and Case Management project. This, in conjunction with the fact that a number of ‘near’ Care Management pilot projects had either been implemented or were planned across the health boards, led to the decision to reformulate the original aim of the study (to develop a model which could be launched as a pilot project) and instead work to further the development of ‘best practice’ models of Care and Case Management in the context of the Irish health care system.

With this aim in mind, two possible models of Care and Case Management were explored in Phase Two and were based on the literature and Phase One and focus group findings. Model A posits the existence of one dedicated Case Manager within a defined catchment area working under a Co-ordinator of Services for Older People. Model B does not provide for a dedicated Case Manager. Rather, on referral to the Co-ordinator
of Services, the needs and wishes of the older person and appropriate informal carers are assessed by a multi-disciplinary team. A key worker is appointed according to the main needs of the older person.

Phase Two: Feedback On Models A And B

Models A and B were presented to a number of key informants in health boards and other agencies working with older people. Comments were received on eight topics.

Devolved budgets: the issue of devolved budgets was seen as highly complex. The key area of concern was to which level in the health board hierarchy budgets should be devolved. If budgetary control rests in the hands of Case Managers, it was felt that there could be a danger that Case Managers’ time would be increasingly taken up with cost control. On the other hand, Case Managers need the authority to buy in services, co-ordinate different services, and, ultimately, to deliver comprehensive person-centred packages of care.

Evaluation and assessment: it was emphasised that Care and Case Management evaluation should be focussed on quality of life outcomes for older people over and above financial considerations.

Communication and reporting relationships: both informal and formal aspects of communication were felt to be potentially very useful in implementing Care and Case Management. Informal communication could help Case Managers to overcome resourcing difficulties. However, there may be a need to clarify reporting relationships before Care and Case Management is implemented at national level.

Education and training: this was viewed as extremely important. Key aspects of training recommended included:

- conflict resolution and negotiation skills
- counselling skills
- advocacy
- management skills
- knowledge of organisational structures.
**Terminology:** the question of how to describe Care and Case Management gave rise to a variety of responses. Concerns were expressed that referring to individuals who would fulfil a Case Management function as ‘Case Managers’ would carry connotations of the depersonalisation of older people into ‘cases’ managed by professionals.

**Links between health and social services:** this arose as a key issue. The view was expressed very strongly that the Irish care system was far too dominated by the medical model of health care which acted as an obstacle to developing links with social services.

**The background of a Case Manager:** all concerned took the view that Case Management requires specific core skills. However, there was no consensus as to the appropriate professional background of a Case Manager. Responses ranged from social work, to the allied medical professions, to the view that that professional background was not important but that training was essential in order to practice Case Management.

**Model A or Model B:** Model A emerged as the preferred model for the structure of Care Management, for a number of reasons:

- the problems of older people are complex, and carers’ needs must also be taken into account. The presence of a dedicated Case Manager would greatly facilitate this

- unless there is a designated person with a specific remit to organise care, the person involved may be compromised as they seek to balance their role as Case Manager against their general professional remit

- trained professionals in all areas of current service provision are over-stretched and so may not be able to make the extra commitments required of a Case Manager

- the training of all staff, many of whom may not be interested in Case Management, would not be feasible or cost-effective.

Any plan for the implementation of Care and Case Management in an Irish context must not only acknowledge the systems, assumptions and constraints particular to Irish health and social services, but also identify aspects of service planning that must be in place if Care Management is to achieve its aims. For this reason, the prerequisites that follow should be regarded as essential for the effective implementation of Care Management.
The task of developing a coherent and consistent terminology for Care and Case Management in Ireland should be made a priority.

The principles set out in this report should be adopted on a local and national basis and be made applicable to all potential recipients of care.

The needs of informal carers should be sought and supported throughout the processes of both Care and Case Management.

Care Management should be firmly situated in a vision of a flexible continuum of care that empowers older people and their carers to make their own choices about care, be it self care, informally assisted care or Care Management. Care Management should be used as a model only when it is appropriate to do so. The continuum of care represents different states of care that an individual can move in or out of according to his or her changing needs and circumstances.

The perspective of the individual older person and his or her family or informal carers should be placed firmly at the centre of any Care Management initiative.

The core skills of Case Management should be clarified and used as the basis for role description and education and training of Care Managers in the future.

The position of a Case Manager should be seen as a new specialisation, with training courses open to all those with a qualification in a health or social care discipline and relevant work experience.

Proactive steps should be undertaken to ensure that adequate numbers of qualified professionals are available to staff a comprehensive Care and Case Management programme. This can be achieved by:

a) producing higher numbers of highly qualified graduates in relevant disciplines such that sufficient are available and can be attracted to work with older people

b) providing incentives such as flexible working conditions and clear and attractive promotional strategies to help maintain experienced professionals in the public sector. This can be done by providing more places on training courses and providing incentives for graduates to choose to work in services for older people.
Incentives should be provided for continued professional development in services for older people (such as grant schemes, scholarship schemes and rewarding placements during training).

Recruitment procedures must be made more efficient by reducing the length of time between application, interview and commencing employment and increasing pay levels to reflect the skills, workload and responsibility of the workforce.

A multi-level training system for Care and Case Management must be developed and incorporated into general training and promotional considerations. Training should be built on the principles of Care Management and incorporate evaluation skills as a core component.

The development of a standardised generic assessment tool must be made a priority with a view to its implementation as a pilot project.

Care and Case Management for people with specific needs such as those with dementia ought to be designed in consultation with specialised care teams, and the Case Manager should have specific training and experience in working with such groups of people.

Caseload sizes should be maintained at a level which enables the core tasks of Case Management to be carried out effectively.

The roles and duties of Care and Case Management, and the reporting relationships required, must be clearly defined. Existing reporting relationships should be considered in relation to this plan and a consultation process carried out to address areas of potential conflict before Care or Case Management is implemented on a larger scale.

The process of devolving budgetary control down the health board hierarchy should be continued to the appropriate level.

Health information systems should be developed to meet the complex information management requirements of Care and Case Management. Systems need to facilitate service co-ordination and evaluation. The development of a Unique Patient Identifier to track clients across different health care settings is one such necessity. The forthcoming Health Information Strategy should provide the basis for this system.
An external working group should be formed to develop a working plan for a programme of evaluation. The working group should ensure comparability in evaluation methods across programmes.

The type of evaluation selected include, at the minimum:

a) Some measure of the service users’ perspectives of the Case Management services provided to them. Service users must be consulted during the development and planning of those aspects of the evaluation

b) Costing information on any system alterations required to implement a Care and Case Management programme.

The key indicators should be selected on the basis of their relevance to the goal of the evaluation and the philosophy of Care Management, while also being seen to be of apparent relevance to those conducting the evaluation. The procedures of the evaluation should be integrated into the daily work routine of the service providers.

Key resources should be ring-fenced for evaluation efforts, including personnel, funding, time and appropriate computer and analysis infrastructure.

Progress on the recommendations of this study should be monitored on an ongoing basis by a working party on Care Management. This group should establish a monitoring mechanism to include key stakeholders such as health board managers; health and social service professionals; members of the community and voluntary sector, and representatives of carers and older people. The working party should produce a report summarising progress within five years from the initiation of an implementation plan for the introduction of Care (and Case) Management.
Chapter One

Introduction
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1.1 Introduction

Older people constitute a significant portion of the overall population of people needing ongoing and specialised health and social care services. Others include those with physical or learning disabilities and those with mental health problems. While the proportion of those aged 65 years or older in the population is expected to change little over the next five years, the number of older people in the following twenty years (2006 – 2026) is estimated to increase by up to seventy-seven per cent with those over 80 expected to double.¹ As the number of older individuals increases, so too will the need for these services. The challenge for health and social services is not just to meet these needs in a cost-efficient manner, but to deliver a quality of service that maximises the older person’s quality of life. Central to the concept of quality of life for many people with health or social care needs is the desire to remain in their own homes while enjoying the same access to care as those who cannot or choose not to remain in that environment. A recent Irish study of almost 1,000 community-dwelling older people confirmed the primacy of home as their location of choice to live in, even in the face of long-term care needs (Garavan et al, 2001). The most favoured long-term care option for these people was remaining at home with minimal health board care in the form of respite services.

The introduction of community and domiciliary-based services for older people has been slow. Because of the sometimes multi-faceted and varied health and social situations of older people, the current service delivery systems are often inadequate or inflexible in accommodating the needs of this group. For instance, services are too compartmentalised and fragmented to cater for individual situations, with linkages across services in the face of transitions to or from home, hospital or other institutions being weak or non-existent. This can lead to inappropriate use of acute hospital care or long-term care institutions especially when home services are not easily available (Bergman et al, 1997). Access to appropriate and timely services may be difficult, especially when a situation demands the expertise and co-ordination of an array of professionals, voluntary organisations and informal carers to meet the needs of the


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individual. When the existing situation changes in some way, no one person or agency may recognise the need for reassessment or take responsibility for ongoing monitoring. Further, older people are often faced with a lack of real choice and control over the types and conditions of various services (Challis et al., 1995). In addition, informal carers are often left with little or no support.

One possible solution to the burgeoning problem of delivering community services in a harmonised way is the adoption of a Care and Case Management style of service delivery. In this report, the term Care Management is used to refer to the process of service co-ordination and planning at management level, and the term Case Management is used to refer to the provision of individually tailored care plans delivered through a Case Manager or team. This type of care is marked by its ability to individually tailor care plans in a system of consultation between the older persons themselves, their informal carers, general practitioners, and other health and social service professionals. Its structure allows the flexibility to rapidly respond to changes and maximise resources. Interdisciplinary and inter-agency communication is encouraged to increase access to needed services. The focus of Care Management is more concerned with the quality of care than its cost-effectiveness, although the two are, of course, inter-connected (Malin, 1994; Challis et al., 1995). Care Management approaches have been developed for older people in a number of countries. These will be described in detail later.

Care Management at the management and organisational levels, and Case Management as a mode of service delivery should both be situated in the context of a larger continuum of care. The World Health Organisation (Edwards, 2001) provide a useful framework to describe this continuum. It comprises three different dimensions: self care, where the individual is able to look after him- or herself without direct intervention but with the support of the health promotion and health information agencies and a low level of family/informal assistance; informally-assisted care, where the individual is able to look after him- or herself with the assistance of a family member or some other form of informal care; and Care Management (implemented via Case Management), where a Case Manager becomes more involved in organising and providing health and social services to enable that person to stay at home. Informal care is of key importance in enabling older people to maintain their autonomy and decision-making power throughout the continuum of care. It is important to emphasise that these three dimensions are not a strict progression; rather they represent different states of care that an individual can move in or out of according to his or her changing needs and circumstances. In addition Care Management should be used as a model of care only when it is appropriate to do so, and should be implemented according to an ethos of respect for individuals irrespective of their age. Not all health and social services need to be delivered via Case Management.
1.2 The Care And Case Management For Older People Project

Although recommended by the National Council on Ageing and Older People in publications dating back to 1992 (Browne, 1992; Ruddle et al, 1997; O’Shea and O’Reilly, 1999), little has been formally done to date to promote and encourage the development of Care Management initiatives throughout Ireland. In this context, the NCAOP commissioned the present study to provide a first, systematic national review of health and social care delivery practices in the care of older people for the purpose of identifying models of best practice within a Care Management framework in the Republic of Ireland.

1.2.1 Specific Objectives Of The Study

- To review and summarise the literature on Care Management models and their application via Case Management within a range of settings and target groups.

- To identify and document current care delivery practices which approximate to models of Care Management for older people among the health boards in Ireland.

- To develop one or more ‘best practice’ model(s) of Care Management (implemented via Case Managers) suitable to the Irish context.

- To develop a system of evaluation which is appropriate and valid for ongoing quantitative and qualitative review of Care Management Projects.

1.2.2 The Report

This report presents the findings of the Care and Case Management for Older People study. Key literature pertaining to the development of Care Management as a service delivery strategy, and the different Care and Case Management models in use internationally, are outlined in Chapter Two. An outline of the methods used in two phases of data collection regarding the current Irish situation is presented in Chapter Three. Analysis and discussion of the findings from Phase One of the fieldwork and from two focus groups with older people is presented in Chapter Four. Chapter Five presents input from feedback received in Phase Two on possible ‘best practice models’ of Case Management. Chapter Six discusses approaches to evaluation in Care and Case Management. Finally, the best practice model developed, along with key recommendations as to what should be put in place in order to progress Care Management as a model of planning care and Case Management as the consequent service delivery model in Ireland, are outlined in Chapter Seven.
Chapter Two

Literature Review
Chapter Two
Literature Review

Summary

- Definitions of Care and Case Management are varied and it has been difficult to reach agreement on common terminology. For the purposes of this study the term Care Management will be used to mean the process of service co-ordination and planning at management level, and Case Management to refer to the delivery of individually tailored care plans, with a person-centred and multi-disciplinary focus delivered through a Case Manager or team.

- Three features that differentiate Case Management from other key worker approaches have been identified as intensity of care, caseload sizes and duration of involvement.

- Care and Case Management approaches are in use in many countries around the world. These approaches to care have emerged in response to common motivating factors such as increasing fragmentation of services, a trend towards community-based care and a need to reduce unnecessary admission to institutional care.

- There is increasing recognition in Ireland of the need to co-ordinate health services and promote a person-centred approach to care. This is evident in the range of strategies for older people produced by the health boards and in the core principles of the new National Health Strategy.

- Care Management should operate according to an underlying philosophy expressed through a set of principles. The main principles, as promoted in the literature, are empowerment, a person-centred approach, integration of health social services, independence of care recipients, continuity of care, a holistic approach to care and cost efficiency.

- A number of key challenges to the delivery of Care and Case Management have been identified. These include guarding against ageism, achieving a truly person-centred approach, targeting services, education and training, working in a multi-disciplinary team, maintaining reasonable caseload levels and managing resources and budgets.
2.1 Introduction

During the late 1980s and the 1990s, a substantial body of international literature was created covering many different aspects of Care and Case Management. The complexity of community care in general, and the diverse models of co-ordinated care, are reflected in a diverse body of literature that uses similar terminology to refer to quite different concepts that are often contradictory and can be confusing for newcomers to the area. This section aims to summarise key literature, to describe how Care and Case Management have been implemented in other countries and to identify the main challenges that have arisen in the implementation of Care Management (via Case Management delivery practices) in other countries.

2.2 Questions Of Terminology – Definitions Of Care And Case Management

Reaching an agreed definition of what constitutes Care and Case Management has been the focus of much debate in the United States and the United Kingdom (Austin, 1992; Challis, 1994). One of the key areas of confusion was the interchangeable use of the terms ‘Care’ and ‘Case’ Management with no clear description of what was meant by each (Challis, 1994:60). However, more recently, the phrase ‘Care Management’ has come to refer to the general process of service co-ordination at management and administration level, while ‘Case Management’ refers to the implementation of Care Management policies at client level, with the Case Manager operating as a ‘key worker in the field’ (Challis, 1990, 1994; Challis et al, 1998: 155). A recently approved definition of Case Management by the Case Management Societies of America and Australia is as follows:

‘Case Management is a multi-disciplinary, collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.’

(Case Management Society of Australia, 1999:5)
An alternative definition which places more emphasis on the service user and the specific core tasks of Case Management is offered by Moxley (1989:17):

‘... a dedicated person (or team) who organises, co-ordinates, and sustains a network of formal and informal supports and activities designed to optimise the functioning and well-being of people with multiple needs.’

For the purposes of this study we will use the term Care Management to mean the process of service co-ordination and planning at management level, and Case Management to refer to the delivery of individually tailored care plans, with a person-centred and multi-disciplinary focus delivered through a Case Manager or team.²

2.3 Key Differentiating Features Of Care And Case Management

Over the years, many care planners and providers have recognised the need to co-ordinate services and to develop individualised care plans, and many of them have described their efforts as a form of Care or Case Management. However, Applebaum and Austin (1990:5-6) have outlined three key features which distinguish ‘comprehensive long-term care case management’ from a type of Case Management which is provided simply as an add-on to existing service provision. Firstly, there is the intensity of care – that is the amount of time Case Managers spend with their clients. Caseload sizes should be small enough to permit managers to engage in intensive interactions with their clients. Secondly, the range or breadth of services available to meet the needs of the older person is broad. Case Managers should not be restricted to the services of one agency, but be able to access services right across the spectrum. Thirdly, the duration of involvement is long, and follows the individual through a continuum of care. Longer-term Case Management should involve ongoing monitoring and reassessment according to the needs of the client rather than funding considerations. These key features can be used to distinguish between long-term Case Management and other forms of service co-ordination, such as hospital discharge planning, and within home health agencies (Applebaum and Austin 1990:6).

² International literature uses a wide range of terminologies, and this may be reflected in some of the quotes included in this report. In the main, however, Care Management is used by most authors to refer to the overall concept of this approach to care.
2.3.1 The Core Skills Of A Case Manager

There is a general consensus across the literature that the core tasks of a Case Manager should include case finding and screening, assessment, care planning, implementing and monitoring the care plan (Challis, 1994:62; Steinberg and Carter, 1983; British Columbia Ministry of Health, 1992; Mykyta, 2001). In addition, Capitman et al, (1986) have pointed out the need to include less concrete tasks such as advocacy and the integration of formal and informal care, which is of fundamental importance in the care of older people. The Case Management Society of Australia (1999) has stated that communication and facilitation are integral to the skills of a Case Manager.

2.4 The Evolution Of Care And Case Management In The United Kingdom

Care management as an approach to community care in the UK arose out of changes in service organisation in three closely linked areas (Challis, 1992, 1994; Kraan et al, 1991):

1. moves away from institutional-based provision
2. a strengthening and investment in the scale and content of home-based care
3. the development of a range of methods of co-ordination of care.

In 1986, Horrocks, a consultant in geriatric medicine, outlined what he considered as necessary ‘... components of a comprehensive district health service for elderly people’ (Horrocks, 1986:321-342). The components he included were as follows:

- provision of care by general practitioners
- community-based health services
- hospital departments which treat older people as part of wider responsibilities
- specialised hospital-based departments of geriatric medicine and psychiatry which deal exclusively with older people
local authority social services

housing

private and voluntary provision.

This article contains many of the initial ideas which were to influence the policy and service organisation changes which took place in the UK in the late 1980s and early 1990s and led to the establishment of Care Management as a mainstream service planning and administration approach, using Case Managers as key service delivery agents. Perhaps one of the most interesting recommendations in the article, in the light of the subsequent expansion of Care Management, is the recommendation that as services for older people were significantly fragmented at the time, one manager should be identified who would ‘… adopt a specialist responsibility for elderly patients in the District. The designated manager would have a remit to identify resources used across the District and would take a principle role in service planning and development’ (Horrocks, 1986:338).

Up to the end of the 1980s, there was rapid growth of ‘… residential and nursing home care … funded through the public sector with no control over eligibility on the basis of need’ (Challis et al, 1998:153). The UK Government responded by releasing Caring for People in 1989 (Secretaries of State for England, Scotland and Wales, 1989) which set out six key objectives in order to shift the focus of care from the institution to the community:

1. to promote the development of day, domiciliary and respite services to enable people to live in their own homes where possible

2. to ensure that providers give high priority to the needs of caregivers

3. to build upon high-quality assessment and Case Management as the cornerstone of community care

4. to promote a flourishing independent sector alongside public services

5. to clarify agency responsibilities (principally between health and social services)

6. to achieve better value for money by reducing a funding bias in favour of institutional care.

(Secretaries of State for England, Scotland and Wales, 1989:1.1.1)
Social services departments were made responsible for assessing the needs of service users, the provision of packages of services to meet these needs and the appointment of Case Managers to act as a single point of contact for recipients of services (Challis et al, 1998:153).

The motivating factors for the development of Care Management in the UK have been identified as the fragmentation of services and therefore the need to co-ordinate and integrate services, the need for cost-efficiency due to the growth of residential and nursing care homes, and to promote ‘greater competition between providers of care with the objective of achieving better value for money’ (Challis et al, 1998:154). In addition there was an attempt to enable people to remain at home if that was their choice by providing a comprehensive range of services and extending the choices that service users could make.

Since the release of Caring for People, the National Health Service and Community Care Acts of 1993 have been implemented and have resulted in the development of Care Management approaches to service planning in the UK. Care and Case Management have been implemented on the basis of detailed guidance issued by the Department of Health (Department of Health, 1990; Social Services Inspectorate/Social Work Services Group 1991a, 1991b; see also Challis, 1999:69). However, the potential for a high degree of interpretation of these guidelines exists between and within different authorities. This has resulted in variability, especially in the areas of assessment, definitions of Care and Case Management and differentiation of different levels of Case Management (such as intensive Case Management for those with severe and complex needs, as opposed to other organisational procedures for the assessment, plan development and review of those service users who are less dependent). Challis et al, (1998:157) has pointed to the danger that lack of clarity in this area can lead to the redescription of existing service arrangements as Care or Case Management in the absence of the restructuring of services according to the underlying principles specific to this model of care:

‘... in some settings care management could be seen as a specific job undertaken by Care Managers and in others it was merely a description of an organisational process by which people were assessed and services arranged, as had always been the case ... lacking real organizational change, this could be seen as the “old-wine-in-new-bottles phenomenon”’

(Challis et al, 1998:157)
2.4.1 Research On Care And Case Management In The United Kingdom

There have been a number of research initiatives on Care and Case Management in the UK, as elsewhere. The Personal Social Services Research Unit (PSSRU) at the University of Kent at Canterbury is, however, notable in its sustained focus on care in the community over the last quarter of a century. A series of five research and development studies has been undertaken by the PSSRU which attempt to ‘… evaluate the provision of care management using a single model for a range of different high-need target populations, basing the Care Managers at different key sites within the service provision network.’ (Challis et al., 1998:154, see also Challis et al., 1988; Challis et al., 1990; Challis et al., 1997a). These were the Kent Community Care Project, the Gateshead Community Care Scheme, the Gateshead Primary Health Care Scheme, the Darlington Community Care Project and the Lewisham Care Management Scheme.

All of these studies attempted to evaluate the provision of Case Management using a single model for a range of different high-need target populations, basing the Case Managers at different key sites within the service provision network (Challis et al., 1998:154). The Kent Community Care Project and the Gateshead Community Care Scheme both targeted residential care populations. The Gateshead Primary Health Care Scheme targeted older people in hospitals, nursing homes or other forms of residential care, while the Darlington Community Care Project focussed on hospital or nursing home populations. Finally, the Lewisham Care Management Scheme targeted older people with dementia who were at high risk of admission to institutional care (Challis, 1999:70). These research and development studies were cited in Caring for People.

The broad trend of the findings of these different studies indicated that it was possible to provide home-based care for a significant proportion of individuals who would otherwise have had a high probability of entering long-term institutional care. Costs were found to be similar or lower than those of institutional care. The only exception to this was the Lewisham scheme (Challis et al., 1997a). The scheme appeared to only have an effect of improving the probability of remaining at home in the second year of support compared with existing services. However, it was clear that both experimental and comparison group patients were receiving support from a relatively resource-rich community-based old age psychiatry service, atypical of services in most of the UK. There was evidence of improved well-being for the older people and more markedly so for the carers receiving the intensive Case Management support. However, the cost of obtaining these benefits was significantly higher for the experimental group (Challis, 1999:71).

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Since then the PSSRU has carried out ongoing research and evaluation work on Care and Case Management in the UK, culminating in a major study entitled *Mapping and Evaluation of Care Management Arrangements for Older People and those with Mental Health Problems* (Challis *et al.*, 1997ab; PSSRU, 1998, 2000; Challis *et al.*, 1999, 2000). This study started in 1996 and consists of three phases.

The first phase consisted of a national survey on quantifying assessment and Case Management practices for all local authorities in England. Key findings from this phase of the research indicated that nearly two-thirds of local authorities defined Care Management as an organisational process, one-fifth as a specific job role and the rest as both. Health professionals co-ordinated assessments in approximately one-quarter of authorities. Most authorities had two or more levels of assessment, with a small number only having one. Generic assessment documents were used in 61 per cent of local authorities. In terms of care planning, all elements of the care package were costed in 61 per cent of local authorities. Caps on expenditure were commonest in older persons’ services. In the face of budgetary pressure, some authorities were controlling expenditure decisions about care packages at third-tier level. Intensive Case Management, targeted at high risk individuals requiring high levels of support through small caseloads, was very rare. Under 20 per cent of authorities provided an intensive Case Management service in any part of the service. These services were focussed on a number of specific user groups, most commonly people with mental health problems, and rarely for older people. Overall, aspects of Case Management judged not to be working well included the performance of reviews and some specific operational issues, including problems of speed of response, lack of flexibility and inequity of resource distribution. The most commonly cited reasons for these difficulties included information systems, increasing workload and financial and resource constraints.

The second phase entailed more detailed data collection in a sub-set of authorities in order to identify different models of Care Management for two service user groups (older people and those with mental health problems). The aims of this phase were to:

- provide more detailed information concerning patterns of Care Management arrangements for older people and people with mental health problems
- understand more clearly the relationships between organisational structures of Care Management and the process of Case Management
- explore the human resource implications of different Care Management models.

3 N = 110, response rate = 84%
The authorities were categorised using data from the first phase of the study based on assumptions derived from current policy and relevant literature. Visits were made to social services departments deemed to be examples of the most representative patterns of Care and Case Management (at organisational and operational levels). Key areas of enquiry included skill mix in terms of the range of staff undertaking Case Management, how staff use their time, case mix (the range of service user needs and characteristics within different types of Care Management arrangements), links between social services departments and other statutory agencies, and the influence of local factors. This phase is not yet complete.

The third and final phase will be an efficiency and evaluation phase where a small number of differing arrangements for these two user groups will be evaluated to examine their performance (to follow the second phase).

(Challis et al., 2000a).

2.4.2 Care And Case Management In Northern Ireland

The policy situation in Northern Ireland is different from that in England or Ireland, in that health and social services have been integrated in the form of four health and social services boards (HSSBs) since 1973. Until the early 1990s each HSSB had responsibility for delivering health and social services at an ‘area’ level and at a ‘district’ or local level. However, in the early 1990s, with the introduction of the Trust system, the HSSBs became commissioners of health and personal social services and the Trusts, smaller sub-organisations, became responsible for the provision and delivery of services (Donnelly, 2000:3).

Following the publication of Caring for People in 1989, the Department of Health and Social Services in Northern Ireland (DHSSNI) published People First: Community Care in Northern Ireland for the 1990s in 1991. Perhaps due to the higher levels of integration in health and personal social services in Northern Ireland, this document reiterated the importance of Care and Case Management as integral aspects of community care. The term Care Management was used to describe the concept which embraced the key functions of assessing need, care planning and managing, co-ordinating and reviewing services. The term Case Management was used to identify the activity of acting as an advocate and co-ordinator of services for an individual. A distinction was also made between those people with complex health and social care needs and those who required a prompt response to an immediate practical need (Challis, 1999:73). Responsibility for care delivery was left to HSSBs and Trusts to implement in an integrated service.
However, in a study carried out during 1995 and 1996 on health professionals’ perspectives on service delivery, evidence was found of fragmentation in service delivery, tensions between different professional groups, poor coherence and collaboration. Consequently, disparate and unconnected sets of activities were being carried out by different groups of health workers (Mason et al, 1999). However, this study was based on extraneous data from an earlier study on a different topic and the numbers involved were small (the paper was based on data from interviews with fifteen health professionals and a number of community development workers in two rural communities, one Roman Catholic and the other Protestant). The authors make it clear that the study did not aim to be representative of the broader context in Northern Ireland.

An earlier study, published in 1996 (Halliday et al, 1996), examined user and carer perceptions of Care Management in the Southern Health and Social Services Board area. The findings from this study were quite positive in that on the whole, the community care reforms were found to have had a positive impact on both users and carers, and both groups felt that they had significant levels of involvement in the assessment and care planning process (Halliday et al, 1996:5). However, a number of areas of concern emerged. There was limited understanding among users and carers of the terminology associated with Care and Case Management, pointing to the need for more awareness-raising on the part of the board. Referral procedures were felt to be confusing, and awareness of the monitoring and review process was very limited. Finally, only twenty-nine per cent of carers were aware of complaints procedures, but this was tied to a very small number of people having made complaints – six per cent of carers and one per cent of users.

2.5 Care And Case Management In The United States

The American system of health care is based on health insurance programmes for the public to cover the cost of health care (Boult et al, 2000:1011). Two major insurance programmes, Medicaid and Medicare, bear two-thirds of the health care costs for older people (Moneyham and Scott, 1997:68).

In the mid 1980s Medicare began looking to ‘managed care’ to help control high expenditure. Under managed Medicare, an insurance company known as a health maintenance organisation (HMO) accepts a fee from the Medicare programme for each person it enrolls. The HMO agrees to provide him or her with, at the very least, the standard package of Medicare benefits (Boult et al, 2000:1011). However, Medicaid and

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4 171 users and 90 carers were interviewed.
Medicare have been criticised for focusing too much on acute services at the expense of long-term and community-based options that assist older people to remain in the community, to prevent illness or to maintain the highest level of health possible (Marek and Rantz, 2000:1). Care Management has therefore been promoted as an alternative approach to addressing the long-term care needs of older people (Moneyham and Scott, 1997:69). Many managed health care organisations are now utilising Care Management as a mechanism for improving the quality of care, reducing inappropriate use of services, and controlling costs (Hawkins et al., 1998:15; Hicks et al., 1993:49). As a result of increasing dissatisfaction with the managed care model, a number of models of Care Management have been developed in the US in recent years. These are summarised next.

### 2.5.1 Ageing In Place (Marek and Rantz, 2000)

Marek and Rantz developed this model of care as an alternative to nursing home care. This model offers care co-ordination (or Case Management (sic)) and health care services to older people with the aim of allowing them to ‘age in place’ (Marek and Rantz, 2000:2). This entails the delivery of services to older people either in their own homes or in sheltered housing developed as part of the project. The timing and intensity of health and personal care services are directed by the clients themselves. Case Managers, or ‘care co-ordinators’ as they are described, are nurses specially trained in Case Management. Their role is to assess and reassess the needs of clients, develop and implement a care plan, monitor the quality and efficiency of service delivery, and ensure throughout the process that clients receive quality services that continually meet the needs of clients and support informal carers (Marek and Rantz, 2000:4). On admission, clients receive a comprehensive assessment of their functional and cognitive capacity, strengths, abilities, limitations, existing resources and supports. A plan is developed in partnership with the client based on the results of the assessment. In the plan, services are ‘bundled’ in packages designed specifically to meet the needs of the client. Clients are monitored and services altered as clients’ health care needs change. Reassessment is conducted as needed or at least every three to six months depending on the client’s needs. In-home services are provided by professional and non-professional staff including: assistance with daily living activities such as bathing, dressing and shopping; assistance with medications; social services; recreational activities; skilled nursing services; communication with other health care providers, and rehabilitation therapy such as physical, occupational and speech therapy (Marek and Rantz, 2000:4). In addition ‘wellness centres’ have been designed that are located in sheltered housing sites which provide a range of health services including screening and educational programs.
An evaluation is planned for the ‘Ageing in Place’ study. Individuals in the project will be compared to clients of similar case-mix in nursing homes as well as to clients in the community receiving services but not participating in the project. Both quality of care and costs of care will be investigated during the evaluation.

2.5.2 Community-Based Nurse Care Management Of Older Adults
(Moneyham and Scott, 1997)

Moneyham and Scott devised a model for nurse-based Care Management. It targets older adults living in the community and consists of:

- comprehensive assessment
- care planning
- information and referral
- directed nursing care services
- co-ordination and monitoring of services.

(Moneyham and Scott 1997:70-71)

The goal of this approach to Care Management is to provide services at various points along the health care continuum to decrease fragmentation while improving the quality of life and reducing costs (American Nurses Association, 1988). Moneyham and Scott (1997:71) have identified three critical aspects of service delivery according to this model. Firstly, comprehensive assessments should be carried out which include evaluation of the client’s physical, social, functional and cognitive/mental status, available resource systems, financial resources and environmental conditions. Such assessment should not be regarded as a once-off occurrence, but rather an ongoing intervention. Secondly, the authors place great emphasis on the importance of a good long-term relationship between clients and service providers, as the therapeutic relationship is viewed as one of the key routes by which older people, their families and informal carers can be supported in practising self care:

‘It is the relationship that creates a foundation for therapeutic intervention by providing older adults and their families the sense of support, security, confidence and competence which is needed to perform self-care.’

(Moneyham and Scott 1997:71)
Finally, information and referral services, although somewhat 'invisible', are viewed to be an integral function of nurse-based Care Management. The authors believe that experienced Case Managers should know that older people are capable of making changes to maintain and improve their health and social independence if relevant information and knowledge are made available to them (Moneyham and Scott, 1997). They view nursing Case Managers as being in a strategic position to provide information on health concerns and community resources before problems arise. Such people may also be in a position to give older people and their families the knowledge and skills they need to act as advocates for themselves:

“The nurse Care Manager may intervene in various ways including doing for and doing with the client and family, while at the same time modeling and teaching self-care, negotiation, and self-advocacy skills”

(Moneyham and Scott, 1997:72)

The model proposed by Moneyham and Scott had not been tested in the field at the time of publication, and the authors point to the lack of evidence of demonstrated effectiveness of the nurse-based Care Management model. In a small number of descriptive studies, nurse-based Care Management has been associated with improved quality and access to health care services and reduced costs (Cohen, 1991; Etheridge and Lamb, 1989; Lamb and Stempel, 1994; Newman et al, 1984; Parker and Secord, 1988; Rogers et al, 1991; Zander, 1988). These studies indicate that individuals who work with nurse Case Managers spend fewer days in the hospital and intensive care unit, have fewer hospital admissions and use accident and emergency facilities less frequently. However, there have been few efforts to examine the effectiveness of specific interventions carried out by nurse Case Managers (Moneyham and Scott 1997:73).

2.5.3 The Biopsychosocial Individual And Systems Intervention Model (BISIM) (Hawkins, Veeder and Pearce, 1998)

Hawkins, Veeder and Pearce propose a model for nurse-social worker collaboration known as the Biopsychosocial Individual and Systems Intervention Model, or BISIM. This model encompasses both the Care and Case Management levels in that it:

‘... derives from a combination of the most workable inter-disciplinary collaboration models at the organisational and administrative levels and a broadly conceived case

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This model assumes nurses and social workers to collaborate as equal partners and involves initial client contact, assessment of services required, development of a plan of care, linking clients to services and community resources, implementation and co-ordination of effort to ensure that the plan is implemented efficiently with an equal distribution of health and social aspects, and advocacy where necessary.

The design of the BISIM model was based on a qualitative study of thirty-three nursing and social work leaders in 1995 and 1996. In-depth interviews were carried out with these participants, lasting for approximately thirty minutes. The major topics explored included:

- the history of collaboration between social workers and nursing in a variety of agencies and institutions
- the advantages and disadvantages of the ways in which social workers and nurses interact, and how they evaluate the outcomes of their practices or interventions
- the opportunities that a managed care system could offer to nurses, social workers and their clients and informal carers for access to care, a holistic approach to care, health promotion, disease prevention and integration of alternative or complementary therapies
- new opportunities for collaboration between these two professions.

The model is currently being tested in practice in two arenas: a social work-police team project in the area of domestic violence, and with a coalition of social workers, nurses and teachers addressing violence in a semi-urban community (Veeder, 2001).

2.6 Care Management In Other Countries

2.6.1 Canada

As a result of budget constraints, technological advances and a growing population of older people, the Canadian health care system has recently undergone major reforms
(Bergman et al., 1997:1117). These reforms have resulted in fewer acute care hospitals, and those that do exist tend to be smaller. Pressure on primary and continuing care networks has consequently increased. As in many other areas, the present system of care for the frail elderly is characterised by ‘... fragmentation of services, negative incentives and the absence of accountability’ (Bergman et al., 1997:1117).

In response to this situation, a number of initiatives have been instigated to improve service integration and reduce over-utilisation of acute hospitals and long-term care institutions. Two of these initiatives, *Systeme de Services Integres pour Personnes Agées en Perte d’Antonomie* (SIPA) and *Best-Practice Models of Self-Managed Care: Their Application for Seniors*, will be examined in more detail next.

**Systeme De Services Integres Pour Personnes Agées En Perte D’antonomie (SIPA)** (Bergman et al., 1997)

The SIPA model of care is based on a patient-focused model designed to meet the needs of vulnerable older people and to assure service integration, comprehensive care and continuity of care by all professionals involved. It covers primary and secondary medical and social services and long-term care along with prevention, rehabilitation, medication and technical aids. Care is provided by a multi-disciplinary team comprising health and social service professionals. The team is responsible for evaluating patients’ needs and planning and delivering services. The SIPA model uses a form of Case Management through the organisation and provision of most community services. There are four main dimensions to the SIPA model of care:

- **assessment and eligibility**: SIPA is designed to function as a single entry point for all frail elderly people, who are deemed eligible if they have severe disability in one, or mild to moderate disability in two, of the following areas: activities of daily living, instrumental activities of daily living (such as financial management or meal preparation), mobility, mental status and continence (Bergman et al., 1997:1118)

- **clinical model**: care under SIPA would be provided by an ‘interdisciplinary team’, made up of both health and social service professionals, along with the patient’s family physician. This team would be responsible for evaluating the patient’s needs and planning and delivering services to the patient. The aim is to reduce the risk of inappropriate admission to acute and long-term care institutions, and so ‘... flexibility and rapidity in meeting patients’ needs using community-based interventions’ is of paramount importance (Bergman et al., 1997:1119)
Empowerment and choice: the dignity and preferences of elderly people and carers are central to the functioning of SIPA. Older people are encouraged to remain with their family physician or choose a SIPA-appointed physician if they wish, and they may change SIPA care centres if they wish.

Governance and co-ordination: since SIPA is designed as a community-based system, it is envisaged that a community-based organisation should have responsibility. The proponents of SIPA also emphasise the importance of collaboration with acute care hospitals and long-term care institutions, physicians and community organisations.

This project was funded by the Quebec Ministry of Health and Social Services with a view to implementation of a pilot project under the auspices of the Montreal Regional Health board. This pilot commenced in 2000. Thirteen thousand individuals are being tracked in two districts in Quebec. Interim findings indicate that the SIPA approach leads to more preventive measures, greater use of community resources and less use of emergency room services.

**Best-Practice Models Of Self-Managed Care (Nahmiash, Delisle and Carrier, 2000)**

There has been increasing recognition of the important role that home care has to play in care for older people. This has been accompanied by a philosophy of ‘empowerment’ and personal involvement in health care practices and delivery. Both these trends have combined to produce an interest in the idea of self-managed care, where clients control the management of the services they receive (Anderson et al., 1999; Martin 1999; and Nahmiash et al.; 2000).

This approach was initially used for people with a disability, but its potential for use with older people is now being examined. In 2000, under the auspices of the Canadian Home Care Association (CHCA), the local centre for community services (CLSC Le Norois), and the Université Laval in Quebec, a pilot project was conducted to test the usefulness of self-managed care for older people and to provide ‘... recommendations for the implementation of ‘best practice’ self-managed care models’ (Nahmiash et al., 2000:2). Although initial plans were to conduct the pilot study in two sites, one rural and one semi-urban, the study was eventually only conducted in one, a semi-urban francophone region of Quebec (CLSC Le Norois). The design of the project was qualitative. Participants in the project were evaluated twice – before and after the self-managed care experience. Health and social care workers were only interviewed at the end of the project. Nine persons were assessed and received self-managed care services.
Comparisons were made between the preliminary and final data collection phases – these were the main source of findings. When assessing the cost of the self-managed care project, comparisons were made between the cost of the project and the cost of services which would have been offered by the public home care programme. It was found that older people were able to make decisions about the services they desired, with more flexibility and less cost than with regular services. Case Management support varies in self-managed care, according to whether self-managed care is offered as part of a ‘traditional home care programme’, or whether ‘... individuals are responsible for self-assessing their needs and developing their own care plans’ (Martin 1999:16). In the former option, Case Management support requirements are greater than in the latter.

2.6.2 Australia

In Australia, the health and social system has experienced dilemmas similar to other developed countries in trying to provide quality care across the continuum within limited resources (Fine and Thomson, 1995; Palmer and Short, 1994; Yarmo et al, 1998). The first traces of Care Management as an organised care delivery model became visible in the public sector in the area of disability and have since been implemented to meet health care needs in many areas such as mental health, aged care and chronic diseases such as diabetes and cancer (Baldwin, 1994; Commonwealth Department of Health, Housing, Local Government and Community Services, 1994; Commonwealth Department of Human Services and Health, 1995a, 1995b). The government showed that by utilising the principles of Care Management to ensure quality cost-effective care, client needs could be met in the home and in community settings rather than in institutions such as hospitals and nursing homes (Commonwealth Department of Health, Housing and Community Services, 1992; Commonwealth Department of Health, Housing Local Government and Community Services, 1994). However, public and private hospitals have also utilised Case Management as an effective way of delivering care, recognising that ‘... care does not end when the patient leaves the hospital’ (Yarmo et al, 1998:128). For example, Warringal Private Hospital, an acute medical/surgical facility located in Melbourne, operates a Case Management model based on a multi-disciplinary approach facilitated by a designated ‘nurse Care Manager’ (Yarmo et al, 1998:133). The hospital found that Case Managers were able to provide a quality service to patients because of their flexibility and ability to transcend various care settings. Case Management in hospitals was found to facilitate care which was collaborative, client focused, quality-driven and cost-effective. On the other hand, two major obstacles faced Case Managers in their attempts to provide continuity of care: ensuring that the quality of care provided in the home was equal to that in the hospital, and co-ordinating the care between the various service providers (Yarmo et al, 1998:133).

5 The amount paid directly to the families or employees only amounted to CA$2,447.80 as compared with the cost of a home maker at CA$5,487 (Nahmiash et al, 2000:35).
2.6.3 Italy

In the early 1990s, a national health plan was introduced in Italy which required local health agencies to expand the range of health services available for older people (Bernabei et al., 1998). However, in many cases there was no co-ordination of these new health services, nor were they integrated with social services in certain areas. In response to this, a team of researchers from the Universita Cattolica del Sacro Cuore (Rome), Brown University Medical School and the UCLA School of Medicine collaborated to pilot an ‘integrated programme of case management and care planning’ by the community geriatric evaluation unit and general practitioners (Bernabei et al., 1998:1348). The pilot was evaluated by means of a randomised trial. A control group of 100 subjects received primary and community care within the conventional arrangements. Services included general practitioner’s regular visits, nursing and social services, home help and meals-on-wheels. The intervention group also consisted of 100 subjects and received Case Management and care planning services administered by the community geriatric evaluation unit and general practitioners. In addition to general practitioners, the community geriatric evaluation unit included a geriatrician, a social worker and several nurses. All professionals were already employees of the local health agency. Two Case Managers were selected among the trainees of a course on Case Management and comprehensive geriatric assessment (Landi et al., 1996) and represented the operational side of the programme. They performed the initial assessment and repeated this every two months afterwards. They were also constantly available to deal with problems, monitor the provision of services and to guarantee extra help as requested by patients and general practitioners (Bernabei et al., 1998:1349). In their trial of a model of integrated care, the researchers found that admission to hospital or nursing home occurred later for those receiving Case Management than for those who did not. Estimated financial savings were around £1,125 per person per year of follow-up, and the intervention group showed improved physical and cognitive function (Bernabei et al., 1998:1348). The research team attributed these results to the fact that Case Managers had been intensively trained, improving their ability to design care plans and co-ordinate available agencies. A second factor was the gate-keeping role undertaken by the community geriatric evaluation unit to health services. This was viewed as providing a unique community-based setting for the referral of patients, regardless of specific needs. Finally, the close collaboration between Case Managers, the community geriatric evaluation unit and general practitioners was identified as being critical to the success of the intervention.

In considering Care and Case Management in Ireland, it is important to provide an outline of the context in which Care and Case Management will be implemented.
During the 1970s and 1980s, the strategies employed by the Department of Health focussed mainly on the regulation of health services, the development of acute hospitals and the curative aspects of care (O'Reilly-de Brun et al, 2001). However, the publication of *Shaping a Healthier Future* in 1994 signalled a policy shift towards principles of equity, quality and accountability, coupled with the twin concepts of health and social gain. In response to this new strategy, the regional health boards began to develop new local plans which attempted to be more responsive to the needs of service users across the entire population. A new national health strategy for health services across the population has since been launched, emphasising the need for further development of the principles of equity, quality and accountability, along with the addition of person-centred care as a core principle of the new strategy (Wiley, 2001).

### 2.7.1 Care For Older People In Ireland

However, policy development specific to the needs of older people started much earlier with the publication of *The Years Ahead – A Policy for the Elderly* in 1988. This was the first major national policy to focus on the need to develop services for older people. The National Council on Ageing and Older People’s *A Review of the Implementation of the Recommendations of The Years Ahead Report* (1997) recommended that the Department of Health should develop a new health strategy for health and social care services for older people which would include a clear philosophical framework to inform service delivery.

In response to these developments in health and social care for older people, many health boards have developed new strategies aimed specifically at improving service provision for older people, including the *Action Plan for Health and Social Gain for the Elderly* (Midland Health Board, 1997); *Ageing With Confidence: A Strategy for the People of Cork and Kerry* (Southern Health Board, 1999); *Towards the Golden Years* (South-Eastern Health Board, 1996); *Services for Older People: A Strategy for Health and Well-being* (Western Health Board, 2001); *A Strategy for Elderly Care* (Mid-Western Health Board, 1999); *A Strategy for Health and Social Gain for Older People* (North-Western Health Board, 1999); *Healthy Ageing – A Secure Future: a five year strategy for the delivery of services to older people* (North-Eastern Health Board, 2001); the *Review of Services for the Elderly and 4 Year Plan 1995-1998* (Eastern Health Board, 1995) and the later *10 Year Action Plan for Services for Older Persons 1999-2008* (Eastern Health Board, 1998).
The health boards have recognised that there is an urgent need to co-ordinate and integrate services, to make them more accessible and equitable, and to have a person-centred focus. In terms of care for older people, with the aim of maintaining them with dignity in their homes, these needs become even more important. The introduction by health boards of Care Groups or Service Planning Groups with a multi-disciplinary focus was an attempt to increase co-operation and integration in planning and strategising. The creation of service co-ordination posts such as Co-ordinators of Services for Older People also opened the way for the development of care packages as an approach to care for older people. In the Eastern Regional Health Authority, for instance (the former Eastern Health Board divided into three area health boards with an Authority acting as an overseeing body), a new management structure has been put in place with the appointment of three Directors of Services for Older People and ten Area Managers of Services for Older People. The Area Manager’s role is the overall management of non-acute resources at area level. This entails planning and development of services, forming partnerships with voluntary and acute services and identifying service gaps and areas for potential development. These Area Managers have only been in position since late 2000 and therefore there is some variation in their precise roles across areas. However, the fact that co-ordination posts have been created in this large board area could facilitate the task of implementing Care and Case Management.

2.7.2 Care Management In Ireland

The National Council for Ageing and Older People recognised the potential of Care Management as a service planning model, with Case Management as the key mode of service delivery, and published a report on two pilot projects aimed at improving service co-ordination almost a decade ago (Browne, 1992). This report recognised the intricate challenges posed to service providers and planners in achieving multi-disciplinary team work, role definition and ‘crossing administrative boundaries’ (Browne, 1992:56). The Council also referred to Care Management as a person-centred approach to service co-ordination and pointed to the fact that at that stage, no formal studies of Care Management had taken place in Ireland (Browne, 1992:16).
Care Management appeared again in Irish health care literature at the end of the 1990s as a strategy for caring for people with dementia in the *Action Plan for Dementia* (O'Shea and O'Reilly, 1999). This plan clearly endorsed Care Management as the best approach to care for people with dementia:

‘The most effective way of ensuring flexible and integrated care provision is through the introduction of a case management model to plan and co-ordinate services for people with dementia and their carers.’

(O'Shea and O'Reilly, 1999:14)

O'Shea and O'Reilly’s proposed model for Care Management was based on studies carried out in the UK and recommended that the Case Manager should act as the single point of contact for an older person with dementia. This Case Manager would be able to draw on the full range of community services and be allocated a budget to enable him or her to purchase any additional services required. The Case Manager was envisaged as forming a close working relationship with the older person and his or her family or informal carers. The process of Case Management in the *Action Plan for Dementia* begins with the initial diagnosis of the older person with dementia. The case is then referred to a Co-ordinator of Services for people with dementia, who in turn delegates a Case Manager to meet with the client and his or her family or informal carer. A care plan is then designed by the Case Manager, the client and informal carers in consultation with the general practitioner and the relevant specialist services. As the care plan is implemented, the role of the Case Manager then becomes one which monitors and reviews the ongoing service provision, with occasional input from the Co-ordinator of Services when necessary.

### 2.8 The Underlying Principles Of Care Management

It is essential that Care Management operates according to a coherent philosophical framework and set of underlying principles. These help to clarify the goals of both Care and Case Management and facilitate the different professionals involved in understanding their respective roles in the process of service delivery. The explicit principles informing the various models outlined in the preceding sections are summarised in Table 2.1.
Table 2.1: Principles informing models of Care and Case Management across models and countries
UK literature

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<tr>
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<tbody>
<tr>
<td>Interventions of all types must be based on accurate assessment which embraces the social, psychological and functional status of the older person as well as the medical problem</td>
<td>Increasing choice for service users and carers</td>
<td>Developing the capacity of social networks and services to promote client well-being</td>
</tr>
<tr>
<td>All care and treatment must be informed by full knowledge of the special features of illness in very old age</td>
<td>Greater independence for service users and carers</td>
<td>Promoting service effectiveness and efficiency</td>
</tr>
<tr>
<td>Effectiveness of treatment must be combined with the least disruptive solution for the older person in social, psychological, medical and functional terms</td>
<td></td>
<td>Improving client utilisation of support and services.</td>
</tr>
<tr>
<td>Interventions must be prompt. Delay is a hallmark of inadequate services and is profoundly self-defeating</td>
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</tr>
<tr>
<td>Treatment of older patients must be responsive to, and actively involve, informal carers (the friends, relatives and neighbours of the elderly)</td>
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<td></td>
</tr>
<tr>
<td>Most work with older patients will need to be agreed and implemented by a range of professional staff, usually from more than one agency</td>
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</table>
Table 2.1: Principles informing models of Care and Case Management across models and countries

USA literature

<table>
<thead>
<tr>
<th>Underlying Principles of Community-based Nurse Care Management of Older Adults (Moneyham and Scott, 1997)</th>
<th>Underlying Principles of Ageing in Place – a New Model for Long-term Care (Marek and Rantz, 2000)</th>
<th>Principles (or ‘Meta’ Variables) of Case Management according to the BISIM Model of Case Management (Hawkins et al, 1998:65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic approach to care based on nursing perspective of health and illness</td>
<td>Independence for older adults</td>
<td>Both client and system-focused</td>
</tr>
<tr>
<td>Respect for clients’ decision-making power</td>
<td>Co-ordination of care services</td>
<td>Provides a holistic view of the person in a wider context</td>
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<tr>
<td></td>
<td>Allowing frail adults to remain in one setting as their health needs intensify</td>
<td>Uses interdisciplinary team case management</td>
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<tr>
<td></td>
<td></td>
<td>A strong advocacy component</td>
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<tr>
<td></td>
<td></td>
<td>Based on collaboration between nurse and social workers</td>
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</tbody>
</table>
Table 2.1: Principles informing models of Care and Case Management across models and countries (continued)

<table>
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<tr>
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<tbody>
<tr>
<td>Personal involvement in health care practices, where users and not providers control the management of their care</td>
<td>Patient-focussed model</td>
<td>Delivery of co-ordinated care which is patient/client focused</td>
<td>Integration of medical and social services</td>
</tr>
<tr>
<td>Assuring comprehensive care</td>
<td>Improvement in quality cost-effective care</td>
<td>Responding to the demands of older people</td>
<td></td>
</tr>
<tr>
<td>Integration of all available services</td>
<td>Collaboration among patients/clients, carers and various groups that impact on care</td>
<td>Enabling older people to stay in their own homes for as long as possible</td>
<td></td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Evaluation of impact on patient/client care using outcome-based research</td>
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</table>
In the Irish setting, O’Shea and O’Reilly (1999:66-68) developed a set of six core principles to inform their Action Plan for Dementia:

1. respect for the preferences and rights of the person with dementia should be at the core of the action plan

2. the plan should be comprehensive

3. it should be biased towards home care solutions

4. dementia care requirements should determine funding, rather than funding determining needs

5. access to services should be on the basis of need rather than geographical location or ability to pay

6. national quality targets and outcome targets should be established.

From the above tables, seven core aims and principles of Care Management as they have been conceptualised in national and international literature can be identified:

- empowerment of recipients of care and their informal carers to make informed choices about their care
- a person-centred approach to care
- integration and co-ordination of health and social services
- increasing independence for care recipients
- continuity of care – providing a ‘seamless service’
- a holistic approach to care
- reducing the high costs associated with unnecessary admission to institutional care.
These principles have been taken as the basis for development of a set of principles for Care Management in Ireland by a working group of the National Council for Ageing and Older People in Ireland (see Chapter Five).

2.9 Key Challenges To The Implementation Of Effective Case Management: Lessons From The Literature

Although Care and Case Management appear in principle to be an effective approach to care provision, a number of key challenges have emerged when specific programmes have been implemented.

2.9.1 Guarding Against Ageism

When proposing a care system that aims to place the service user at the heart of planning and decision-making, ageist preconceptions of older people must be brought to light and examined. Traxler (1980:4) has defined ageism as:

‘Any attitude, action, or institutional structure which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age.’

A survey carried out in the United States (Palmore, 2001) found that the experience of ageism was widespread and frequent among the respondents (n = 84). The National Service Framework document published by the National Health Service (NHS) in the UK acknowledges the existence of discrimination against older people throughout the health service. For example, in some localities, the eligibility criteria for non-residential services means that older people have had to demonstrate higher needs to qualify for services compared with younger adults. Among the recommendations drafted to ensure that age discrimination is tackled within the NHS are a) the representation of older people across every organisation in the NHS, b) the representation of a council member or NHS non-executive director who will lead for older people across each organisation, in order to ensure that older people become and remain a priority within their organisation and c) the appointment of an older people’s champion through each Patients’ Forum to be involved in decisions about NHS services and in scrutinising the quality of care provided. In Ireland, less work on age discrimination in the health system has been carried out. However, O’Loughlin and Duggan (1998) have pointed to the devalued social status of older people and the reality of ageism as adversely affecting the ability of professionals to detect and deal with elder abuse. It is essential
that Care Management is founded upon a clear ethos of anti-ageism and that this is incorporated into training and service delivery.

2.9.2 Towards A Truly Person-Centred Approach

O’Shea and O’Reilly (1999:66) have placed ‘respect for the preferences and rights of the person with dementia’ at the core of their Action Plan. They point to the lack of power or control of people with dementia and their carers in interactions with health care professionals, and view Case Managers as the people who potentially will be required to elicit and express the needs and wants of their clients and families. However, Barr (1996) has pointed out that current literature on the implementation of Case Management has raised several key challenges to the development of such needs-led and person-centred services. One of the key challenges is the definition of ‘need’. Braye and Preston-Shoot (1995) have distinguished between needs felt by the client and needs expressed by the client. Clients who feel disempowered in health care encounters may express needs that are at odds with their felt needs and wants. Other definitions of need include prescribed need (those needs prescribed by care professionals), normative needs (those needs that conform to societal norms) and comparative needs (where the needs of an individual or group are compared to available resources). Evidence from government literature indicates that the definition of need most often utilised in Care and Case Management is that of prescribed need rather than a true attempt to listen and respond to both the felt and expressed needs of the client:

‘... the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence as defined by the particular care agency or authority’

(Social Service Inspectorate/SWSG 1991a:14)

Barr argues that this situation can be linked to the continued unequal balance of power between clients and professionals which places clients and their carers at the periphery of the care system. Lutz and Bowers (2000:165) have pointed out that patient-centred care as a whole ‘... is still most often implemented from a traditional provider-centred, disease-focused framework that often results in patient care and outcomes that are not congruent with the patient’s preferences’. They argue that health care professionals often feel that patients are not competent enough to make choices about their care. These assumptions directly challenge the basic tenet of patient-centred care, that consumers are qualified to determine their own needs and expectations and that they
are able and have the desire to make decisions and choices about what they need and want (Lutz and Bowers, 2000:173). These underlying assumptions and prejudices must be actively challenged if Care and Case Management are to truly place users and carers at the centre of the system.

2.9.3 Targeting Services

Deciding who should receive Case Management is a challenging task. Not all service users require the intervention of a Case Manager, and costs would quickly become prohibitive if this model were applied across all community settings. One example of targeting criteria is that of the UK Audit Commission (1986). It has identified four target populations as suitable for Case Management:

1. those at high risk of entry to institutional care (including those with chronic mental health problems)
2. those with stressed informal carers
3. those who need to be transferred back to the community from long-stay facilities
4. those requiring intensive short-term support following acute illness or injury.

(Audit Commission, 1986)

The lack of comprehensive and reliable indicators means that defining what specifically is ‘high risk’ or ‘vulnerable’ is a matter of debate. Some have tried to use objective measures, such as a significant score on a standardised measure or questionnaire, while others rely on professional judgement, such as an evaluation by a public health nurse. Some have then developed comprehensive registers of older people who are considered vulnerable. However, Ireland currently has no such register.

2.9.4 Education And Training

The extent to which training takes place for Case Management has been questioned (Challis 1990:18). Interestingly, Challis pointed out that the areas of particular concern were a lack of clinical knowledge and the lack of a client-specific knowledge base among Case Managers. O’Shea and O’Reilly (1999) have recommended that Case Managers working with people with dementia receive specific training in the needs of that client group alongside training in management and negotiation skills.
Clearly the Care Management approach has much to recommend it. Service user satisfaction is high across the range of countries studied and level and frequency of intervention is reduced with a corresponding enhancement of autonomy and self-reliance on the part of the older person. The observed improved cognitive functioning of older people using this system testifies to the efficacy of the approach. In the light of these clear benefits it is to be recommended that the situation in Ireland be examined with a view to learning from international success in order to enhance our provision for older people at home.

2.9.5 Working As A Multi-Disciplinary Team

Multi-disciplinary and inter-professional collaboration are integral to both Care and Case Management’s effective functioning. Foster et al, (1994:19) have emphasised how previous relationships among staff can be good predictors of the success or failure of programmes. Existing tensions between and within services will greatly affect the degree to which the service co-ordination aspect of Care Management can be implemented. Issues such as existing reporting relationships and hierarchies and the distribution of decision-making power will have to be carefully studied and any adjustment to the status quo carefully negotiated before Care or Case Management is put in place. As Austin (1992:64) points out, ‘case management alone will not cure the fragmentation and complexity that afflicts local service provision’. Problems such as ‘friction, incongruent role expectations, poor communication and status concerns’ (Browne, 1992) with inter-professional or multi-disciplinary working pose a significant challenge to the development of Care and Case Management in Ireland.

2.9.6 Caseload Size

As previously discussed, the intensity of care, with subsequent smaller caseloads, is a defining feature of Care Management. Most primary health care workers in Ireland are over-stretched at present due to demand. In the UK, Challis has recommended an average of 25-30 cases (1994:68). In the US, on the other hand, Applebaum and Austin (1990) cite 30-50 cases as the manageable caseload per month for Case Managers. The Case Management Society of America report an actual average caseload of 16-75 active cases per month (CMSA 2001:1). These discrepancies between UK and US recommendations can be attributed to the different health care systems and approaches to Care and Case management in each country. Nevertheless it is important to note that unless caseload sizes are defined at the initial stages of programme development, Case Managers can quickly build up caseloads which render them unable to perform the core tasks of Case Management.
2.9.7 Resources And Budgets

Truly holistic care plans that offer real choice to service users are only possible if a range of services is available. Kubisa (1990) has expressed concern about ‘... Care Managers’ ability to have access to resources to create packages of care with ease and flexibility’. In order to achieve this, Care Managers at the very least should have some form of devolved budget to enable them to obtain the services they require without recourse to senior management. However, these budgets should be sufficient to enable the Care Manager to deliver care:

‘Delegated budgets are therefore a means to an end; the cost-effective provision of services to meet needs. Delegated budgets which are simply the product of fashion or ideology ... will inevitably fail.’

(Vass, 1990).
Chapter Three
Methodology
Chapter Three
Methodology

Summary

- The research strategy for this study consisted of a qualitative exercise in the form of two phases of semi-structured interviews with forty-two health and social care professionals.

- The first phase of interviews investigated current service provision in Ireland which identified any care delivery systems that approximated to Care and Case Management.

- The information from the first phase of interviews was used to inform the design of two working models of best practice in Care and Case Management for an Irish setting.

- The second phase of interviews involved obtaining appraisals from specific professionals working with older people of the likely feasibility, flexibility and efficiency of the models within an Irish context.

- A number of older people and carers (n = 11) were consulted, through two focus groups, for their views on Case Management as a strategy for the delivery of their health and social care.

- Consultations were also held with key experts both from Ireland and overseas during the study.

- The design of semi-structured interview schedule designed was based on current literature and the agreed terms of reference of the study and subsequently amended in consultation with the project consultative committee.

- Data were analysed using a computer-assisted data analysis package that aided the identification and assignment of named codes to major themes which informed the development and refinement of the models of best practice in Care and Case Management.
3.1 Design

The main research strategy in the Care and Case Management study was a qualitative exercise in the form of semi-structured interviews with designated professionals and others representing the health board areas. Two phases of interviews were carried out; the first phase aimed to investigate current service provision in Ireland and to identify any emerging systems which approximated to Care or Case Management. Based on information from this stage, two working models of best practice in Case Management for the Irish setting were designed. The second research phase involved obtaining appraisals of the likely feasibility and efficiency of the models from specific professionals working with older people. A number of older people were also consulted for their views on Case Management as a potential strategy for the delivery of their health and social care. This information, obtained in a focus group setting, complemented evidence from a previous NCAOP study where almost 1,000 older people were asked specific questions about their health and social care preferences in the case of needing long-term care (Garavan et al., 2001).

3.2 Procedure

Key informants were interviewed by experienced interviewers according to a semi-structured protocol devised for the study. These informants were identified through a variety of sources, including the members of the consultative committee overseeing the project, information resources such as health board internet pages, and others as suggested through the conduct of Phase One interviews. The aim of Phase One fieldwork was to access information on current strategies and practices employed by health board administrators and practitioners, to identify perceived strengths and weaknesses of these strategies and practices and to describe plans for future directions in care. Phase Two aimed to assess feasibility, efficiency and flexibility of any models of best practice in Care and Case Management developed as a result of the information gathered in Phase One.
3.2.1 Fieldwork

Phase One interviews consisted of semi-structured interviews carried out with service providers. They included senior management, service management, front-line staff and the voluntary sector (see Appendix H for interview schedule).

Phase Two consisted of two unstructured focus groups carried out with older people in a rural and an urban area. Endeavours were made to obtain the experiences, views and needs from a broad range of participants from different backgrounds. For this reason, the two focus groups were held, one from a rural and relatively isolated area in the Western Health Board catchment area (County Roscommon), and one from an urban area in the Eastern Regional Health Authority catchment area (Greater Dublin Area). Each focus group lasted approximately one-and-a-half hours. Sessions were recorded with the participants’ consent. The aim was to obtain feedback from the participants on their opinion of Care Management as a new approach to care for older people. An honorarium was given to participants in appreciation of their contribution and to cover travel expenses.

When candidate best practice models had been developed from Phase One information, these were forwarded by email or fax to key interested parties (organisations and individuals) for feedback and comment. Feedback was received via telephone interview, or, in the case of five participants, in written form.

3.3 Sample

The study targeted key informants working in all areas of health care provision in each of the eleven health board areas in the country. Purposive sampling, in which the principle of selection is ‘... the researcher’s judgement as to typicality or interest’ (Robson, 1995:141) was the strategy used. This technique was complemented by a snowball approach, where one or more of the key informants were used to identify other members of the population who were then used as informants, and so on. In this way a comprehensive cross-section of the relevant population was accessed (see Table 3.1).6 Invitees for focus groups were contacted through the participant list from the Health and Social Services for Older People (HeSSOP) study. Finally consultations were held with key experts, both from Ireland and overseas, during the study (see Appendix A).

6 In Phase One, thirty-five health and social care professionals were interviewed. Eight professionals took part in Phase Two. One person (a social worker) took part in both phases. It was hoped that other participants from Phase One could take part in Phase Two, but of ten asked, the others were unable to assist due to work or holiday schedules.
<table>
<thead>
<tr>
<th>Category</th>
<th>Number interviewed Phase One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>7</td>
</tr>
<tr>
<td>Area Managers of Services for Older People</td>
<td>6</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>4</td>
</tr>
<tr>
<td>Health Board Senior Managers</td>
<td>4</td>
</tr>
<tr>
<td>Co-ordinators of Care for Older People</td>
<td>3</td>
</tr>
<tr>
<td>Social Workers</td>
<td>4</td>
</tr>
<tr>
<td>Superintendent Public Health Nurses</td>
<td>2</td>
</tr>
<tr>
<td>Home Help Organisers</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric Nurses</td>
<td>1</td>
</tr>
<tr>
<td>Director of Services for Older People</td>
<td>1</td>
</tr>
<tr>
<td>Medical Co-ordinator of Care for Older People</td>
<td>1</td>
</tr>
<tr>
<td>Community Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Co-ordinator of Packages of Care</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Psychogeriatrician</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Geriatrician</td>
<td>1</td>
</tr>
<tr>
<td>Matron – Care of the Elderly Hospital</td>
<td>1</td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>42</td>
</tr>
</tbody>
</table>
3.3.1 Focus Groups With Older People

Six participants took part in the Roscommon focus group, and five in the Dublin group. Although twelve participants were recruited from each group, there was a level of attrition due to a number of factors: two participants had difficulties in travelling to the location of the session; two became ill prior to the session; and the spouses of three participants became ill prior to the session. The final six participants, on receipt of the follow-up letter, declined to take part as they had initially thought that the interview would be conducted over the phone.

A total of seven women and four men took part in the focus groups. The average age of participants was approximately 73 years. Six participants were assessed as being at no health risk at the time of the HeSSOP survey, two were assessed as being at borderline health risk and one participant was assessed as being at definite health risk. The health risk of two of the participants was not known.

3.4 Semi-Structured Interview Schedule

The interview schedule for Phase One was initially designed by the research team based on current literature and the agreed terms of reference of the study. The schedule was further amended in consultation with the project steering committee in subsequent meetings. A copy of the final interview schedule is provided in Appendix H.

3.5 Data Analysis

Data were analysed using a computer-assisted qualitative data analysis package which aids in the analysis of text-based data. Major themes occurring across interviews were identified and assigned named codes. From this a pattern of findings was identified, which informed both the initial development and later refinement of models of best practice in Care and Case Management.

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7 Two of the participants in the focus groups were not participants in the HeSSOP study. One person was the wife of a HeSSOP participant who had since become hearing impaired and she was keen to represent their situation, and another woman accompanied a participant and requested permission to take part. The majority of focus group participants had experience both of caring for family members and receiving health and social care.

8 Health risk was measured using the Stanford Health Assessment Questionnaire (Fries et al., 1982.)
Chapter Four

The State of Care in Ireland
Chapter Four
The State Of Care In Ireland
A Backdrop To Best Practice In Care And Case Management

Summary

- Results from both Phase One and the focus groups held with older people showed that community services for older people, as with other sectors, were under severe strain due to lack of resources and serious difficulties with staff recruitment and retention.

- Services were seen as fragmented into separate disciplines within the health boards. Relationships between the health and social services were seen as underdeveloped.

- Interviewees also reported underinvestment in infrastructure and administrative resources, with a consequent inability to gather and maintain up-to-date records that can track clients across different health care settings and monitor their changing health status and needs.

- Older people in particular pointed to the increased need for care workers to take over the role that would once have been filled by the extended family. Problems with public transport, or the lack of it, made travelling to access services increasingly difficult.

- However, there was also substantial acknowledgement and evidence of a concerted policy and organisational shift throughout the health services, and a growing recognition of the need to integrate services and adopt a person-centred approach to care for older people.

- A strong informal communication network was seen to exist among health and social service professionals.

- There was also an expressed understanding of the rights and dignity of service users and a concern that older people might not feel able to speak out.

- Older people interviewed in the two focus groups reacted positively to the concepts of Care and Case Management as approaches to care for older people.
4.1 Phase One Interviews

Ten main themes were identified through analysis of the Phase One interview:

- social and cultural factors in the delivery of care
- aim and underlying philosophy of services
- services available for older people in the community
- the process of delivering care
- management structure and reporting relationships
- communication
- Care and Case Management
- pilot projects
- the status of care in Ireland
- staffing and recruitment.

These are discussed in more detail below. The information presented is a representation of the views and opinions of the participants interviewed and does not necessarily represent the official views of any organisation or group.

4.2 Social And Cultural Factors In The Delivery Of Care

Two themes emerged spontaneously during the course of discussions that pertain to the social and cultural assumptions that accompany the planning and delivery of care.

4.2.1 The Medical Model Of Health And Personal Care

Several interviewees discussed the dominance of the biomedical model of healthcare. This approach is ‘rooted in an idea of nature conceived of in mechanistic terms’
(McKeown, 1971). According to this model, illness is perceived as a failure of the mechanism to work, or a deviation from some undefined norm (Stacey, 1988; O’Reilly-de Brun et al, 2001). All those who raised this issue were critical of the dominance of the ‘medical model’ in Irish healthcare and felt it had a number of consequences. Firstly, it constructed age as an ‘illness’ and therefore older people as sick:

‘Older people can be looked at from a very “medical” point of view ... [I] don’t think that everything in terms of services for older people should be led by medical personnel.’

Secondly, reliance on a medical model was seen to risk recurrence of mental distress if social and psychological factors are ignored:

‘Treatment in psychiatry of old age is not just drug-based, it also addresses the social and psychological factors involved and looks at the core reason why someone has become ill. If you do not do this the same problems will occur once they are put back in the same situation.’

Finally, it was seen as posing a challenge to the development of Care and Case Management in Ireland:

‘The challenge that care management is facing is the dominance of the medical model across all clinicians including nurses.’

If the concept of ‘holistic’ care is seen as one of the core principles of Care Management, then a model of health care that is mechanistic and biomedical in outlook cannot match the vision of care espoused. A model of health and well-being that encompasses all aspects of the person must be developed and promoted if Care Management is to be implemented via Case Managers according to a philosophy of person-centred, holistic and responsive care.

4.2.2 Changes In Social Structures And Attitudes

Interviewees also discussed the fact that Irish society has changed rapidly in a short space of time. One major factor discussed was the change in family systems and structures and the implications of this for care of older people now and in the future:
'Family units have changed, the tie is no longer there. Families are more scattered.'

' Relatives have their own difficulties, in that more women enter the workforce than they did years ago. Families now live further apart from each other.'

'Change in family structure and community is reducing support, [the] key worker [has to] replace social support as far as necessary.'

Others outlined the extent to which ageism operates within healthcare and how important it is to guard against this:

'We have been very ageist, and there are ageist practices ... our role is to show that things can be done differently.'

'Need to be very aware of the ageism operating in health services and guard against that. This can lead to older people not receiving adequate care. This can operate in families as well, constructing old age as an illness.'

### 4.3 Aim And Underlying Philosophy Of Service

Interviewees were asked to outline the underlying aim of current services. Responses showed a clear ethos of enabling older people to stay at home for as long as they wish, or as long as is possible, throughout the different sectors. This reflects the current restructuring of policy and practices in care for older people outlined in the literature review. Two respondents, however, did feel that services did not have a coherent philosophy. Table 4.1 outlines the aims and philosophical frameworks perceived to underlie current service provision.
<table>
<thead>
<tr>
<th>Professional Role/Perspective</th>
<th>Aim/Philosophy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>To keep older people in the community for as long as possible</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>To make older people as comfortable as possible</td>
</tr>
<tr>
<td>Senior management</td>
<td>To maintain the older person with dignity at home for as long as possible and to support informal carers or when above not possible to provide high quality residential care in the community</td>
</tr>
<tr>
<td>Senior management</td>
<td>To maintain older people in their homes. To try to keep them as independent as possible. To provide the services to enable them to do this</td>
</tr>
<tr>
<td>Senior management</td>
<td>To help older people to stay at home</td>
</tr>
<tr>
<td>Middle management</td>
<td>To maintain the older person at home for as long as possible</td>
</tr>
<tr>
<td>Middle management</td>
<td>To keep people at home with a good quality of life for as long as possible</td>
</tr>
<tr>
<td>Middle management</td>
<td>No coherent philosophy to current service provision, but evolving and improving. Recent document used language such as equity, people-centred, quality-driven and accountability – all for new health strategy</td>
</tr>
<tr>
<td>Medicine (geriatrics)</td>
<td>To prepare older people to return home with as high a quality of life as possible</td>
</tr>
<tr>
<td>General practice</td>
<td>Ethos of practice – to give prescription with full information and enable the patient to make his or her own decision</td>
</tr>
</tbody>
</table>

9 Each row in the tables represents responses from one individual participant.
Table 4.1: Perceived aim and underlying philosophy of current service provision for older people* (continued)

<table>
<thead>
<tr>
<th>Professional Role/Perspective</th>
<th>Aim/Philosophy</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice</td>
<td>To maintain older people in their own homes for as long as possible</td>
</tr>
<tr>
<td>General practice</td>
<td>To keep older people at home for as long as possible</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>To support older people in the best possible way at home for as long as possible and to support carers to help them. The older person’s wants and needs are fundamental. Also to maintain and increase the quality of housing to enable people to stay at home longer</td>
</tr>
<tr>
<td>Social work</td>
<td>The whole idea is to have people at home</td>
</tr>
<tr>
<td>Psychology</td>
<td>No coherent aim to current services, discrete services that do not link in with each other. Mostly bed-focussed or service-focussed</td>
</tr>
</tbody>
</table>

4.4 Services Available For Older People In The Community

When queried about service availability, a wide variety of different services were mentioned. However, some of these were regarded as being more relevant or accessible than others. A list of the main community services available for older people referred to by interviewees is given in Table 4.2.
Table 4.2: Community-based service providers and perceived availability for older people

<table>
<thead>
<tr>
<th>Service</th>
<th>Perceived Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health nursing</td>
<td>Available but over-stretched in most areas. Caseloads too large. Public health nurses have to cover the population ‘from cradle to grave’</td>
</tr>
<tr>
<td>Community mental health nursing (formerly community psychiatric nursing)</td>
<td>High caseloads in more rural areas. Good distribution in ERHA catchment area</td>
</tr>
<tr>
<td>General nursing (RGNs)</td>
<td>Some areas have introduced RGNs to support the work of the public health nurse</td>
</tr>
<tr>
<td>Home help</td>
<td>Although a vital part of community services, recruitment is becoming increasingly difficult</td>
</tr>
<tr>
<td>Meals-on-wheels</td>
<td>Volunteer recruitment is becoming very difficult</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>There is a lot of variety in service provision from region to region, but on the whole the community physiotherapy service is very limited</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>The occupational therapy service is severely understaffed and under-resourced</td>
</tr>
<tr>
<td>Social work</td>
<td>Overall, the social work service for older people is very understaffed. There is variation in service provision from region to region, for example there are two community social workers for older people in [County], whereas there are none in [County]. There are medical social workers in some of the acute general hospitals who deal with older people</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>Very severely understaffed – minimal service provision</td>
</tr>
<tr>
<td>Dietetics</td>
<td>Service is under development but still severely under-resourced</td>
</tr>
<tr>
<td>Chiropody</td>
<td>Service described as ‘embryonic’. Service heavily reliant on voluntary organisations</td>
</tr>
</tbody>
</table>
Other services mentioned included those provided by housing resource officers, psychologists, counsellors and community welfare officers.

Interviewees also referred to in-patient and out-patient services available for older people and to voluntary as well as statutory services. These included local health centres, day centres, day hospitals\(^\text{10}\), community and district hospitals, respite services, rehabilitation centres, statutory and private nursing homes, long-stay and extended care services and acute and general hospitals. Psychiatric services for older people were also mentioned including community psychiatric units, dementia-specific day centres, psychiatric day hospitals, psychiatric respite services, long-stay psychiatric care and acute psychiatric units.

These services form an important part of the continuum of care for older people. They provide facilities to help them stay in the community if they can no longer stay at home, or to maintain their well-being in a safe environment if their needs become so complex that residential and/or acute care become necessary. In addition, services such as respite and day care are essential for informal carers and family members.

4.4.1 Key Service Providers In The Community

When asked to identify the key service providers in the community, all but one research participant named the public health nurse without hesitation. However, the concern was expressed that the primacy of the public health nurse could (unhelpfully) serve to reinforce the dominant medical model of health care in Ireland. One respondent, a rural general practitioner, felt the general practitioner and practice nurse were the key service providers in the community. Ten others also identified the general practitioner as a key service provider alongside the public health nurse.

4.4.2 Administration And Information Technology Resources

Ten interviewees raised concerns about the lack of administration and information technology (IT) resources available to them. They viewed this deficit as a huge strain on their ability to function efficiently and saw it as preventing service development. For instance:

‘There is no software package to record returns, it is currently manual. Therefore we are not recording information. We need to set up patient records which track patients and install a whole system.’

\(^{10}\) Day hospitals provide primarily clinical services, whereas day centres focus more on social services and activities.
'IT resources are essential in order to keep an at-risk register. There has not been an IT investment in community services over the years. They have been working off notebooks, off old hardcopy notebooks.’

Three interviewees who raised this issue indicated that there were some moves towards remedying this situation.

‘There is an inadequate standard of documentation. Records and care plans are totally sub-standard ... we now have a database. We have also been given funding to purchase hospital evaluation software.’

‘[Local] Partnership has software to communicate with hospitals ... we’re just waiting for hospitals to speed up and get computer-friendly.’

This lack of administrative back-up or resources has serious implications for Case Managers. There is a danger that increasing amounts of Case Managers’ time would be spent in dealing with paperwork rather than in client contact. Parry-Jones et al, (1998), in a postal survey of all front-line staff in a Case Management role in Wales, found that the intrinsically rewarding aspects of practitioner work appear to be under threat from time pressures and the more dissatisfying elements of Case Management such as paperwork. They recommended handing over some of these tasks to administrative staff in order to alleviate this problem.

4.5 The Process Of Delivering Care

Interviewees were asked to describe the main procedures involved in delivering care to older people. These included the referral pathways in use, criteria used to determine eligibility, tools used to assess service requirements, procedures for dealing with complaints and feedback, monitoring and evaluation systems, how information about services are disseminated and how older people and their families are included in the decision-making process.
4.5.1 Referral Pathways

A variety of referral pathways were described by interviewees. These included referral through social workers, by word of mouth, through consultants, or, in some cases, self-referral (see Table 4.3). The type depended on the service in question. Some services appear to have several points of access. The two social workers interviewed, for instance, indicated that they would accept self-referrals and two Area Managers of Services for Older People also felt that self-referral was an important route that older people took to access services. However, public health nurses, general practitioners and consultant geriatricians emerged as key referral points across the interviews. One interviewee suggested that the need for general practitioners to refer to geriatricians for assessment and testing slowed the whole process of care down. Another interviewee, a general practitioner, did not feel that there were any referral procedures in place in his area.

Table 4.3: Profile of referral pathways to care for older people

<table>
<thead>
<tr>
<th>Category of occupation</th>
<th>Referral pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>Meals-on-wheels are based on referral from doctors, social workers, PHNs or hospital</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Referral mainly through PHN, sometimes word of mouth, sometimes GP</td>
</tr>
<tr>
<td>Senior management</td>
<td>Referral – direct GP admission or referral can come through the PHN</td>
</tr>
<tr>
<td>Senior management</td>
<td>Referral can be accessed either through a geriatrician, other hospital staff or GP</td>
</tr>
<tr>
<td>Middle management</td>
<td>Mainly through PHN or GP. Referral needed through geriatrician for long-stay</td>
</tr>
<tr>
<td>Middle management</td>
<td>Referral to any community services is through the GP. Referral to long-stay care is through GP and then to geriatrician for assessment. Once someone is in a home referral can be made through GP, PHN or social worker in unit</td>
</tr>
</tbody>
</table>
Table 4.3: Profile of referral pathways to care for older people (continued)

<table>
<thead>
<tr>
<th>Category of occupation</th>
<th>Referral pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle management</td>
<td>Referral can be through self-referral or relatives. Crisis usually initiates contact, although sometimes the contact just a query for future reference</td>
</tr>
<tr>
<td>Middle management</td>
<td>Care totally demand-led so if somebody is referred to the health board then the health board pays attention. So it could come from GPs, PHNs, etc.</td>
</tr>
<tr>
<td>Middle management</td>
<td>Referral is focussed too much through hospital, should be more from GP</td>
</tr>
<tr>
<td>Medicine (psychiatry)</td>
<td>Referrals from two sources, GPs (majority of cases) and general hospitals in catchment area. However, in the case of dementia it is very often the PHN who has picked up the problem and organised for GP to see the person</td>
</tr>
<tr>
<td>Medicine (geriatrics)</td>
<td>Three pathways, one directly through A+E, from other wards in the hospital, biggest from GPs (majority of cases)</td>
</tr>
<tr>
<td>General practice</td>
<td>No assessment and referral procedures</td>
</tr>
<tr>
<td>General practice</td>
<td>Refer to hospital almost 50 miles away. If an assessment in out-patients is necessary, the patient is referred to the geriatrician</td>
</tr>
<tr>
<td>General practice</td>
<td>Referral through GP for further services</td>
</tr>
<tr>
<td>General practice</td>
<td>GPs have no direct access. Referral needs to go through a geriatrician. Referral process is therefore GP to consultant to health board services. This slows the whole thing down</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Referral process – 99% of applications through GP/PHN</td>
</tr>
<tr>
<td>Nursing – hospital sector (continuing care)</td>
<td>Main referral – acute general hospital. Processed through consultant geriatrician and his team. Can refer directly to orthopaedic hospital. GPs across [area] refer to the hospital. Also acute services from neighbouring counties</td>
</tr>
</tbody>
</table>
Table 4.3: Profile of referral pathways to care for older people (continued)

<table>
<thead>
<tr>
<th>Category of occupation</th>
<th>Referral pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work</td>
<td>Older people are referred to the community social worker when their care comes into crisis due mainly to hospital admission, family problems or self-problems</td>
</tr>
<tr>
<td>Social work</td>
<td>First get a referral from the ward. As a social worker this interviewee accepts referrals from anyone. However, if doctors have a problem about a social worker being involved, then ask doctor to sign a referral</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Physiotherapist gets referral from PHN, GP, family, hospital</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>Referral for speech and language therapy comes mostly through the geriatrician to the senior speech and language therapist on the ward or in day hospital or the community health centre</td>
</tr>
<tr>
<td>Home help service</td>
<td>Only the PHN assesses and refers (to assistant director/director PHN) for decision. When approved, back to the home help organiser who sends someone out to set up the service</td>
</tr>
</tbody>
</table>

4.5.2 Eligibility

Two main criteria were cited for assessing eligibility for services – possession of the ‘medical card’ and level of assessed need. However, there were some variations to this pattern. In particular, two people who worked in the voluntary sector described how they decided whether someone was eligible to use their services:

‘Open-door policy. There is an application form that has to be signed by the general practitioner and the public health nurse. The only exception is that we do not take people with dementia because there is an Alzheimer Society unit in the town.’

‘Eligibility is based on medical requirement. The public health nurse decides whether someone needs meals or not, decides on eligibility. The public health nurse then rings the receptionist and requests a place for the older person.’
Many of those who cited possession of the medical card as a criterion for eligibility made the point that exceptions could be and are made if the level of need is great enough:

‘... the medical card is the general criterion ... however exceptions are made, [I] would never say no to an older person.’

‘Eligibility is based purely on needs not money. The medical card is an important indicator but not solely.’

4.5.3 At-Risk Registers

An interesting issue which arose out of the discussions about referral, eligibility and assessment was the role of at-risk registers in screening the population of older people in order to enhance service planning. A considerable degree of uncertainty and unease was evident amongst the six interviewees who talked about the practicalities of devising and implementing an at-risk register. Doubts were expressed over the ability to easily define the concept of being ‘at-risk’:

‘... what’s “at-risk”, what does “at-risk” mean? Is it at risk of abuse? Where do you start and stop with this?’

A second issue, confidentiality and the right to privacy, was also raised:

‘We need a balance between [at-risk registers and] people’s right not to be screened just because they’re a certain age.’

Another major obstacle identified in developing an at-risk register was a practical one, namely the lack of information-gathering resources in the health boards. It was felt that staff are so over-stretched, and technology so under-resourced, that developing a comprehensive register and keeping it up-to-date is simply impossible at the moment:

‘If you have a good system of surveillance it really works, but the public health nurses can’t do it at the moment because they’re working so hard.’

‘Public health nurses wouldn’t have seen what a computer looks like in the health centres – that’s a reality whether we like it or not ... there’s a whole investment needed to keep a register because you need to update a register.’

Care and Case Management for Older People in Ireland
'We cannot keep up with it [the at-risk register] on a manual basis, we have to have some IT system which providers can feed in to ... no baseline data. It’s going to take resources to do that.'

4.5.4 Assessment

Interviewees referred to a variety of assessment tools that are used with older people including the BARTHEL, Roper-Tierney, and Winchester instruments. These tools are mainly used by public health nurses, in conjunction with other assessment instruments used by the different disciplines. However, some unease was expressed about the efficacy of assessment procedures: both about the tools used and the way in which assessment is carried out across disciplines:

‘Assessment in the community is very arbitrary – each head of discipline does their own assessment. People have been looking for common assessment tools for a while – there are a few like BARTHEL but they’re mainly dependent on how a person functions that day. It needs to be based more on outcome and ability to progress.’

This anxiety about the multiplicity and utility of assessments carried out by different disciplines is confirmed by the number of interviewees who referred to various attempts to define generic assessment tools that could be used in the community. A number of assessment tools were described. One interviewee had designed an assessment tool for older persons and those with a neurological disorder. This had not been tested at the time of the interview. In one health board, a new home assessment tool had recently been devised to assess a person’s needs and the skill-mix necessary to meet those needs. Another health board had also planned a generic assessment tool:

‘This form comprises personal information, a BARTHEL scoring section, a 10 point mental test score, home and social circumstances and a section for specific professional assessment. There is a plan to make it a patient-held document, in the form of a smart card.’

The EasyCare generic assessment instrument (Philp, 2000) had been piloted in the South-Western Area Health Board (ERHA), specifically in Tallaght Hospital with positive feedback from nursing staff, and it was planned to pilot it further in Community Care Area 4 (ERHA) in October, 2001:
4.5.5 Service Flexibility

As a consequence of the severe staffing and resource constraints on all aspects of health care for older people, it is not surprising that all but two of the fourteen interviewees who discussed service flexibility felt that services found it very difficult to adapt to the changing circumstances of older people:

‘Services are not able to adapt to changing needs at all.’

‘We haven’t got a very good community care service, all along the continuum of care there are deficits.’

‘Services are unable to deal with crises.’

Two interviewees did feel that services for older people were reasonably flexible. The first person worked in management in a board which is undergoing a significant level of change and innovation in its care strategies for older people. The second person worked in the psychiatry of old age service and felt that:

‘The service is quite flexible, [there is] ready movement back and forth between different services. So someone can be discharged from psychiatry of old age services and re-admitted if need be – and can go back on to the same [community mental health] nurse’s list if need be.’

4.5.6 Information Dissemination

Information straddles the boundary between the discrete procedures involved in providing health care to older people who need it and the less tangible aspects of care such as consultation, inclusion and empowerment (O’Reilly-de Brun et al, 2001). The provision of information is key to empowering older people to make fully informed choices about their future. Two interviewees emphasised the importance of information for the well-being of care recipients:

‘Information on what’s available is very important for the empowerment of older people’.
‘Health promotion and information are important in that we can educate people in what’s out there so that when the need arises they can identify it at an earlier stage’.

The main route for dissemination of information is through the publication of information leaflets and booklets detailing the statutory and voluntary services available for the public at local, regional and national levels. These publications often include details of eligibility and cost and who to contact to find out more information (this is often the public health nurse):

‘Every doctor’s surgery has a leaflet on the [local] Social Services Council. Also available in churches.’

However, other dissemination points were cited by interviewees, including local newspapers, radio and television, citizens’ advice bureaux (CABs) and informal communication:

‘Other information sources include the internet, day centre or day hospital, and most importantly the PHN. There is a strong informal communication system in [County], this works well especially in rural areas with high isolation and low infrastructure.’

‘The community welfare officers are very important in the dissemination of information. CABs are also good dissemination points. A newsletter devoted to carers is published quarterly, there’s information TV in [County].’

Some interviewees did feel that there were problems with the dissemination of clear accessible information to the public. One respondent felt that there was too much emphasis on the printed word and that it was important to be more proactive in providing high quality information to the public:

‘... generally very poor on information, dissemination is the main problem. Communication is about using different media and it could be in the written form, it could be a newsletter, it could be the local paper, but it has to be a variety of forms, no one form gets everybody. I think really we have to be more proactive. One thing we can all defend is a lack of resources, but one thing we can’t defend is lack of information.’
Three interviewees pointed to the fact that there is no one named individual whom the public can ring to access information:

‘No one person in the community that people can ring for information on what’s available. Heath board trying to do various bits about information.’

‘... there is no one place you can ring in the health board and find out information on services for older people or carers. Information is key – just producing glossy brochures is not enough and putting them in GPs offices. A post should be created like that of the Area Managers, but for carers, and that person should be au fait with what’s available in a particular area. If there was a post at health board level, that person could be a resource for fieldworkers, training them and bringing them up-to-date, also taking referrals from the public.’

An interesting theme that emerged in two interviews was the feeling that many people are apprehensive of seeking information on what to do in potentially difficult situations before they have arisen:

‘Older people do not have good access to information – people don’t take an interest in what doesn’t concern them. People have a choice to turn off. Even with health promotion people can choose not to.’

‘The health board is poor at giving people real information in hard English as to how they get services. However, I have found that often people don’t want to believe that in 10 years time they are going to have a problem with their mother. They don’t want a book that will give them potential bad news.’

4.5.7 Feedback And Complaints By Service Users

Feedback and complaints seemed to operate along two dimensions. The first was a reliance on existing informal communication networks, where complaints or feedback were provided over the phone or via a conversation with health workers in the field (especially the public health nurse). Many interviewees referred to this informal system
as an important conduit for dealing with difficult situations. The second strand was the formal complaints and grievance procedures set up by the various health boards. Many interviewees said that these guidelines were followed, while some said that both the informal and formal strands operated concurrently as strategies for dealing with problems (see Table 4.4).

### Table 4.4: Receiving complaints and feedback from service users

<table>
<thead>
<tr>
<th>Occupation Category</th>
<th>Feedback and Complaints Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>There are no official mechanisms for receiving feedback from service recipients. Care recipients and carers can complain to drivers (however the organisation has never had a problem)</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Informal, no guidelines, but people can say it to the staff in an informal manner</td>
</tr>
<tr>
<td>Senior management</td>
<td>No formal guidelines for receiving feedback – trying to set up evaluation at the moment</td>
</tr>
<tr>
<td>Senior management</td>
<td>Customer care programme available – complaints process based in larger institutions, and it is valued. Suggestion boxes available. Evolving aspect of the service. Board visit once a month to various community care centres, day care etc. Opportunity for staff and voluntary organisations to feed back</td>
</tr>
<tr>
<td>Senior management</td>
<td>Complaints/appeals policy within the board. It is clearly identified within every health board where there is a nominated person dealing with complaints. Try to deal with complaints at the local level</td>
</tr>
<tr>
<td>Senior management</td>
<td>There are very strict appeals procedures in the health board. There is now a Director of Customer Service and Appeals. So instead of appealing back into the service to which one originally applied, one can either go straight to the person or appeal to the director, or the Ombudsman</td>
</tr>
<tr>
<td>Middle management</td>
<td>If someone rings up (to complain) generally the call is passed on to the person closest to the situation. The caller is encouraged to put complaint in writing. Regarding appeals against assessment, there are procedures in place and the subvention assessment is being reviewed at the moment</td>
</tr>
<tr>
<td>Occupation Category</td>
<td>Feedback and Complaints Guidelines</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Middle management</td>
<td>Culturally, older people at the moment can look at certain professions in awe. The main way people complain is that they can phone and complain directly to a professional, or else they go to their local politicians.</td>
</tr>
<tr>
<td>Middle management</td>
<td>We have to create opportunities for people. We have to train people into it. It’s not about making everyone fill in a questionnaire but making it easy, creating opportunities.</td>
</tr>
<tr>
<td>Medicine (geriatrics)</td>
<td>There is dialogue and informal feedback both positive and negative. There is a health board complaints procedure.</td>
</tr>
<tr>
<td>General practice</td>
<td>No formal guidelines for receiving feedback.</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>No guidelines for feedback. Grievance procedures – health board guidelines dealt with at one’s own management level first, then passed up the levels of management.</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Appeals can go to the chief executive. The health board has a complaints policy – complaints officers in each sector. If an older person wants to complain, the PHN has forms with her, these completed are sent to the complaints officer. A significant number of complaints come in by phone either through the general practitioner, the public health nurse or the local TD.</td>
</tr>
<tr>
<td>Community mental health</td>
<td>Feedback limited.</td>
</tr>
<tr>
<td>Social work</td>
<td>Complaints follow health board guidelines.</td>
</tr>
<tr>
<td>Social work</td>
<td>Community feedback – main conduit is the PHN. Also liaison nurses, occupational therapist, physiotherapist.</td>
</tr>
<tr>
<td>Home help</td>
<td>Accountability – for staff, take it to the line manager. Most problems can be solved at this level. Staff made aware of whole hierarchy of people they can go to. Clients and family can go to home help organiser. Always have the right to appeal higher up the line.</td>
</tr>
<tr>
<td>Home help</td>
<td>Home helps can complain to the home help organiser about their job description. The organiser will also go out to families and explain terms of contract. Clients mainly complain to the public health nurse (more familiar) or by phone to the home help office.</td>
</tr>
</tbody>
</table>
Three people mentioned the local politician as one route by which service users fed back any difficulties they had with care services. One person also voiced her concerns that older people can be reluctant to step forward and complain about aspects of the service they were not happy with, and felt that service providers and planners have a responsibility for facilitating people in feeling able to complain.

4.5.8 Monitoring And Evaluation

Although there was some variation in the extent to which formal monitoring and evaluation procedures took place, in the main formal guidelines were not in place. Some interviewees said that there were no procedures for evaluation, and that more resources, especially IT systems, would need to be provided before proper monitoring and evaluation could be carried out. Where evaluation did take place, there was a recognition that there is an over-reliance on admission statistics and the cost of the service to the detriment of the qualitative outcomes for older people themselves. However, the Southern Health Board was reported as having baseline data about morbidity, mortality and categories of diagnosis, and that this was used to track health status. In addition, its Department of Strategy and Planning evaluates feedback from service users and service providers, as well as monitoring service cost. An interviewee from the Mid-Western Health Board had just been allocated funding to purchase an evaluation software package and will soon start to evaluate hospital services. Another interviewee from the Mid-Western Health Board reported that there is regular review and monitoring of the home help service with the public health nurse (see Table 4.5).

Table 4.5: Monitoring and Evaluation Procedures

<table>
<thead>
<tr>
<th>Rank in Hierarchy</th>
<th>Monitoring and Evaluation Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>Sometimes a dietician is brought in (approximately every 18 months) to talk to cooks about good practice. That is the main way they deal with food quality problems – for fear of causing offence and losing staff</td>
</tr>
<tr>
<td>Senior management</td>
<td>Department of Public Health has an important development and monitoring strategy. Have baseline data on morbidity and mortality and categories of diagnosis, and use this to track health status. Department of strategy and planning evaluate feedback from users and providers</td>
</tr>
</tbody>
</table>
Table 4.5: Monitoring and Evaluation Procedures (continued)

<table>
<thead>
<tr>
<th>Rank in Hierarchy</th>
<th>Monitoring and Evaluation Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior management</td>
<td>No formal guidelines for receiving feedback – trying to set up evaluation at the moment. Would like to see something along the lines of a Patient’s Charter developed and have exit questionnaires based on that. In the past there was an over-reliance on admission statistics rather than the quality of care provided</td>
</tr>
<tr>
<td>Senior management</td>
<td>No analysis is carried out on nature of complaints – have been very weak about putting policies and procedures in place in response. Poor in getting outcomes from our complaints</td>
</tr>
<tr>
<td>Senior management</td>
<td>Prefers to monitor those who are moving up the dependency ratings and getting towards the brink of long-stay care. Too much emphasis on monitoring admissions and length of stay</td>
</tr>
<tr>
<td>Middle management</td>
<td>Quality of nursing homes and services are monitored, but the impact of current service provision is not tracked</td>
</tr>
<tr>
<td>Middle management</td>
<td>No established criteria for tracking outcome – that is something that will have to be looked at in the future</td>
</tr>
<tr>
<td>Middle management</td>
<td>Staff can be very defensive, wary of upsetting older people and wary of hearing criticism</td>
</tr>
<tr>
<td>Middle management</td>
<td>Accountability and evaluation both need to be put in place urgently (to include qualitative as well as quantitative). Case manager would be useful for this. Evaluation limited currently</td>
</tr>
<tr>
<td>Medicine (geriatrics)</td>
<td>No established framework for monitoring and evaluation, or deciding on outcome criteria. Outcomes like bed days or length of stay are not appropriate for older people, it is the outcome of care that is important</td>
</tr>
<tr>
<td>General practice</td>
<td>No measures to ensure accountability are in place. No tracking mechanisms, or outcome measures</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>No evaluation and monitoring because assistant directors taken up with their own administration work</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>No formal tracking of impact of service provision. ‘Gut-feeling’ that the right service provision post-discharge reduces re-admission. No facts and/or figures</td>
</tr>
<tr>
<td>Nursing – hospital sector</td>
<td>Have just been given money to purchase a software package for health services evaluation (hospital) and have started using it</td>
</tr>
<tr>
<td>Home help</td>
<td>Ongoing review and monitoring monthly with PHN</td>
</tr>
</tbody>
</table>
4.6 Management Structure And Reporting Relationships

The management and reporting systems in place for care provision were explored, as often the situation ‘on the ground’ can differ dramatically from the ideal system represented in the public domain. Further, perceptions of the organisation can vary according to the hierarchical system in place (Ogbonna and Harris, 1998).

The main finding from this section was that health boards use a line management arrangement which is deeply embedded in day-to-day service provision. The different services therefore have their own discrete reporting systems. This can lead to a tendency for services to operate in parallel with, rather than in tandem with, each other:

‘Individual managers manage their own service.’

‘[I] report to the senior physiotherapist … the senior physiotherapist reports to the general manager of community services.’

Study participants did recognise that this arrangement could lead to difficulties and confusion:

‘… the organisational structure is confusing.’

‘The health board needs a management system put in place for older people both at the macro and micro level. There are too many parallel strands at the minute.’

These problems were described across the different health boards and have been recognised to a certain extent within the Irish system. Efforts have been put into the development of strategies to improve communication and service co-ordination.

4.6.1 Budgetary Arrangements

Budgetary arrangements were discussed with participants to discover to what extent devolution took place. Table 4.6 illustrates how funding and budgets across the health boards were described by participants. Although there have been some moves towards devolving budgets down the hierarchy, in general control over budgets rests with middle or senior management. The process of devolving financial and decision-making power down the hierarchy will take some time to achieve.
Table 4.6: Perspectives of budgetary arrangements across the health boards

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEHB*</td>
<td>Statutory funding from the health board (approximately 70% of funds required to run the service)</td>
</tr>
<tr>
<td>NEHB*</td>
<td>Receive (a fixed amount) from the health board, some of which goes to social work provision, and some to day care. Also apply for many grants but difficult to get funding for older people. All budgetary decisions have to be passed by the health board</td>
</tr>
<tr>
<td>NWHB</td>
<td>Funding of care for older people in Donegal is based on service planning. The NWHB sets the budget with the Department of Health and Children. The budget is split into subvention and community funding</td>
</tr>
<tr>
<td>NWHB</td>
<td>Budget managed by director of PHN – budget and number of hours</td>
</tr>
<tr>
<td>WHB</td>
<td>Last year, Department of Health and Children allocated funding based on proportional population of older people per county</td>
</tr>
<tr>
<td>WHB</td>
<td>The director is in charge of older and mental health – has the money/budgetary responsibility – answerable to board</td>
</tr>
<tr>
<td>WHB</td>
<td>Western Health Board controls funding</td>
</tr>
<tr>
<td>MWHB</td>
<td>No devolved budgets – petty cash and account to pay patients’ stipend for any work. No control over what is spent in the day hospital</td>
</tr>
<tr>
<td>SHB</td>
<td>Funding devolved down to heads of departments (mostly for salaries). Committee exists for non-salary budgets such as aids and appliances. Major changes are discussed with the central co-ordinator of the budget – the general manager for community services</td>
</tr>
</tbody>
</table>
Table 4.6: Perspectives of budgetary arrangements across the health boards (continued)

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEHB</td>
<td>Centralised funding, although there is a move to develop the client groups and divide funding accordingly</td>
</tr>
<tr>
<td>SWAHB</td>
<td>Annual budgets are very restrictive. Re: devolved budgets – not at that stage at area level of devolving budgets to service managers</td>
</tr>
<tr>
<td>SWAHB</td>
<td>Funding: initial stage – community care area allocated money for all services across care groups. In terms of residential homes, the budget is delegated to the residential manager and the Area Manager monitors situation. Aim is that heads of services become responsible for their own budgets</td>
</tr>
<tr>
<td>NAHB</td>
<td>In the past – there was an acute hospital and a non-acute hospital budget. Then there was the community care budget. There was a mental health in-patient budget. Present – assistant chief for services or operations is the only budget holder of the totality of the budget. But feeding into him will be general managers, who have a total budget for community care services</td>
</tr>
<tr>
<td>NAHB</td>
<td>Budgets not devolved at all</td>
</tr>
<tr>
<td>ECAHB</td>
<td>Area managers have no budget. Far more desirable for Care Managers to have budgets. Devolved budgets in community care areas have only happened in the past 10 years. It was totally demand-led and totally dependent on who made a better case</td>
</tr>
<tr>
<td>ECAHB</td>
<td>Budgets not devolved at all. System too centralised and allocation ad hoc</td>
</tr>
<tr>
<td>MHB</td>
<td>Home Helps are all funded and organised by the Midland Health Board</td>
</tr>
<tr>
<td>MHB</td>
<td>Recently obtained funding to appoint assistant home help organiser, also more full-time home helps, secretaries/office support, upgrade home help organisers. No control over these sorts of decisions</td>
</tr>
</tbody>
</table>

* voluntary sector
Throughout the interviews, reference was made to the important role that communication between service providers plays in current service delivery, especially with regard to quality assurance and complaints/grievance procedures. The interviewees who talked about communication in detail offered a variety of opinions about the quality of communication in their area.

Eight people describe communication as mainly informal – there was some difference of opinion as to whether this informal communications system was a good or bad thing. Two voluntary workers, for instance, felt that informal communication facilitated their work:

‘Communication is mainly informal, if you need something just ring.’

A general practitioner working in a rural group practice also felt that the fact that communication mainly took part on an informal basis was positive:

‘Relationships between [GP] and community are good, especially as the public health nurse works out of the health centre. Informally and every couple of weeks, the general practitioner, the practice nurse and the public health nurse go for lunch and discuss any patients that are of concern to any of them.’

One interviewee, however, said that although there was a degree of informality, there was a management structure behind this to keep an eye on service delivery:

‘Communication is as informal as it needs to be. We have to be seen to be relaxed but there is a tight monitoring system behind this. There is a management structure for reporting and an attempt at a team approach. Strict procedures are adhered to but there is free communication and good communication.’

Other people were concerned that an overly-informal communication structure could lead to problems:

‘No set protocol here. Informal communication depends on personality. Time is a big problem. There is no clear understanding of the different roles of professionals.’
Another person was uncomfortable with ‘haphazard’ approaches to communication, but felt that measures such as the development of hospital-community discharge plans could go some way towards improving matters:

‘Communication has improved (but still haphazard) between the general practitioner, the public health nurse and secondary social work, occupational therapy, physiotherapy and families. There have been measures such as discharge planning groups to make sure that people are aware of care plans.’

An interviewee working in the psychiatry of old age service described clearly the work that goes into building up an effective communication system:

‘Relationships have mainly been formed from the bottom up over the years, very much people getting to know each other, takes a bit of time, particularly for community mental health nurses getting to know the public health nurses and also the GPs over a period of time. Depends on making an effort to phone people really, but it’s well worth it and it’s important to have in place before a problem arises.’

However, another interviewee felt that the care groups were acting as an obstacle to good communication:

‘Communication is difficult due to care groups – child health, disability, elderly.’

4.7.1 The Role Of Service Users And Families

The extent to which older people and their families were involved in making decisions about their care varied greatly across interviewees and settings. Although there was a general recognition that the dignity and rights of older people and their carers should be central to care planning, in general there were no formal guidelines for consulting older people or their carers. This appears to have enabled different services and carers to take their own approach, ranging from not having any formal consultation guidelines, but having strong informal links with older people, to developing new and coherent ‘person-centred’ strategies. It remains to be seen whether these strategies translate into practice on the ground. One potential point of conflict that a few interviewees identified was the tension that can exist between the wishes of an older person, i.e. to stay at home, and the needs of their carers who may not have the physical, emotional or financial resources to look after them at home.
'If there’s a willingness on the part of the family to look after relatives at home, if they want to do it, they will do it. If they don’t, nothing is going to change their mind. An awful lot has to do with the attitude of the older person themselves, if they have been easy to get on with throughout life, there’s a good chance of it working, but if not there are far more problems.’

‘[Social Workers] … are very conscious of the needs of carers … and they would be saying to some carers ‘don’t take him out because clearly you can’t’. The social worker gives their assessment … and the patient’s point of view is important, but it’s not the most important thing.’

Finally, there was the concern that older people are reluctant to speak up, have very low expectations of services and are even reluctant to access the services to which they are entitled. This reflects the ‘stigma’ attached to certain services by older people discussed in the HeSSOP report (Garavan et al, 2001:182-185). Specifically, older people reported that they would be reluctant or embarrassed to use more social and ‘visible’ services such as home helps and meals-on-wheels even if they needed them.

4.7.2 Multi-Disciplinary Teams

A number of measures were described that aimed to improve communication between different disciplines. Again the extent to which these measures had improved the situation varied. A key development cited was the setting up of multi-disciplinary initiatives such as care groups/service planning groups and multi-disciplinary teams. Care groups and service planning groups operate at planning and administration level and are comprised of the various heads of discipline (e.g. social work, public health nursing, physiotherapy and so on), the consultant geriatrician and/or the consultant psychogeriatrician, health board managers such as Directors and Area Managers of Services for Older People or Co-ordinators of Services for Older People. Multi-disciplinary teams, on the other hand, function at operational level and are made up of service providers and front-line workers. Tables 4.7 and 4.8 summarise the different initiatives described by interviewees at both care group/service planning group and multi-disciplinary team levels. A respondent who had earlier cited the care group as blocking information expanded on her concerns – the fact that the care group executive is solely hospital based, that ‘paramedical’ services were not assigned across the care groups, and that there was no structure for communication across care groups.
Table 4.7: The role of care groups and service planning groups in facilitating communication

<table>
<thead>
<tr>
<th>Occupation Category</th>
<th>Care Planning and Service Planning Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior management</td>
<td>Two years ago, service planning groups were set up including one for older people. The older people service planning group is comprised of an occupational therapist, GP, matron, director PHN, physiotherapist and a service user, or rather an advocate voluntary group. This has improved communication</td>
</tr>
<tr>
<td>Senior management</td>
<td>Everything is organised according to the care groups</td>
</tr>
<tr>
<td>Middle management</td>
<td>Proposals to set up older persons regional committees. Sharing information between professionals. To include older people themselves. To be made up of a number of professionals – directors of nursing in hospitals, community services, allied medical services/paramedical services, GPs, dental, social workers and management and one representative of older people (individual)</td>
</tr>
<tr>
<td>Middle management</td>
<td>Care groups decide on policy, look at issues or gaps in the area and managers co-ordinate all the activities of the care groups in their area together</td>
</tr>
<tr>
<td>Middle management</td>
<td>Each of the areas would have a care group for older persons which we would each chair (Area Managers) comprised of heads of disciplines, possibly someone from the wider community. This helps communication</td>
</tr>
<tr>
<td>Middle management</td>
<td>Care groups try to encourage communication between services</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>The care group executive is only based in hospital and doesn’t involve community-based services. Occupational therapy, physiotherapy and speech and language therapy have all been delegated to disability and all funding comes in through disability. The other care groups suffer as a consequence. No structure for communication between care groups</td>
</tr>
<tr>
<td>Occupation Category</td>
<td>Multi-disciplinary Teams</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Senior management</td>
<td>At community level, there are multi-disciplinary teams. Leadership of these teams open to everyone</td>
</tr>
<tr>
<td>Middle management</td>
<td>Multi-disciplinary approach only available in District Care Unit</td>
</tr>
<tr>
<td>Medicine (psychiatry)</td>
<td>Psychiatry of old age service run according to multi-disciplinary team comprised of assistant director of nursing, three community mental health nurses, senior registrar and three registrars, and staff in two day hospitals (one per catchment area)</td>
</tr>
<tr>
<td>General practice</td>
<td>Services very badly integrated. The local district care team has a good model of communication</td>
</tr>
<tr>
<td>General practice</td>
<td>Partnership (GPs). One of the services involved is a wound clinic based in the local long-stay hospital, and both GPs and PHNs can refer to that which has instigated some communication and liaison</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Skill-mix teams report to area PHN. Comprised of RGNs, Home Care attendants, home help. Function: to provide service to facilitate early discharge. Community care has only eight nursing homes. Trying to maintain people at home for as long as possible</td>
</tr>
<tr>
<td>Nursing – hospital sector (continuing care)</td>
<td>Each week there is a case conference where all referrals are processed and prioritised, or it is decided that further information is necessary before a decision is made. There is a small multi-disciplinary team consisting of a physiotherapist, occupational therapist, consultant, PHN, assistant matron, matron, medical officer and speech and language therapist if necessary. This team covers both the community and the hospital</td>
</tr>
</tbody>
</table>
While difficulties with the interface between the hospital (specifically the acute hospital) and the community were described, it appeared that these difficulties were well recognised and being acted on. Measures such as hospital community liaison committees and discharge planning have been put in place in order to smooth the transition between the two settings and so improve outcomes for older people. However, without proper monitoring and evaluating systems in place, it is impossible to determine the impact these measures may have.

4.7.3 The Relationship Between Health And Social Services

In general there was a consensus that although care of older people should ‘encompass health and social aspects, such as sorting out health care, benefits, housing and so on’, links between health and social service agencies and staff (including social workers) were far too underdeveloped:

‘There doesn’t seem to be a role for social workers for older people and that’s because of our ageist assumption about older people that most of their needs are physical.’

‘Care of people involves health and social aspects, and the link between the two is not strong enough. There are not enough social workers in the community. For example, there are lots of social aspects of caring for someone with dementia that are difficult for carers to access.’

‘[I] met all the county councils and corporations and found that they didn’t want to meet because they found it hard to believe they had a role to play in the health and welfare of older people. [I] argued that the way they provided houses, the way they set up the infrastructure, security, wardens etc., had a very real effect on older people.’

There was one exception to this perspective – one interviewee felt that the health board in which they worked had a very close relationship with social services because the board covered both health and social services.
4.7.4 The Relationship Between The Voluntary Sector And The Statutory Sector

Interviewees talked about the links between the voluntary and statutory sector. The general pattern is that health boards are very dependent on the voluntary sector to assist them in providing care in areas that the boards cannot cover adequately themselves, for example, community care. Some people felt that these links could be strengthened. One person felt that relations between the voluntary sector and the health board were difficult, mainly due to funding problems and mutual distrust. This may be related to the fact that in Ireland, GP services, hospital services and public health nursing are provided mainly by the health boards. However, social services for older people have never been provided directly by the statutory sector, rather they have been delivered through the voluntary sector most often through religious organisations. This has lead to an imbalance between health and social service provision, with health care having undue dominance over social care (Blackman et al, 2001:84).

4.8 Care And Case Management

A number of interviewees spontaneously mentioned the terms Care and Case Management. These terms were not included in the interview schedule as the consultative committee felt that there was a danger of confusing participants and biasing responses in the interview. The main focus of these discussions was about how services would react to the introduction of Case Managers. There was a real concern that it would be very tricky to negotiate the existing reporting relationships and yet maintain the acceptability of the Case Managers:

‘Area managers have assumed the lead role of the care group for older people, that’s positive. But that person then is leading all the disciplines. The biggest problem will be separating relationships ... a physio only reports to a physio, an occupational therapist only to an occupational therapist, and so on.’

‘The Care Manager must be acceptable to the care team.’

‘How will the system react to the introduction of a Care Manager? There will be interdisciplinary issues.’
Another key issue that arose was whether a Case Manager should be from a specific professional background. Responses varied widely – some people felt that Case Managers should have a medical (preferably nursing) background, while others felt that the key skills of Case Management were negotiation, communication and general interpersonal skills and that these were not specific to a medical background. All agreed on the fact that experience of working with older people was very important, and that education and training was necessary for those coming to the job for the first time. One respondent also felt that training would be necessary for the teams who would be working with the Case Manager:

‘[I] feel that public health nurses should be the Case Managers because they are already trained to the level of work that they’re doing. But it doesn’t have to be restricted to nursing.’

‘Perhaps a social worker could take on that role quite nicely, would fit into that brief, or just having a co-ordinator’s role could come from any of the disciplines.’

‘Doctors think that managers who haven’t a medical background are unlikely to think on the same wavelength and that probably is arrogant of us. [I] think that if the co-ordinator is properly trained in healthcare management that would be OK.’

4.9 Pilot Projects

Nine pilot projects that the research team have deemed as ‘near’ Care Management have been identified in this consultation exercise. While the study aimed to examine the activities that were ‘near’ Care Management of all the health boards in Spring 2001, other projects may be in place since Phase One interviews were completed. A useful way of analysing Care and Case Management projects would be to consider each one under such headings as origins, operation, financing, sustainability and replication. However, this analysis was felt to be premature in the present context due to the fact that many respondents described their projects as so embryonic as to reduce the worth of such an exercise. This imbalance of available project data (in that some projects were set up on a more formal basis in terms of financial, staffing and structural resources than others) could lead to a misrepresentation of some projects as inferior to others. A brief description of each is illustrated in Table 4.9.
Table 4.9: Pilot projects with a ‘near’ Care or Case Management approach to health and social services for older people identified across the Irish health boards in Spring, 2001

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Key Features</th>
<th>Current Status</th>
<th>Challenges</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Choice’ Programme</td>
<td>Sligo-Leitrim West-Cavan Donegal (NWHB)</td>
<td>Care is delivered to older people according to their wishes. The older person and/or carer makes the choice. The programme is individualised to meet the needs of the person. It is home-based or home-from-home. It is flexible – available 7 days by 24 hours. The focus of the programme is health maintenance. It is person-centred and needs-driven, and links health and social services</td>
<td>Consultation with older people completed. Identified 3 implementation areas for Sept 2001 in Sligo-Leitrim</td>
<td>Changing mind-sets. Building partnerships between different agencies. Recruitment</td>
<td>Evaluation will commence with implementation of project in September</td>
</tr>
</tbody>
</table>
The objectives of this project are to improve the quality of life for older persons in the target group, to provide high support services at home tailored to the specific needs of clients and carers, to facilitate the transfer of older persons from hospital to community who require high support, to prevent the unnecessary transfer of older persons to institutionalised care settings, and to maximise the independence of older persons to their full potential according to a Care Management model (Roscommon Care Services, 2000). The target group consists of older people with a potential for rehabilitation, those moving from hospital to the community who require intensive home-based services, those in the community at risk of institutionalisation and those with high dependency who require short-term intensive services. The team will comprise an assistant director of public health nursing as a Care Manager to oversee service co-ordination, and a multi-disciplinary team comprising a home help, an occupational therapist, a physiotherapist and a registered general nurse (RGN).

<table>
<thead>
<tr>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>‘Comprehensive Home Based Service’</td>
<td>County Roscommon (WHB)</td>
<td>The objectives of this project are to improve the quality of life for older persons in the target group, to provide high support services at home tailored to the specific needs of clients and carers, to facilitate the transfer of older persons from hospital to community who require high support, to prevent the unnecessary transfer of older persons to institutionalised care settings, and to maximise the independence of older persons to their full potential according to a Care Management model (Roscommon Care Services, 2000). The target group consists of older people with a potential for rehabilitation, those moving from hospital to the community who require intensive home-based services, those in the community at risk of institutionalisation and those with high dependency who require short-term intensive services. The team will comprise an assistant director of public health nursing as a Care Manager to oversee service co-ordination, and a multi-disciplinary team comprising a home help, an occupational therapist, a physiotherapist and a registered general nurse (RGN)</td>
<td>In the process of interviewing for a Care Manager</td>
<td>Recruitment was very problematic. Consequently the project was delayed by a year</td>
<td>Outcome measures had not been identified at time of interview</td>
</tr>
</tbody>
</table>
Table 4.9: Pilot projects with a ‘near’ Care or Case Management approach to health and social services for older people identified across the Irish health boards in Spring, 2001 (continued)

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Key Features</th>
<th>Current Status</th>
<th>Challenges</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Elderly Project’</td>
<td>Waterford (SEHB)</td>
<td>All those in the area over age 75 and in possession of a medical card were assessed by the local PHN using the Winchester Disability Score. A care plan for those who were deemed to be at risk was drawn up according to identified needs. If no service existed to meet needs, an attempt was made to put that service in place. Skill-mix teams were created which included home helps/home care attendants, registered general nurse and twilight nursing. This was a pilot project and when it finished the additional staff recruited for the project were made redundant</td>
<td>This project ran from November 1999 to February 2000</td>
<td>Pilot Project not continued when funding ended</td>
<td>At time of interview, a report was being compiled in order to obtain additional funding</td>
</tr>
</tbody>
</table>
This project aims to facilitate the discharge of older people who would otherwise be at risk of institutionalisation. Extra domiciliary services are provided by [Voluntary agency], who supply trained home assistants. The project is based on a Case Management model. A project co-ordinator is employed to co-ordinate the project, liaise with patients and relatives and community rehabilitation staff. The co-ordinator also responds to the changing needs of patients, and deals with after-hours and weekend care needs. The target group comprises older people who should be at home but have some difficulties such as slight confusion, living on their own or are at risk of falling.

Commenced in April, 2001

Slight delay due to difficulty in recruiting people

Observational study for a year. Two randomised groups of patients (30 patients in each group). One receives standard services, what’s already there. The other (intervention) group will receive ‘home first’ services. Outcome measures will be developed during the evaluation.

Table 4.9: Pilot projects with a ‘near’ Care or Case Management approach to health and social services for older people identified across the Irish health boards in Spring, 2001 (continued)

<table>
<thead>
<tr>
<th>Name</th>
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<th>Key Features</th>
<th>Current Status</th>
<th>Challenges</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Home First’</td>
<td>Beaumont Hospital, (NAHB)</td>
<td>This project aims to facilitate the discharge of older people who would otherwise be at risk of institutionalisation. Extra domiciliary services are provided by [Voluntary agency], who supply trained home assistants. The project is based on a Case Management model. A project co-ordinator is employed to co-ordinate the project, liaise with patients and relatives and community rehabilitation staff. The co-ordinator also responds to the changing needs of patients, and deals with after-hours and weekend care needs. The target group comprises older people who should be at home but have some difficulties such as slight confusion, living on their own or are at risk of falling</td>
<td>Commenced in April, 2001</td>
<td>Slight delay due to difficulty in recruiting people</td>
<td>Observational study for a year. Two randomised groups of patients (30 patients in each group). One receives standard services, what’s already there. The other (intervention) group will receive ‘home first’ services. Outcome measures will be developed during the evaluation.</td>
</tr>
<tr>
<td>‘Keeping People Well’</td>
<td>Carnew, County Wicklow (ECAHB)</td>
<td>Based in Carnew Community Care, a sheltered housing community for older people. This project has a strong emphasis on health promotion. A Care Organiser has been appointed who acts as the principal contact and support for older people and their families</td>
<td>Ongoing</td>
<td></td>
<td>Independent evaluation planned</td>
</tr>
</tbody>
</table>

11 Those projects marked with an asterisk are part of the Home First Projects Scheme run under the auspices of ERHA, the relevant area health board, the voluntary hospitals and other statutory organisations.
## Table 4.9: Pilot projects with a ‘near’ Care or Case Management approach to health and social services for older people identified across the Irish health boards in Spring, 2001 (continued)

<table>
<thead>
<tr>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>'Packages of Care'</td>
<td>County Mayo (WHB)</td>
<td>The aim of this project is to ‘maintain the client in a domiciliary environment and thereby reduce the client’s need for nursing home or hospital admission’. Older people are eligible if they are aged 65 or over, have a demonstrated health care need, live in County Mayo and have a level of disability that prevents independent living. A Co-ordinator of Packages of Care has been appointed who works in conjunction with a multi-disciplinary team. Services available include meals-on-wheels, occupational therapy, physiotherapy, respite care, general practitioner, family support, day hospital, home help and public health nursing.</td>
<td>This project has been running since October 2000</td>
<td>It has been difficult to recruit personnel for the home help service, but now that new pay rates have been introduced, it is hoped that more people will come forward.</td>
<td>A preliminary cost-based evaluation was carried out in January 2001. A more comprehensive evaluation will be carried out when the project has been running for a year.</td>
</tr>
<tr>
<td>'Primary Care Partnership'</td>
<td>Community Care Areas 6+7 (NAHB)</td>
<td>This project will aim to access people not currently covered by District Care Units, in order to improve their quality of life at home and to avoid unnecessary admission to long-stay care. Plan to recruit a social worker and an occupational therapist who will operate as a ‘key-worker’ team to identify older people at risk of unnecessary admission and to develop care plans for these people. It is envisaged that referral will come via general practitioners.</td>
<td>Earliest planning stage only</td>
<td></td>
<td>There will be a steering committee and it will be evaluated. Details have not been finalised.</td>
</tr>
</tbody>
</table>
The aim of this project is to enable older people to stay at home with high quality services. A team approach is espoused, where the local public health nurse works with a registered general nurse (RGN) and a home help. The client is referred to the team and an assessment is carried out in conjunction with the client and his or her family. The public health nurse is given the power to decide on a care plan and the required inputs of the RGN and the home help. If a client has other requirements (such as dementia services, day care, respite care, the social club, occupational therapy or physiotherapy) the PHN links in with the relevant statutory and voluntary services. A care plan is drawn up and there is constant liaison with the services involved to ensure effective implementation of the plan. The team also link in with the GP in the area.

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>No title given</td>
<td>Longford/ Westmeath (MHB)</td>
<td>The aim of this project is to enable older people to stay at home with high quality services. A team approach is espoused, where the local public health nurse works with a registered general nurse (RGN) and a home help. The client is referred to the team and an assessment is carried out in conjunction with the client and his or her family. The public health nurse is given the power to decide on a care plan and the required inputs of the RGN and the home help. If a client has other requirements (such as dementia services, day care, respite care, the social club, occupational therapy or physiotherapy) the PHN links in with the relevant statutory and voluntary services. A care plan is drawn up and there is constant liaison with the services involved to ensure effective implementation of the plan. The team also link in with the GP in the area</td>
<td>This project is still being developed</td>
<td>Recruitment and training will be difficult, which will affect continuity. The public health nurses are already very busy. The project planners are not sure how to put the services in place at local level</td>
<td>Evaluation criteria have not been decided on at this point</td>
</tr>
</tbody>
</table>
Table 4.9: Pilot projects with a ‘near’ Care or Case Management approach to health and social services for older people identified across the Irish health boards in Spring, 2001 (continued)

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>No title given</td>
<td>County Galway (WHB)</td>
<td>This project follows the Packages of Care model espoused by the other two Western Health Board projects in Mayo and Galway. It aims to provide a tailored package to older people in their own homes. The project covers over 65s in a 10 kilometre radius of Galway City. There is a multi-disciplinary team comprising a physiotherapist, an occupational therapist, a speech and language therapist, a chiropodist and a public health nurse</td>
<td>This project was delayed for a year due to recruitment difficulties. Started early 2001</td>
<td>Severe problems with recruitment have delayed the project. Catchment area of project too large. At the moment reporting relationships have not been fully worked out, there is a need to put a key worker in place</td>
<td>Outcome measures and evaluation have not been finalised as yet</td>
</tr>
<tr>
<td>‘The Inchicore Conversations’</td>
<td>Inchicore (SWAHB)</td>
<td>Open discussion forum where older people in the area can voice their own wants and needs</td>
<td>Ongoing</td>
<td></td>
<td>Independent evaluation planned</td>
</tr>
<tr>
<td>Joint Ventures’</td>
<td>ERHA</td>
<td>Developing further links and ideas between ERHA, local authorities and social welfare</td>
<td>Ongoing</td>
<td></td>
<td>Independent evaluation planned</td>
</tr>
</tbody>
</table>

12 Those projects in italics are not based on a Care or Case Management Model, however they do espouse a similar philosophy to that of Care and Case Management.
Table 4.9: Pilot projects with a ‘near’ Care or Case Management approach to health and social services for older people identified across the Irish health boards in Spring, 2001 (continued)

<table>
<thead>
<tr>
<th>Name</th>
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<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Home Respite Care'</td>
<td>St James’ Hospital (SWAHB)</td>
<td>This project aims to provide respite-at-home for people with dementia. This project is a three-way initiative between the Dementia Services Information and Development Centre, the SWAHB and the Medical Social Work department in St James. The person with dementia is offered the opportunity to spend time with a fully trained respite support worker. Four support staff along with a care organiser have undergone extensive training and now work with families.</td>
<td>April 2001</td>
<td></td>
<td>Monitoring is an integral part of the project and an independent evaluation is planned for the end of the year</td>
</tr>
<tr>
<td>Home from Home’</td>
<td>St James’ Hospital (SWAHB)</td>
<td>This project involves reorganisation and renovating the long-stay unit for older people.</td>
<td>Ongoing</td>
<td></td>
<td>Independent evaluation planned</td>
</tr>
<tr>
<td>Not designated</td>
<td>County Donegal (NWHB)</td>
<td>Regular meetings are held with local Public Health Nurses to identify ‘vulnerable’ older people (such as an older person with an older informal carer) who are then prioritised for care. If a call is received about a priority case that person is ‘fast-tracked’ in to the district hospital.</td>
<td>Ongoing</td>
<td>None identified</td>
<td>None identified</td>
</tr>
</tbody>
</table>

April 2001
Ongoing
Monitorin...
These projects illustrate the diverse range of activities being undertaken across the country at varying levels of development and yet meeting similar challenges such as recruitment.

### 4.10 The State Of Care In Ireland

In order to identify the strengths and weaknesses of current care provision for older people in Ireland, opportunities for service development and possible obstacles or threats to that development, interviewees were asked to undertake a SWOT (strengths, weaknesses, opportunities and threats) analysis. The analysis basically asks the interviewees, in an open-ended manner, to comment on the current system.

#### 4.10.1 Strengths

Various aspects of care were identified as working well, ranging from individual professionals and their efforts, to specific services and changes in policy and organisational culture. However, the voluntary sector, the public health nursing service and the home help service arose as key strengths in a number of cases (see Table 4.10).

**Table 4.10: Strengths of Current Service Provision (arranged by occupation)**

<table>
<thead>
<tr>
<th>Occupation category</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>The energy of the people running the service. Informal communication. Service Planning Groups</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Daycare and range of activities available there. Older people enjoy the fact that the day care keeps them very well stimulated</td>
</tr>
<tr>
<td>Senior management</td>
<td>Community teams and the development of the therapy services. Strong network of daycare services, nursing care. Partnership with voluntary providers very important. Voluntary sector very strong, covers all aspects such as housing, social and health</td>
</tr>
<tr>
<td>Senior management</td>
<td>Home help service absolutely marvellous. Meals-on-wheels absolutely fantastic. Many voluntary agencies provide a fabulous socialisation service</td>
</tr>
<tr>
<td>Occupation category</td>
<td>Strengths</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Senior management</td>
<td>Much more openness about the way we do our business. Much clearer in admitting to what we’re good at and what we’re bad at. Much better relationship with voluntary organisations</td>
</tr>
<tr>
<td>Middle management</td>
<td>Respite service working well giving a lot of help to people. Assessment for long-stay working well. Throughput of people through system working well</td>
</tr>
<tr>
<td>Middle management</td>
<td>Local respite service working very well</td>
</tr>
<tr>
<td>Middle management</td>
<td>Home helps are a fabulous resource in the community</td>
</tr>
<tr>
<td>Middle management</td>
<td>PHNs are excellent – very compassionate and work very hard within terrible time constraints. Voluntary organisations are doing a lot of work for no return – there are brilliant things happening and that’s good in that we still have some kind of community spirit</td>
</tr>
<tr>
<td>General practice</td>
<td>Making people use their own resources wherever possible. Self-reliance</td>
</tr>
<tr>
<td>General practice</td>
<td>Day-care in [local town] is tremendous. Home help is a great thing if you can get it</td>
</tr>
<tr>
<td>General practice</td>
<td>The psychiatry of old age service. Also the medical director of services for older people in [local area] for providing excellent services</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Area PHN manages from cradle to grave. Commission on nursing places PHN at the core of care in the community. Their proposals on the future role of the PHN if implemented are very strong</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Care packages are good if the resources are there and locally based and monitored by key front-line worker</td>
</tr>
<tr>
<td>Nursing – hospital sector (continuing care)</td>
<td>Far greater focus and liaison with community than there had been</td>
</tr>
<tr>
<td>Community mental health nursing</td>
<td>Key working system – enables them to run a very personal service</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>[Local voluntary group] has recently acquired a new building with a new physiotherapy room. Generally your voice as a professional can be heard – good communication and improving. More funding is available for positions, but people not coming forward</td>
</tr>
<tr>
<td>Home help service</td>
<td>The home help service is basically a good service</td>
</tr>
</tbody>
</table>
4.10.2 Weaknesses

Three main areas of weakness emerged from the research (see Table 4.11). Lack of resources and staff were the most commonly cited weaknesses which affected all aspects of care as is illustrated in the responses from interviewees:

‘Lack of facilities and staffing. No day centre, no hostel, no in-patient. Not able to give the care I would like to give.’

‘Community care services. We don’t have care services, really, we have PHNs who go in and out but can’t spend the time looking for people. Not enough voluntary domiciliary services to cover the gaps.’

‘... struggling to have a responsive community service. We keep talking about moving resources from one area to another, but are the resources in the area you’re moving them from already inadequate?’

Transport, or the lack of it, was also seen as a problem, especially in rural areas:

‘All forms of transport are under strain so it’s difficult to hire buses for day trips.’

‘Need to break transport up more, send out taxis. Public transport is very very poor. CIE is doing the best they can do with what they have.’

The gathering and dissemination of information was also identified as a weakness:

‘Very poor on information – mainly a problem with dissemination.’

‘Very poor at keeping hard statistics of what we do. Particularly in the community – but how do you expect to get more money unless you can tell what you did with the last lot?’
### Table 4.11: Weaknesses in Current Service Provision (arranged by occupation)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>Lack of staff. Also all forms of transport under strain</td>
</tr>
<tr>
<td>Senior management</td>
<td>Need to break transport up more, send out taxis. Public transport is very poor. Need a subsidy for isolated areas</td>
</tr>
<tr>
<td>Senior management</td>
<td>Need more geriatricians (although this has improved), need more continuing care beds (400 extra over next year for two counties). Need more staff in the community. Transport must be improved</td>
</tr>
<tr>
<td>Senior management</td>
<td>Very poor on information – mainly problem with dissemination. It should be very transparent and obvious that you contact your PHN who will arrange a visit and will then do a means test or medical assessment</td>
</tr>
<tr>
<td>Senior management</td>
<td>Very poor at keeping hard statistics of what we do. Particularly in the community – but how do you expect to get more money unless you can tell what you did with the last lot? There should be hard qualitative data out there that will assist people in planning</td>
</tr>
<tr>
<td>Middle management</td>
<td>Community care services. We don’t have care services, really. We have PHNs who go in and out but can’t spend time looking for people. Not enough voluntary domiciliary services to cover the gaps. The traditional attitude towards volunteers here has been that it is a vocation and so they are owed nothing</td>
</tr>
<tr>
<td>Middle management</td>
<td>Care Management for people out in the community is not as good as it should be. Services should be expanded</td>
</tr>
<tr>
<td>Middle management</td>
<td>District Care Unit, need to increase staff and level/range of services that DCU can provide</td>
</tr>
<tr>
<td>General practice</td>
<td>Separation of social and medical needs</td>
</tr>
</tbody>
</table>
### Table 4.11: Weaknesses in Current Service Provision (arranged by occupation) (continued)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice</td>
<td>Two year waiting list for placement in long-stay care which leads to patients either ‘blocking beds’ or going home when they shouldn’t</td>
</tr>
<tr>
<td>General practice</td>
<td>Lack of resources, lack of teamwork, lack of access to tests, lack of PT + OT, no structure for case conference on a regular basis</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Support/supervision for crisis or decision-making</td>
</tr>
<tr>
<td>Public health nursing</td>
<td>Staff turnover and recruitment – OT/nursing/HH/PT/Chiropody/Consultants. Not enough services for confused elderly/dementia</td>
</tr>
<tr>
<td>Nursing – hospital sector (continuing care)</td>
<td>Resources. Structure and staff</td>
</tr>
<tr>
<td>Community mental health nursing</td>
<td>Lack of facilities and staffing. No day centre, no hostel, no in-patient. Not able to give the care [participant] would like to give</td>
</tr>
<tr>
<td>Home help service</td>
<td>Distribution of care services very patchy. Get rid of means testing, should give service to all over 70s</td>
</tr>
</tbody>
</table>

#### 4.10.3 Opportunities

Only a fifth of interviewees were able to identify specific opportunities for improvement. These tended to take the form of concrete actions that could be undertaken by themselves, rather than larger policy or planning work. It is possible that the other interviewees found it difficult to think of achievable opportunities to improve current service provision. A range of opportunities were named:

- improve transport facilities
- invest in community care and home-based care
• recruit more registered general nurses to support public health nurses
• review the role of the public health nurse
• up-skill staff such as care attendants to take over personal care tasks
• increase the flexibility of existing services.

4.10.4 Threats

A similar number of interviewees identified additional key threats to service improvement. Most people who were asked referred to the weaknesses they had identified earlier, and staffing and financial resource constraints were identified as a key threat. Other threats cited included:

• poorly organised referral pathways
• a reluctance to identify older people, especially those with dementia, as a priority
• communication and inter-professional collaboration difficulties
• high demands placed on informal carers.

4.11 Staffing And Recruitment

It became clear during the research that problems to do with recruiting and retaining staff were the main difficulties faced by all those who took part in the first phase of fieldwork. The table below (Table 4.12) sets out those services which were identified as being understaffed. It is evident that these staffing problems run through all aspects of care – in hospitals and in the community.
### Table 4.12: Staffing and recruitment difficulties in health and social services for older people

<table>
<thead>
<tr>
<th>Professional Role</th>
<th>Services Where Understaffing Was Identified</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector</td>
<td>Cooks for meals on wheels</td>
<td>Voluntary recruitment is becoming increasingly problematic for staff</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Community employment (FAS) staff</td>
<td>High turnover, have to leave when course over. In addition, the job market is so good that there is a high degree of competition for staff. Women can’t be flexible without adequate child care</td>
</tr>
<tr>
<td>Senior management</td>
<td>Public health nursing – many locum public health nurses are being used. Shortage of social workers</td>
<td>The lack of staff puts pressure on the individuals within the service</td>
</tr>
<tr>
<td>Senior management</td>
<td>Shortages throughout the health service</td>
<td>The lack of staff puts pressure on the individuals within the service</td>
</tr>
<tr>
<td>Middle management</td>
<td>Difficulty in recruiting occupational therapists and physiotherapians for District Care Units</td>
<td>We need to start recruitment drives abroad. Change job structure to encourage applicants</td>
</tr>
<tr>
<td>Middle management</td>
<td>Problem throughout community services</td>
<td>Used to have no money yet enough staff, now have enough money and no staff</td>
</tr>
</tbody>
</table>
Middle management

- Community services understaffed, very difficult to get nursing, paramedical staff at the moment. Also variability in complement, nursing has more than occupational therapy/physiotherapy which can be as low as 1:10 or 1:20
- Internal problems – health board is slow in processing applications. Often mistakes are made with wages and this makes people leave. The system is too hierarchical especially the personnel section

Middle management

- Home help, meals-on-wheels, care assistants – right throughout service. In addition no-one to co-ordinate services on the ground
- Type of work and huge workload – everything takes too long to setup and get running in health board

Medicine (psychiatry)

- Within psychiatric service the situation is not too bad, one of the bigger problems now is that it’s very hard to get good junior doctors – every six months recruitment has to start again
- Lucky on the nursing side in terms of the community team

General practice

- Difficult to hire home helps. One physiotherapist per community care area – very stretched. One occupational therapist per area

Public health nursing

- Public health nursing – 28 posts, only 21 filled in one health board area. The 7 posts left over are filled by RGNs. Little or no clerical support
- Health boards are not advertising to recruit staff. Recently a lot of temporary PHNs were told that they were to be made permanent, but this has not been processed and the health board will not recruit until this has cleared. Could take up to 3 years

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### Table 4.12: Staffing and recruitment difficulties in health and social services for older people (continued)

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<th>Professional Role</th>
<th>Services Where Understaffing Was Identified</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health nursing</td>
<td>Continence Adviser – one for whole health board area. Not enough home helps or care attendants. No social worker in care of the elderly, either in hospitals or the community. Chiropodists are scarce, mostly voluntary, funded by board</td>
<td></td>
</tr>
<tr>
<td>Nursing – hospital sector</td>
<td>Lack of nursing staff in hospital. There is so little access to occupational therapy or physiotherapy that both attend on an advisory basis only</td>
<td></td>
</tr>
<tr>
<td>Social work</td>
<td>No social workers (for older people) in the community</td>
<td>Traditionally, community care social workers were not interested in working in hospitals. That perception has almost reversed now, it is not so difficult to recruit people to work in a hospital</td>
</tr>
<tr>
<td>Psychology</td>
<td>Care attendants, physiotherapy, occupational therapy, clinical psychology, speech and language therapy, District Care Unit staff</td>
<td>Pubic health nursing is restricted to delivering injections to infants and implementing the mother and child scheme</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Physiotherapist, occupational therapist, speech and language therapist and chiropodist</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.12: Staffing and recruitment difficulties in health and social services for older people (continued)

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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and language therapy</td>
<td>Speech and language therapists. In recent years, 360 people have left the higher grades, but only 27 graduate per year from TCD. At the moment there are 430 basic posts, only 265 of which have been filled. There are 12 vacant posts in the MWHB alone.</td>
<td>Pay is a big issue, so is the very limited grading structure. If a post is not filled within a year, the money that resources that post is taken back by the Department of Health and Children.</td>
</tr>
<tr>
<td>Home help service</td>
<td>Home helps</td>
<td>In the past, remuneration for home helps had been very low and variable across boards, and there had been no guarantee of work until the end of the week. However, recently, pay has increased dramatically.</td>
</tr>
<tr>
<td>Home help service</td>
<td>Home helps – there are currently 400 part-time home helps for 600 clients. Difficult to recruit in isolated areas.</td>
<td>The job is not attractive to many people. Salary arrangements – the new pay conditions can put staff at risk of losing existing entitlements such as medical card.</td>
</tr>
</tbody>
</table>
However, a number of people proposed possible solutions including:

- targeting active retired people as volunteers
- changing part-time positions into full-time ones
- looking at international recruitment possibilities
- increasing the number of people being trained
- providing opportunities for up-skilling, i.e. training home helps to become care assistants
- introducing more grades within professions
- improving pay and conditions.

### 4.12 Focus Groups With Older People

Two focus groups were carried out with older people in two areas, Roscommon (rural) and Dublin (urban). The aim was to obtain their views on Care and Case Management as potential strategies for the delivery of their health and social care. Six people attended the Roscommon focus group and five attended the Dublin focus group. The Care Management concept was presented to both groups and feedback was invited. The groups were also asked to identify the key issues of importance to them in planning and receiving care.

#### 4.12.1 Staying At Home – Problems With Current Service Provision

Both groups clearly voiced the desire to remain in their own homes, rather than be admitted to institutional care:

>'There are a lot of people would love to be at their own fireside ... and it’s still the cheapest place to keep them.’

Roscommon

>'... you don’t want to end up staying in hospital for months.’

Dublin
The main obstacle to achieving this desire was identified as changes in family structures and cultures, the lack of community services and the cost of being forced to pay for private care:

‘There are so many families away, Dublin, America – they try but they’re so busy with work, they’re all working.’

Roscommon

‘... need more public health nurses, more home help to supply the hours, equipment, there’s a six month waiting list for your first visit with the occupational therapist. Rural transport, accessibility to respite care, that’s the other thing, and accessibility to day care.’

Roscommon

‘I know a case where the person is old and incapacitated, and his wife is in pretty much the same situation, and she has to look after him with no services, and she’s stuck there 24 hours a day with him ... what help is there for her, rather than going into an institution? There isn’t anything!’

Dublin

‘I know a lady now she’s at home and she loves being at home, but she has to pay night and day, just because her son is working, her daughter is a teacher ... Sure they [her children] have plenty of money to pay for these people but it’s not them! It’s her! And if she went into the home they’d keep her, but the woman is perfectly capable of being at home provided she has assistance!’

Roscommon

‘There shouldn’t be a means test for carers ... you take a male or female working, and suddenly ma or da gets ill, and they have to leave their job and there’s a means test! Which is crazy!’

Dublin
Public and private transport

Other problems identified included difficulties with transport. One Dublin participant described the difficulties involved in travelling to obtain services:

‘... you have to stand for the train and then you have to pay for a taxi from the station or footslog! But ... I’m on free travel so I can’t travel before a quarter to ten, and if you ask the doctor for a taxi he’ll tell you you can’t have one.’

General practice services

General practitioner services arose as another area of difficulty. Participants in the group from Dublin felt that general practitioner services were very over-stretched:

‘... they’re falling apart, just falling apart, all they can see you for is two or three minutes, and they’re not even listening to you.’

The Roscommon group described difficulties in the relationship between general practitioners and hospitals and how this can sometimes prevent older people from making complaints about the care they receive:

‘... how do you make a complaint? You go to the GP and he goes to the health board? No GP is going to do that – you come in and say “I didn’t like the consultant”. If that GP is going to take it further he’s going to have to make a case against the consultant. There is no protection for GPs to do this.’

Evaluation

One member of the Roscommon group referred to the fact that the local hospital carried out evaluation in the form of questionnaires. However, she was slightly wary of the process as she was unsure whether patients were singled out to respond and whether they could be identified from their responses. This, she felt, might act as a deterrent to people giving their honest opinions about the quality of care they received:
A – ‘A lady I knew came in to the hospital and she had to fill in a questionnaire about her visit to the hospital, how she found the consultant and whoever she had met. So she wondered after was it a routine thing or was it just specifically about this consultant.’

B – ‘But did she give her honest opinion?’

A – ‘God I don’t know! [Laugh] … But I’d be afraid to go back to that person again [the consultant]! ... they might be able to relate that back.’

4.12.2 Case Management

Both groups reacted very positively to the Case Management approach to care delivery for older people as described by the researcher. The Roscommon group felt that a Case Manager would help to empower older people, especially vulnerable people, to speak their mind about the quality of care they receive:

‘... you wouldn’t be dealing with authoritative people and you could get your point across, ok, some of us here I suppose we can talk, but those people that can’t would be afraid to take their point to anybody, but if they had someone sitting beside them at the fire or whatever, they could say “Well, such a thing happened to me”.’

A participant from Dublin said that Case Management would be an excellent way of helping people return home from hospital with proper care, rather than being left to look after themselves:

‘... there’s a friend of mine who was hospitalised ... and they wanted to discharge him in a day, now his wife was invalided ... his wife couldn’t look after him! If this can [Care and Case Management] sort it, it would be brilliant.’

Overall this group felt that Care and Case management were very ‘sensible’ ideas, but it depended on the government and the health boards supporting it:

‘It’s a good plan provided that the health boards and the government decides yes, operate ... couldn’t possibly get it to work unless they and the nurses themselves and so on decide to run it.’
Involving older people and their families

In terms of the role of older people and their families in the planning of their own care, there was a general consensus that if they still had ‘all their faculties about them’ then older people themselves should be making the decisions about the services they might require. The family and the Case Manager should become more prominent in the decision-making process if the older person becomes less well. However, one member of the Roscommon group made the point that some families will try to admit their older relatives to nursing home care without their consent:

‘… a lot of families will say you should go into a nursing home when you don’t want to.’

A participant from the Dublin group, on the other hand, felt that it was very important that families are made aware of the care options available for older people:

‘It’s not just us that need to know about this, the people that need to know about this are our families, not just us. They need to know what systems are in place for us. It’s all about education.’

Information

Information was felt to be a key element in both Care and Case Management. The participants in the Roscommon group said that the Care Manager (or Co-ordinator of Services for Older People) should operate as a mediator between an older person and the health services and find out information on the older person’s behalf:

‘This co-ordinator of services will have to have everything on a computer so that … you do not have to ring six different people for one thing.’

The Dublin group focussed on the most effective way of disseminating information about Care and Case Management. They came up with a variety of access routes for such information, including television, pamphlets in general practice surgeries, and local and national radio.
The skills of a Case Manager

Both groups described what sort of skills a Case Manager would need. Inter-personal communication skills were felt to be of most importance. Participants said that the job of Case Manager would be highly demanding, and managers would have to be remarkably skilled in order to be able to earn the trust of older people, to protect their dignity and confidentiality and to deal with difficult situations:

‘That key worker would have to be terribly understanding and a person who would be able to keep secrets.’

Roscommon

‘- Great patience, that would be the most important thing.

- They’d want great patience because no matter what you propose you’re going to get nagging from the family saying why do you want to do that with ma or da?

- And it’s not only that but ma or da can also be very difficult!’

Dublin

Both groups said that it would be better for the Case Manager to be a stranger rather than someone known to them. The Roscommon group felt that the key worker should not be from the local area; however, the Dublin group were divided on whether the key worker could be local or not.

‘I wouldn’t want the town to know my secrets because I would know her and she would know me [the key worker], and she mightn’t say to me what she would say to you ... Because I would know too much about her and her about me.’

Roscommon

‘- Stranger, always a stranger.’

‘- Should be local, know the area, but maybe not know you personally.’

‘- No, they shouldn’t know you personally’

Dublin
When Care and Case Management should start

Finally, the groups were asked to identify at what point in the life of an older person should a Care Management approach begin. Participants in Roscommon gave a variety of responses. One view was related to age:

‘From the age of about 65 you should be thinking of your old age and I mean you’re still young and ... you should start preparing for it and letting the family know exactly what you want.’

Another felt age was less of a determining factor than the state of one’s health:

‘You can get ill at 50 years or 40 years and you mightn’t be ill at 90 years.’

The participants who took part in the Dublin group viewed discharge from hospital as a key event that would necessitate Care Management:

‘Would it not be a good idea to appoint a key worker to the hospital ... would it not be his or her job to contact the party who organises home care and say “Go to that particular house because so-and-so is coming home in a wheelchair”?’

Another option was to defer to the general practitioner as the key person to determine when Care Management should start. The group did not reach a consensus on what the best way to go was in this regard.

4.13 Conclusion

The results from both Phase One and the focus groups held with older people showed that community services for older people, as with other sectors, were under severe strain due to lack of resources and serious difficulties with staff recruitment and retention. Services were seen as fragmented into separate disciplines within the health boards, and relationships between the health and social services were described as underdeveloped. The interviewees also reported underinvestment in infrastructure and administrative resources, with a consequent inability to gather and maintain up-to-date records that can track clients in and out of different health care settings and monitor
their changing health status and needs. Older people especially pointed to the increased need for care workers to take over the role that would once have been fulfilled by the extended family, and how problems with public transport, or the lack of it, made travelling to access services increasingly difficult.

However, there was also substantial reporting and evidence of a concerted policy and organisational shift throughout the health services, and a growing recognition of the need to integrate services and adopt a person-centred approach to care for older people. A strong informal communication network was seen to exist among health and social service professionals. There was also an expressed understanding of the rights and dignity of service users, and a concern that older people might not feel able to speak out. The older people interviewed in the two focus groups reacted positively to the concepts of Care and Case Management as approaches to care for older people.
Chapter Five

Phase Two: Towards a Best Practice Model for Care and Case Management
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Summary

- A number of projects and activities which shared the aim of preserving the independence and dignity of older people for as long as possible in their own homes were discovered during the course of fieldwork. It was agreed that the best use of the information gathered was to further the development of best practice models of Care and Case Management.

- Two models of Care and Case Management were developed on the basis of a literature review, Phase One interviews and focus groups with older people.

- Model A proposes a dedicated Case Manager working under a Co-ordinator of Services (or Care Manager).

- Model B proposes a multi-disciplinary team from which a Case Manager is appointed per care recipient according to the main assessed needs of that recipient. This team would also work to a Co-ordinator of Services.

- Feedback was invited from key informants working with older people on aspects such as terminology, professional background, education and training, communication and reporting relationships, links between health and social services, devolved budgets, evaluation and assessment, and preference for one model or the other.

- Overall, Model A emerged as the preferred model for the respondents consulted.

The consultation identified many more projects and activities than had been anticipated by the National Council for Ageing and Older People (NCAOP) in planning the study. Nine pilot projects emerged during Phase One of the fieldwork that were either planned...
or had already been implemented within health boards. These projects shared the aim of preserving the independence and dignity of older people in their own home for as long as possible. It also became apparent that all of the pilots were operating under severe external constraints, most notably staffing difficulties and inadequate administrative resources. Thus, the original aim of the study – to develop a practice model which could be launched as a pilot project to stimulate activity for Care and Case Management in Ireland – was deemed unnecessary since there was evidence that such activity had already been evolving independently in a variety of locations. This welcome discovery led to a reformulation of the aim of the project after Phase One following discussion between the research team and consultative committee.

5.1 Phase Two

Because of the current state of development, as identified in Phase One, it was agreed that the best use of the information gathered during the fieldwork was to further the development of ‘best practice’ models of Care and Case Management in the context of the Irish healthcare system.

The purpose of a best practice model is to fix points of reference to which those working in the field of Care and Case Management can aspire. According to the Case Management Society of Australia, best practice standards and models exist in order to ‘... provide a framework for identifying Case Managers’ roles in a range of settings ... [and] ... to provide a framework for translation into working tools to enable Case Managers to function effectively’ (CMSA, 1999:2). Best practice models also provide managers with goals to define and establish criteria for performance evaluation.

One task in developing a best practice model is in discriminating between different structures of care delivery. What specifically does Case Management – as the implementation of Care Management in the community – look like? How will we know it when we see it? Although having a specific organisational structure for delivering care does not in itself constitute a Care Management approach, determining a structure is often a key first step in planning a Care Management programme and often has significant consequences for its subsequent feasibility and ability to deliver quality care.

Challis (1999:72) has previously outlined three main emergent structures that Case Management follows: a) Case Management as a specific job, i.e. the employment of a dedicated Case Manager; b) Case Management as a task within an existing job role within a single agency, i.e. a nurse who also performs Case Management tasks as part
of her job; and c) Case Management as a job or task within a joint health and social work structure. The third approach to Case Management does not apply here as there are no joint health and social work structures currently operating in the Irish health system. However, the first two forms are taken as possible models suitable to the Irish context.

Having a dedicated Case Manager (which we will refer to as Model A) has the advantage of having personnel who devote all their time to the tasks of Case Management. This could facilitate the creation of strong client-provider relationships, the building of good relationships with informal carers and the ability of the Case Manager to give more time to his or her clients than would otherwise be the case. However, in a situation of scarce staff and resources, recruitment difficulties may restrict the number of Case Managers available. In addition, the infrastructural requirements (e.g. a common patient chart database across health services – the unique patient identifier system) for effective dedicated Case Management are currently not in place in Ireland.

Utilising Case Management as a task within an existing job role within a single agency (which we will refer to as Model B) has the advantage of eliminating the need to recruit extra staff on top of the existing complement. Rather, existing personnel could be trained up to become Case Managers while retaining their other roles within the agency. However, there is a danger that these personnel will become so over-stretched that it becomes increasingly difficult for them to carry out the core tasks of Case Management, and almost impossible to build meaningful relationships with either clients or carers. In addition, deciding who should be trained as a Case Manager can give rise to inter-agency, inter-professional and inter-personal tension if Case Managers are perceived to be of higher status. One possible way around this is to adapt the key working system, whereby a multi-disciplinary team is created. A client is assessed by the team and a Case Manager appointed according to the main needs of the client.

Both approaches to Case Management therefore have advantages and disadvantages. Information from the interviews showed evidence of these two main approaches, according to both the expressed desire of the participants and the strategies undertaken by the pilot projects identified in Phase One. The aim of the Phase Two, therefore, was reformulated to specifically address the issue of which structure of Care Management best suits the Irish system of care. Each model as presented in Phase Two will be outlined in more detail below. Both Model A and Model B were presented to key informants in order to learn more about the feasibility of each.
5.2 Model A – A Dedicated Case Manager

The first model posits the existence of one dedicated Case Manager within a defined catchment area who works under a Co-ordinator of Services for Older People. This model is similar to the model proposed in the *Action Plan for Dementia* (O’Shea and O’Reilly, 1999). The older person can access the Care Management service either through self-referral, through the public health nursing service, social work (hospital-based or community-based), hospital-community liaison teams, or the general practitioner. The case is first passed to the Care Manager, or Co-ordinator of Services, who then assigns a Case Manager to the client. The Case Manager, in consultation with the older person and informal carers, assesses the older person to determine his or her needs. Between the three of them, a care plan is drawn up according to the needs and wishes of that person, taking into account the wishes of informal carers. The Case Manager is backed up by a multi-disciplinary team of service providers, including social and voluntary agencies. This team should include services such as public health nursing, occupational therapy, physiotherapy, home help and personal care assistance, counselling, psychology, social work, and community welfare as well as links with consultant geriatricians and key voluntary service providers. Any specialist services required such as speech and language therapy, chiropody, alternative care such as reminiscence therapy, massage and so on, are met with on a regular basis, as are the public health nurse and the general practitioner. The on-going implementation of the plan is monitored and reviewed regularly by the older person, informal carers and the Case Manager, who acts as a key contact for the client.
Model A – Process of Service Delivery

- Self-care and family assisted care until older person decides to notify
- Co-ordinator of services
- Case Manager
- Meets with care recipient and family
- GP and PHN/Social Worker
- Community-based services and additional services
- Case manager, care recipient and family
- On-going implementation and re-assessment of plan
- Care Plan
- Specialist Services
The key difference between this and the previous model is the absence of a dedicated Case Manager. Rather, on referral to the co-ordinator of services, the needs and wishes of the older person and appropriate informal carers are assessed by a dedicated multi-disciplinary team. A Case Manager is appointed according to the main needs of the older person. For example, if an older person’s needs are mainly for social work services, then the Case Manager for that person will be the social worker on the multi-disciplinary team.
Model B – Process of Service Delivery

- Care and family assisted care until older person decides to notify Co-ordinator of services.
- Self-care and family assisted care until older person decides to notify Co-ordinator of services.
- Multi-disciplinary team meets and assesses care recipient and family.
- Care manager from team appointed according to client’s key needs.
- GP and PHN/Social Worker.
- Case plan.
- Specialist Services.
- On-going implementation and re-assessment of plan.
- Community-based services and additional services.
Models A and B were presented to a number of key informants in health boards and other agencies working with older people. They were invited to comment on any aspect of the models of Case Management. However, feedback was invited on the following specific aspects:

- terminology
- the background of a Case Manager (i.e. professional training and work experience)
- education and training
- communication and reporting relationships
- linking health and social services
- devolved budgets
- evaluation and assessment
- preference for Model A or Model B.

The results of this feedback are provided below.

5.3.1 Terminology

The question of how to describe Care and Case Management and what to call a Case Manager gave rise to mixed responses. Concerns included the need to place more emphasis on the social aspect of care. One person felt that ‘a stronger emphasis needs to be placed on the fact that the needs of older people go beyond those which are ... health related’. In terms of the title of the person who would fulfil the Case Management function, concerns were expressed that calling them a Case Manager carries connotations of depersonalisation of older people into ‘cases’ managed by professionals. Suggestions for different titles included Care Managers or Care Co-ordinators.
5.3.2 The Background Of A Case Manager

All concerned felt that Case Management entails specific core skills such as counselling, mediation, advocacy, conflict resolution and management skills. However, the question remained of which, if any, professional background a Case Manager should come from. One view was that the allied medical professions, such as occupational therapy, physiotherapy and so on, were not trained in these skills, but that they could undergo extra training in order to acquire them. Another view was that social work was ideally suited to the role of Case Manager, with nursing and occupational therapy also fairly well suited to the role. Some felt that a training programme would be essential to become a Case Manager.

5.3.3 Education And Training

Education and training for Case Managers were seen as extremely important. One view was that without training, there is a danger that the financial and organisational aspects of service provision will take over the process. One person suggested that training ‘on the job’ might be a way of getting around the difficulty of finding fully trained professionals in the first place. For Case Managers who will be working with older people with specific needs for the first time, training was seen as essential, and experience desirable. Key aspects of training cited were:

- conflict resolution and negotiation skills
- counselling skills
- advocacy
- management skills
- knowledge of organisational structures.

5.3.4 Communication And Reporting Relationships

There was a variety of views on different aspects of communication. One person felt that the existing informal communication system could be useful in helping Case Managers to overcome difficulties in creating comprehensive packages of care in a situation of scarce resources. There was concern that formalising communication networks could result in Case Management being driven by costs and budgets. Another respondent looked at the issue of reporting relationships. This person expressed the
view that trying to negotiate existing reporting relationships could be problematic. However, he felt it important that these relationships be clarified, as ‘... the communication of information regarding the needs of those clients and the lack of services will influence planning for the future.’ Necessary improvements in communication were mentioned, including publicising the service, upgrading communication technologies between different services and standardising record-keeping systems.

5.3.5 Links Between Health And Social Services

This arose as a major area of concern. Respondents felt very strongly that the Irish care system was far too influenced by the medical model of health care, which acted as a block to forming further links with social services. One respondent pointed out that in fact there is no statutory service provision for older people in Ireland, neither is there a Community Care Act like that in the UK. This person was concerned that if this distinction was not made then Care Management would become a purely health-based approach.

5.3.6 Devolved Budgets

The issue of devolved budgets was described as highly complex. Most were concerned as to what level should budgets be devolved. The experience of Case Managers in the United Kingdom, whose time became increasingly taken up with budgeting and cost control, was identified by one respondent as a lesson from which one can learn. As one person pointed out, ‘... the budget will drive the service, and people will feel forced to cut needs out’. On the other hand, if budgetary control remains at senior management level, there is a danger that Case Managers will have no authority to buy in necessary services and it will become increasingly difficult to co-ordinate the different services, negotiate with service providers and, most importantly, to deliver comprehensive packages of care according to the wishes of the recipients of care.

5.3.7 Evaluation And Assessment

Results from Phase Two of this project indicated that of those working with older people in Ireland (e.g. key professionals, volunteers), almost all were interested in evaluation which focuses on the care recipient. The impact that the programme has on their life, and more specifically their quality of life, was of particular importance. One participant in Phase Two indicated that they felt outcome evaluation should be an ‘individualised process’ suited to the needs to the particular person. This participant also admitted that
this would certainly complicate any evaluation efforts, but ‘should nevertheless be an integral part of case management’. A few participants emphasised the need to look beyond the traditional ‘medical’ aspects of care, and the need to include social and community factors and supports. While one participant was interested in evaluation that might reveal if the goal of allowing the older person to remain in their own home was met, another participant pointed out that staying at home may not be in a person’s best interest. They felt that setting such a criterion for success (the person remaining at home), might not be the most appropriate or ‘best outcome’ given a particular person’s circumstances. Thus, having such a strict measure of success might be ‘done to the detriment of the person and their carers’. Very few mentioned the financial aspects of evaluation, but those who did agreed that it should be weighed with outcome indicators.

Others who participated in Phase Two of the project indicated that they felt that they did not have enough expertise to comment on evaluation methods or tools. These types of comments may indicate a level of need for training in evaluation methods for those who are in a position (such as front-line workers) that may require their engagement in evaluation efforts. Education about how and why they are collecting certain kinds of data may serve to solidify their commitment to evaluation efforts.

5.3.8 Preference for Model A Or Model B

Overall, Model A emerged as the preferred model for the respondents consulted. This was felt to be the case for a number of reasons; firstly that the problems of older people are complex. Another view was that carer’s needs should also be taken into account. The third reason that was cited was was that unless there is a designated person with a specific remit to organise care, the person involved may be compromised as he or she seeks to balance their role as Case Manager to a group of older people with their general professional remit. A fourth reason provided was that trained professionals in all areas of current service provision are over-stretched and therefore may not be able to perform the extra commitment of Case Management; and finally it was pointed out that the training of all staff, many of whom may not be interested in Case Management, would not be feasible or cost-effective.

Taking into account this preference for Model A, along with the strong preferences expressed in the focus groups with older people for the presence of one dedicated Case Manager who could act as a point of contact during the care planning and implementation process, and the point made by Challis (1994:63) that in the UK key worker approaches (where a ‘near’ Case Management role is tagged on to a person’s existing job) have ended up aiming to co-ordinate single services or teams with little collaboration between agencies, Model A appears to be the more acceptable option to propose.
Chapter Six

Evaluation of Care and Case Management
Chapter Six
Evaluation Of Care And Case Management

Summary

- Evaluation is necessary to provide a knowledge base of information from which to improve services and demonstrate their impact.

- Evaluation should be distinguished from assessment, monitoring, reassessment and quality assurance.

- Various types of evaluation exist which may be utilised in the context of Care and Case Management, including descriptive evaluations, programme reviews and impact evaluations.

- The focus of any Care and Case Management evaluation needs to be determined; examples of structure, process and outcome, and definition-based; and philosophy-based evaluations are provided.

- The importance and difficulties of including the service user perspective in any evaluation are highlighted.

- The special considerations necessary to undertake an evaluation of Care and Case Management costs are provided.

The final objective of the research project was to develop a system of evaluation which would be appropriate and valid for ongoing quantitative and qualitative review of the Care Management pilot projects. Before discussing the issues relevant to the development of such a system, a brief overview of why evaluation should be a necessary component of any Care Management programs in Ireland is outlined below.
6.1 Why Evaluate?

Although many key professionals have begun to undertake Care Management projects because they have ‘bought into’ its philosophy or believe that ultimately it will make a difference in the lives of older people, the importance of critically evaluating its impact should not be underestimated. In the flurry of activity needed to get a project off the ground, ideas about evaluation are understandably set aside. However, the early stages of project development are often the best times to build in considerations regarding how the project will be able to evaluate its effects.

Why is outcome evaluation important? First, outcome evaluation can provide the base of information that services need in order to improve their services. The methods used to allocate services, target clients, supervise staff and efficiently and effectively operate can all be informed by evaluation. If evaluation efforts do not provide useful information to the providers of care regarding how to best to care for the people they serve, then the service providers will have no incentive to participate in evaluation efforts. Second, at some future point, most services need to not only demonstrate their accomplishments, but also the effectiveness of their services. Third, even though projects and plans begin with the best of intentions, factors such as poor translation of aims into action, ‘real world’ constraints and unanticipated events and effects mean that they sometimes do not provide what may be considered best care.

6.2 What Is Evaluation?

Outcome evaluation should not be confused with other project activities that also critically examine aspects of the programme, such as assessment, monitoring, reassessment or quality assurance. These activities, however, may serve a role in evaluation efforts and need discussion in their own right.

6.2.1 Assessment

Most professionals would agree that in order to develop a care plan, a structured assessment is necessary. Typically, its purpose is to identify the individual’s difficulties or problem areas, but it should also include identification of strengths and supports to that person. While programmes often aspire to undertaking a holistic view of the individual, the individuals administering them often resort to assessing those specific areas and factors that they themselves value most or are most competent at assessing.
Equally they may only assess the factors that are most amenable to change through their given profession at intervention. Standardising the assessment procedures and measures is of key importance in enabling comparisons across projects and/or health boards. Each project must similarly determine the characteristics of the older people that they are serving and their level of need. Without standardised assessments, project evaluation would be akin to comparing apples to oranges. For example, projects that targeted older people who were at much greater risk for hospitalisation or had higher levels of unmet needs might be unfairly evaluated against those projects that targeted a less needy group.

In the UK, the recent policy document *A National Service Framework for Older People* (Department of Health, London, 2001) recommends a ‘single assessment process’. This document underlines the importance of having a standardised assessment process, which is of a high standard, and is tailored to their needs. A ‘fuller’ assessment (which assesses a number of domains to identify any unmet needs) may be required for some older people. This fuller assessment may identify an area of concern that requires a more detailed or specialist assessment by a qualified professional. Thus, although there is a single assessment process, there may be more than one tier of assessment. The single assessment process is designed to decrease duplication and provide a more seamless service.

### 6.2.2 Monitoring

Once a care plan is initiated, procedures must be put in place to ensure that the care plan is appropriately carried out. Monitoring is critical to the role of a Care Manager so that any changes in an older person’s status can be responded to quickly and appropriately. The frequency with which monitoring occurs may largely depend on the scope or intensity of that person’s needs and the types of services provided to them. For example, monitoring may occur much more frequently after a discharge from hospital to ensure that all the community care services are in place and that the transition is smooth. Alternatively, once all key aspects of the care plan are functioning and the person’s situation becomes more stable, intensive monitoring is less necessary and may be much less frequent. Unlike assessment, which has as its primary focus the individual and their situation, monitoring needs to encompass not only the individual’s current status, but also the procedures and processes that make up that individual’s care plan. For example, if communication breaks down between services, a good monitoring system should be able to detect this difficulty before it unduly impacts on the individual’s quality of care. Because monitoring includes activities relevant to the process of care, its undertaking can also inform the process components of any evaluation efforts.
6.2.3 Reassessment

In theory, a good monitoring system should identify any new unmet needs or difficulties of an individual. However, the benefits and importance of a formal reassessment should not be underestimated. Reassessments can be scheduled to occur after a specified period of time, or initiated after some event which may indicate a change in an individual’s status or needs. Because of its regularity, or because it may initiate a change in the care plan, the reassessment period is often a good time to collect data for outcomes research.

6.2.4 Quality Assurance

Also referred to as quality control, quality assurance involves activities that occur after project evaluation. Once it has been established (through evaluation) that a project is achieving its goals and desired effects, the next task is to ensure that it continues to do so. Programmes that are initially successful can easily lose their effectiveness over a period of time because of the interdependent nature of the factors making up the solution to a complex problem. Factors such as changes in key personnel, changes in the characteristics of the older people being served and competing demands on resources such as time and money to name a few, can have a substantial impact on the effectiveness of any programme. Quality assurance effectively means compliance to standards. In order to have any meaningful quality assurance, two components are necessary. First, the project must be operationally defined – what is Case Management and what is not? Second, the standards need to be developed – what exactly constitutes a successful Care Management programme? Setting these programme standards can also be considered establishing ‘best practice’ (see below for further elaboration). Until the programme is defined and the standards set, it is not possible to assess the quality of its service (Applebaum, 1991). Combining the tasks of evaluation and quality assurance results in a comprehensive approach to ensuring high quality care.

6.3 Types Of Evaluation

Programme evaluation can take place to varying degrees. It may be simpler to conceptualise evaluation efforts along a continuum with three main types emerging: evaluations describe the programme’s main components (descriptive evaluations), evaluations that review the quality of a programme’s practice (programme review), and evaluations that determine the effects of a programme (impact evaluation). Each of these types builds on the knowledge of the previous type, with impact evaluation requiring the most expertise and resources to carry out. A full description of each of these types of evaluation is provided in Appendix G.
6.4 What Should Be Evaluated?

Regardless of the type of evaluation undertaken, the content or focus of that evaluation needs to be determined. What aspects of the programme or model should be evaluated – the organisation of the model, the process of delivering the services or the effects on the people it aims to serve? There are several alternatives from which to choose.

6.4.1 Structure, Process And Outcome-Based Evaluations

Traditionally, attempts at evaluating programme quality have focused on three main areas: structure, process and outcome (Donabedian, 1966). Although each of these foci roughly correspond with each of the three types of evaluation (i.e. structure with descriptive evaluation, process with programme review and outcome with impact evaluation), various components of each can be considered in each type of evaluation. For a recently developed measure that specifically focuses on the structure and process of care from the perspective of the service user, see Sixma et al, (2000) (Appendix C).

A focus on the structure of a programme examines the organisational framework from which the programme is managed and the integral components that it constitutes (Appendix D). Examples of structural content include the following:

- access to services
- information
- transportation
- eligibility for services
- timeliness of care
- location and time care delivered (irregular hours?)
- types of services available
- quantity or intensity of care
- co-ordination of services
- qualifications of practitioners or training of service providers
The focus on the process of care, or the way in which the services are provided, can also be a main focus of an evaluation (Appendix E). Example of components which are more process focussed are given below:

- procedures and courses of treatment
- number of individuals served
- quality of care
- appropriateness of care
- comprehensiveness of care
- communication of care
- involvement in decision-making
- feedback mechanisms
- convenience
- responsiveness.

A focus on the outcomes of care results in a different set of criteria, typically focussed around the recipient of care. While traditional characteristics are almost always included, such as the individual’s functional abilities, various other situational aspects of the individual’s circumstances are increasingly included (Appendix F). (Note that specific measures have been developed for many of these types of outcomes and are outlined in Appendix C.) The following list illustrates the scope of personal characteristics that have been used:

- demographic details, financial resources
- psychological well-being: mental status, cognitive functioning, mood/emotional well-being

13 Due to the complexities of evaluating ‘cost’, considerations and guidelines for evaluations of cost will be considered separately at the end of this section.
physical status: medical history, communication and hearing, vision, nutritional status, oral/dental health, skin condition, continence, medications, special therapies, physical functioning, activities of daily living, activity pursuit pattern

social support: family support, degree of isolation

environment: transportation, housing (living arrangement, accessibility, condition)

current use of services

carer’s physical and mental status.

6.4.2 Definition-Based Evaluations

An alternative to working from the above framework is to focus the content of the evaluation around a pre-existing definition, such as an operational definition of Case Management or a definition of an effective Case Manager (e.g. a position description) that outlines their roles and responsibilities. The broad categories that could be considered working from one programme’s description of a Care Manager are as follows:

- case finding
- screening for eligibility
- assessing care plan
- care planning
- implementing care plan
- integrating care
- monitoring care plan
- advocating.

One advantage of this method is that it focuses directly on Case Management and avoids aspects of the situation that are less likely to change. Take, for example, someone with a chronic illness that affects their physical functioning, such as someone with severe arthritis. Part of the care plan may be to have someone come into their
home to help with daily household tasks, such as cooking and cleaning. One may then argue that including those elements that are unlikely to change during an evaluation period, such as that person’s physical functioning, is uninformative. What may be of more importance in the situation is whether the individual believes that the Care Manager has found an appropriate and satisfactory solution to their needs around cooking and cleaning, has increased the communication levels between his or her providers, responded quickly in times of crisis and provided a package of care that meets all their needs. One recently developed measure that specifically evaluates the quality of Case Management activities from the care recipient’s perspective is the Home Care Satisfaction Measure (HCSM). Unlike other measures developed on an ad hoc basis by professionals to cover various aspects of care, the HCSM was developed by the users of the services themselves. They determined the content and the wording and thus defined the ‘standard’ of quality care from their perspective (Geron, 1999).

6.4.3 Philosophy-Based Evaluations

Although similar to the above approach, the development of the content of an evaluation based on the underlying philosophies or values of Care Management can yield slightly different types of questions. The following provide an example of evaluation questions based around various values:

- are the packages of care developed needs-focused?
- are the structure and process person-focused?
- do the assessment and the care plan view the person in a holistic manner?
- is the care plan flexible?
- does the process facilitate or allow choice?
- does it build self-respect and self-esteem?
- does it promote partnership?
- does the care plan maximise the individual’s health and well-being?
- are the services integrated?
- is the process an empowering one to the individual or their family?
- are the services delivered in a manner that promotes anti-ageism?
6.4.4 Service-User Perspectives

Regardless of which type of evaluation is conducted, the actual content of the evaluation can often be viewed from more than one perspective and include that of the service user, the informal carer, the Case Manager or the Care Manager. Considerations should be made as to who might be in the ‘best’ position to evaluate certain aspects of care. Of course, gathering the perspectives of more than one stakeholder in a single evaluation can provide a richer description of situation, but may also yield conflicting findings. Each person involved in the care plan may have their own, very different view as to how the Case Management system worked. For example, the older person may evaluate the care plan as adequately addressing their needs, while a family caregiver may feel the opposite – that the care plan falls short of what the older person requires, as their responsibilities have not decreased. Examining a different aspect of the system, a Case Manager may evaluate their case load as having nearly the maximum number of people that they can serve while continuing to provide a quality service. Alternatively, the Care Manager may evaluate the same case load as too light, with many more people requiring the services of the Case Manager.

Appendix I lists a number of possible evaluation indicators and indicates who in the Care and Case management system might be approached for their perspective or included in the evaluation process. Some indicators can easily be evaluated by any of the parties involved, such as the timeliness of the care provided. Other indicators, such as the qualifications of the service providers involved, are more easily and more appropriately obtained from certain perspectives. In this example, either the Case Manager or the Care Manager would be more knowledgeable about what qualifications a service provider should possess for working with an older person with a specific problem, such as dementia. An example of a recently developed structured assessment that tries to take account of various perspectives is the Camberwell Assessment of Need for the Elderly (Walters et al., 2000) (Appendix C).

While professional perspectives have traditionally been included in evaluation efforts, service users’ (or consumers’) perspectives are now increasingly sought. Indeed, most services and organisations now stipulate that service user perspectives be incorporated into evaluation efforts, including the Department of Health and Children in their new National Health Promotion Strategy (2000). The benefits of utilising service users’
perspective are many: it contributes to improving the quality of care; it brings service users and professionals together; it serves to counterbalance powerful interest groups and professionals, and it raises awareness of both individual and collective needs (O’Sullivan, 1998).

However, as this type of research has become more widespread, many researchers have noted difficulties and limitations in obtaining user satisfaction information, especially among older service users. Bauld et al, (2000) recently outlined some of the major findings in this literature. They found that older people were more likely to report higher levels of satisfaction than younger people, which indicated a certain amount of response bias. Further, the cause of this bias may be due to a number of interrelated factors. Among the factors identified were older people’s dependency on service providers, their reluctance to criticise individual workers, their lower expectations of what a service can provide, their lack of knowledge of alternatives or standards, their unwillingness to criticise entitlements and the power differences between them and service providers. The researchers also found that global measures, such as a single item asking for an overall rating of a service, are more subject to this response bias than questions about specific aspects of the care provided. Further, certain circumstances (e.g. poor health, depression, cognitive impairment, recent discharge from the hospital and changes in medication) may also affect an older person’s responses. Based on their findings, they suggest some strategies for improvement in these types of evaluations:

- combine global satisfaction measures with service specific measures
- assess satisfaction over time, rather than once-off
- assess satisfaction in conjunction with other indicators, such as changes in physical or mental health
- use multivariate techniques to analyse any response bias
- use mixed methods (surveys, focus groups, in-depth interviewing) in the study design (Bauld et al, 2000).
6.5 Who Should Evaluate?

When considering any programme of evaluation, the question of who should participate in the evaluation process is often one of the last questions considered. However, during the initial stages of planning, including those who will play some role in the evaluation is critical. This may include those who collect, collate and analyse the data, and those who will be using the data for service planning and development. A 1993 Social Service Inspectorate (SSI) study of assessment procedures in Case Management in the UK provides an example of why key professionals need to be informed and involved in the evaluation process. When asking key professionals about their assessment procedures, they found that the purpose of the assessment was frequently unclear – whether it was to guide assessors, to demonstrate accountability, or to involve the service user. Further, the information that they gathered lacked reliability and validity as much of what was collected varied in content and quality. Closer examination of the information revealed that the categorisation of the needs of the client was poor, and it was difficult to identify the links between the problems identified and actions undertaken in response to them in terms of the care plan. Staff conducting the assessments found the procedures to be very complex and time consuming. Finally, the study determined that the assessment tools and documentation, which were generic in nature, were not well suited to the needs of specific user groups (Challis et al, 1995). The problems identified in this UK study can provide guidance on how similar difficulties can be avoided or prevented in the development of programmes in Ireland. Specific training in evaluation and the inclusion of all personnel involved in the Care and Case Management process will enable the anticipation and avoidance of these problems.

6.6 Economic Evaluations

Evaluations which are concerned with the costs of a programme require additional considerations; therefore, they are discussed separately below. Although the rationale for adding an economic component to an evaluation is similar to those given for other evaluations, a brief review of the financing of long-term care and Care Management may set the context for this type of evaluation.
6.6.1 Background

Since the early 1990s, the method in which health care is financed and delivered has been undergoing significant review and reform in developed countries. The development and growth of models of Care Management is a part of this process of evolution. This general process of reform and review is being driven by several economic and demographic factors, such as the rising costs of health care, an ageing population, advances in medical technology and people’s increasing expectations of good health over time.

6.6.2 Functions Of An Economic Evaluation

It is against such an economic background that any evaluation of Care Management must take place. Economic evaluations/appraisals are generally undertaken where there is choice to be made, i.e. where different methods of delivering care are available and guidance is needed in identifying the option which gives the best outcome relative to cost. It should be noted that the default decision is to retain the current method of delivering care – to leave the system in its pre-intervention state. While the current state of delivery may be unsatisfactory, any new method of delivery should be formally evaluated and contrasted with current provision.

In the current buoyant economic environment, there has been an increased allocation of funds to the entire health care sector in Ireland. This cannot be guaranteed into the future. In addition, Care Management is in competition for these funds with all other sectors within health care across the entire spectrum from community to acute care. In order to effectively compete for these funds it would be highly advantageous if quantitative data could be drawn upon to show the relative effectiveness of Care Management. Thus an evaluation process can serve three distinct functions, and parallel the three types of evaluations presented earlier:

- to provide a framework for budgeting and planning (descriptive evaluation)
- to justify funding for the programme in the future (programme review)
- to serve as a key indicator to aid in deciding amongst the various proposed models and scope of care delivery (impact evaluation).
6.7 Data Requirements

In order to perfectly fulfil all three functions, complete information is needed on the following:

- the old/current system of managed care – the resources it consumed and what outcomes it achieved
- the new/proposed system – the resources it will consume and the outcomes it is projected to achieve/is achieving.

In reality, some of this information may be impossible to obtain, in other cases it may not be feasible. In all cases one seeks to utilise the best available relevant information. In terms of the above functions and information required it can be broken down as follows:

- budgeting and planning: information required on resource usage of new system (system inputs)
- funding justification: new system inputs and some measure of new system outcomes
- decision making (between different projects): new system inputs, old system inputs, new system outcomes and old system outcomes.

Note that, at the very least, information on new system inputs is required, with the inclusion of the other data dependent on which functions are to be exercised. It is generally the case that much of the information regarding the existing/old system would have to be estimated. The inclusion of an analysis of the cost-outcomes of the existing system as it stands can also play an important role in justification.

Just how broad and inclusive the analysis should be, and the degree to which this is feasible, needs careful consideration. There may be costs (and indeed benefits) which are not immediately apparent and which may be difficult to quantify in monetary terms. The following general costs would have to be calculated or estimated:

- direct costs of care such as hospital care, nursing home care, primary care services, medications, equipment and appliances, home help, service administration procedures, diagnostic tests etc.
- indirect costs of morbidity and mortality including the value of lost productivity through morbidity, disability or premature mortality
opportunity cost to the individual and/or family may not be immediately apparent on preliminary investigation of the service, however the substitution of formal for informal care and any associated loss of earnings of a family carer are relevant in this instance

intangible non-financial costs such as pain, anxiety and reduction in quality of life can affect both the care recipient and society at large.

The costs listed above can be grouped further under the general headings of staff, consumables, equipment and buildings:

- staff: those employed by the system, hours they work, compensation they receive and breakdown of work time, i.e. time spent in transit, actual contact time with clients, time spent in administration, etc.

- consumables: all consumables used in execution of service

- equipment: all equipment/appliances used in execution of service, depreciation on same

- buildings: physical space required to run service, rent of this space.

The above describes in general terms the range of information which could be collected. It may either be impossible or unnecessary to take a very broad view of costs and outcomes; nevertheless it must be acknowledged that there are items of cost associated with Care Management which are not borne by the system directly. Many of the direct costs can easily be collected using relatively straightforward resource analysis. The estimation of indirect costs is more complex, though its exclusion could significantly bias any conclusions.

Economic evaluation projects have the potential to be very complex, particularly when it is necessary to reflect the variety of systems which may develop within a country to service overlapping needs. For example, Canada has undertaken a national evaluation of the cost-effectiveness of home care. It involves fifteen separate studies and three service themes: a) home care as maintenance of the status quo, b) home care as a substitute for long-term care, and c) home care as a substitute for acute care. Thus we must consider what function we wish the evaluation to serve, its depth and scope and its feasibility.
6.7.1 Prerequisites For Economic Evaluations

First, what is the goal of the evaluation? Is it to inform budgeting and planning, justify continued funding or a decision-making aid in choosing between two alternatives? The requirements of each are outlined below:

- **evaluations for budgeting and planning:** good management requires good information. The ability to accurately gauge service needs and the various resources required to satisfy them is fundamental to the efficient provision of any service. Budgeting and planning is not a form of economic evaluation; however, this is a vital function which economic evaluation can fulfil during the course of its normal operation. The information required to undertake service planning provides the core information for any ongoing economic evaluation. This includes investment in relevant information technology and the collection and analysis of data beyond that of accounting purposes.

- **evaluations for funding justification:** as discussed above, access to financial and other resources cannot be guaranteed beyond the short term. At the very least a structured economic evaluation of Care Management will provide solid evidence in an easily understood form of true costs and benefits of the services.

- **evaluations for decision-making:** one of the main problems faced in undertaking an economic evaluation of Care Management at this time is the lack of information which in turn reflects the lack of structure in the current system. We have little information on how the existing service delivery methods have performed in the past and what resources they have commanded. An attempt to reconstruct the inputs and outputs of the existing system so that it may be compared to the costs and benefits of an alternative method of delivery is both unfeasible and unnecessary. Consistent collection of relevant information on any new system of service provision from implementation will not only provide sufficient data for service planning and advocacy, but will also facilitate decision-making in the future when adjustment, additions or alternative methods of service delivery are considered. At a minimum, good management and good planning should require that objective A is realised as a matter of course. The formalised collection and analysis of the information collected to achieve this primary objective will, over time, naturally satisfy the requirements for objective B. The same scope and quality of data thus routinely collected and collated will, when necessary, provide sufficient information to inform decisions under objective C.
Chapter Seven

Discussion –
Prerequisites for Effective Care and Case Management
Chapter Seven
Discussion – Prerequisites For Effective Care And Case Management

Summary

- Both roles – Care Management at the planning and managerial level and Case Management at the operational level – should be situated in the context of the Irish health care system and take account of the particular constraints and opportunities in place.

- A number of prerequisites for the organisation and administration of care in the community in Ireland are necessary before Care or Case Management can be effectively implemented.

- Prerequisites for the effective implementation of Care Management via a Case Management service delivery mode include:
  - a consistent and agreed terminology
  - the adoption of core principles outlined in the report at a national and local level
  - the situation of Care and Case Management within an ongoing and iterative continuum of care
  - the recognition of the central role of the service user and his or her family at all stages of the care continuum and Case Management process
  - the clarification of the core skills, roles and reporting structures necessary for both the administrative tasks of Care Management and the operational tasks of Case Management
7.1 Introduction

Care Management will not work unless the system is embedded in the context of the Irish health care system, with its resource constraints and opportunities afforded by strong informal communication systems and a strong community and voluntary sector. However, while acknowledging the need to situate Care Management in the context of current care provision, Care Management will not be implemented effectively without the development of service policy and increasing the resources of services for older people.

7.1.1 A Consistent Terminology For Care And Case Management

Although the motivating factors for the introduction of Care and Case Management have been clearly outlined (i.e. a need to co-ordinate existing fragmented services with specific emphasis on improving the links between health and social services; a need to reduce inappropriate admissions to long-stay or institutional care, and a general policy shift towards more inclusive approaches to care), the issues of generating a precise definition of Care and Case Management and the development of an appropriate terminology to accompany it have not been resolved. There is considerable divergence...
in understandings of Care versus Case Management. In addition, the fieldwork undertaken in this study has demonstrated that these terms invoke other meanings which imply certain values or political connotations. For example, some service providers feel the term ‘Case Management’ connotes the depersonalisation of people into ‘cases’ which need to be managed, which in turn could lead to an ageist bias in the delivery of care. Some expressed a preference for the term ‘care co-ordinator’ or ‘co-ordinators of care’. In Ireland, however, Co-ordinators of Services for Older People have already been recruited and are now in position. Their remit is quite different from what is normally understood as that of a Case Manager. Participants in the two focus groups felt that the term ‘key worker’ was easy to understand and accessible. However, it has been pointed out by researchers such as David Challis (1994) that key worker approaches are sometimes quite different from Case Managers and that it is essential to distinguish clearly between each approach. Although this report has used the terms ‘Care’ and ‘Case’ Management to refer to the managerial and operational levels of service provision, it is important to stress that the authors are not promoting this usage as best practice. It is a matter of urgency that agreement be reached on a consistent terminology for use in Ireland.

**Key Prerequisite:**

*The task of developing a coherent and consistent terminology for Care and Case Management in Ireland should be made a priority.*

### 7.1.2 Philosophy And Aim

It is essential to provide a coherent set of ‘reference points’ for Care Management in order to develop a comprehensive set of principles according to an overall philosophical framework (O’Shea and O’Reilly, 1999). The philosophy of ‘best practice’ Care Management is humanistic, person-centred and anti-ageist. It respects the right of older people to make their own choices concerning their own care and to maintain their dignity in the face of increasing frailty. One of the main roles of the Case Manager is to make sure that every opportunity is given to older people to achieve these aims. This underlying philosophy is expressed through the following series of principles:14

Care management should:

- promote an anti-ageist philosophy
- be integrated
- be needs focussed

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14 Developed in conjunction with a National Council on Ageing and Older People working group.

*Care and Case Management for Older People in Ireland*
be person focussed
be holistic
be flexible
build self-respect and self-esteem
facilitate choice
facilitate empowerment of both care recipients and informal carers
promote partnership
aim to maximise the health and well-being for all with minimal disturbance to the end user.

These principles bear much resemblance to those principles that were identified through the literature. However, the principles stated here have been expanded to include those pertinent to the Irish context. First, the evidence of ageism in the system has been relatively neglected so therefore, it is essential that any new model of care should have an anti-ageist philosophy at its roots. Second, in the Irish care system where the medical model plays a dominant role, the links between different sectors must be fostered through partnerships. Third, Care Management should aim to empower and support not only care recipients, but also their informal carers who play a vital role in maintaining the dignity and autonomy of older people. Fourth, the need to promote flexibility in service provision is necessary if the system is to respond quickly and appropriately to the changing needs and circumstances of the older person. Fifth, in conjunction with a clear ethos of promoting self-esteem and empowerment, Care and Case Management should facilitate the ability of service providers to maximise the health and well-being for recipients of care. Finally, note that the principle of cost-reduction does not feature in the above list. The motivation for encouraging the development of Care and Case Management in Ireland is not one of cost-effectiveness, but one which will improve an inadequate health and social care structure for older people.

Key Prerequisite:
The principles set out in this report should be adopted on a local and national basis and be applicable to all potential recipients of care. The needs of informal carers should be sought and supported throughout the processes of both Care and Case Management.
7.1.3 Contextualising Care And Case Management

Care and Case Management cannot be treated in isolation. Any new approach to care must be embedded in a wider context. We have already examined the dimension of the Irish system of care provision and how that will affect attempts to implement Care and Case Management in Ireland. However, another dimension that must be examined is how ageing is constructed and how that can determine when and where to intervene.

The term ‘active ageing’ was adopted by the World Health Organisation (WHO) in the late 1990s, in order ‘to ... recognise the factors and sectors in addition to health care that affect how individuals and populations age’ (Edwards, 2001:17). Active ageing refers to continuing involvement in social, economic, spiritual, cultural and civic affairs as well as the ability to be physically active. Crucially, this model views older people who are unwell or have a disability as remaining active contributors to their families, peers, communities and nations.

If we view ageing from this point of view, then appropriate intervention becomes crucial. One useful way of helping us to understand when to intervene is to view care as an ongoing process or continuum that can be conceptualised as three different levels of care (see Figure 7.1). With increasing needs, the older person may move from one level of care to another, more supported level. Alternatively, if the older person regains their independence in some areas and their needs lessen, a move back to a less supported level may be most appropriate. The three different levels are:

- self care – where the older person is able to look after themself without direct intervention. Health promotion and health information agencies play an important role in empowering the person and their family. They can inform themselves about what is necessary for health maintenance and also about what services are available for future need

- informally assisted care – where the older person is able to look after themself in the main, but has some needs that can be met with the assistance of family or informal care. Both the older person and their carers are supported by health promotion and health information agencies, and initial contact may be made with a Case Manager who will advise on aids, appliances, respite services and other supporting services (including financial aid). It is essential that the needs of informal carers are recognised and taken account of by the Case Manager
Care and Case management – where the older person becomes more vulnerable or frail, the Case Manager becomes more directly involved in supporting informal carers and in the organisation and provision of care services to enable that person to stay at home – or to ‘age in place’ (Marek and Rantz, 2000). This can be as a result of hospitalisation for a short period after an acute phase of illness – the Case Manager will only become involved for as long as is needed but will track the patient afterwards so as to be available if needed again. It can also be as a result of chronic, ongoing deterioration in function. However, the decision to intervene needs to be a consensus decision, with all parties made fully aware of the implications of having a Case Manager intervene.

Figure 7.1: Care and Case Management in the continuum of care

Health promotion and health information agencies play a key role all along the continuum of care.

Key Prerequisite:
Care Management models should be firmly situated in a flexible continuum of care that empowers older people and their carers to make their own choices about care, be it self care, informally assisted care or Care Management. Care Management should be used only when it is appropriate to do so. The continuum of care represents different levels of care that an individual can move between according to his or her changing needs and circumstances.

7.1.4 The Role Of The Service User And Their Family

The service user is central to any effective Care Management system. Any care decision should be taken in consultation with the service user or recipient of care. Although this statement appears straightforward and obvious at first glance, there are a number of complexities and potential areas of conflict. These can include: enabling people with dementia to participate in the decision-making process through a variety of communication techniques (O’Shea and O’Reilly, 1999); negotiating between the various parties involved in the care process (e.g. older people, Case Managers, service providers
and family carers) if their interests and priorities are in conflict over appropriate pathways of care; and balancing financial and resource concerns against the felt and expressed needs of older people. There is growing concern in the UK, in a situation of restricted resources (financial, human and structural), about the extent to which local authorities are able to accommodate user and carer choices to remain at home with health and social care support (Hardy et al, 1999:484).

All of these potential obstacles can make empowering the service user complicated and fraught with tension. Leat (1993) has pointed out that increasing user choice implies much more than a macro level increase in the numbers and types of services available in the community. User choice is also about the small, everyday decisions at each stage of the Case Management process. Service providers should actively work to facilitate older people and their carers in having their voices heard.

**Key Prerequisite:**

*The perspective of the individual older person and their family or informal carers should be placed firmly at the centre of any Care Management initiative.*

### 7.1.5 Core Skills

International literature has outlined the core skills of a Case Manager as those of targeting, pre-screening, assessment, goal-setting and care planning, implementation, and monitoring/reassessment, along with management and inter-personal skills. However if Care and Case Managers are to be truly holistic, it is important that these skills are broadened and translated into a job description that clearly defines the role of a Case Manager. The role-specific skills of both Care Managers and Case Managers fall into two main categories. Some of these are specific to either Care or Case Managers, and some are shared by both as indicated below:
### Table 7.1: Role-specific skills for Care and Case Managers – organisational skills

<table>
<thead>
<tr>
<th>Organisational Skills</th>
<th>Care Manager</th>
<th>Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative skills</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Understanding organisational structures and reporting relationships</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Management</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Financial management</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health and welfare assessment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Programme evaluation skills</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Entrepreneurial skills</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Table 7.2: Role-specific skills for Care and Case Managers – inter-personal skills

<table>
<thead>
<tr>
<th>Inter-personal Skills</th>
<th>Care Manager</th>
<th>Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forming good working relationships</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Negotiation and conflict-resolution</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Counselling skills</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Working with organisational sensitivities</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Working with the local community</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Communication</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Advocacy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Political skills</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Experience of working within ‘human care’ services, such as nursing and/or social work (among others) and of working with older people, should be a prerequisite for any person entering the fields of Care or Case Management for older people.

**Key Prerequisite:**

The core skills of Case Management should be clarified and used as the basis for role description and education and training of Case Managers in the future.
7.1.6 The Professional Background Of A Care Manager

The project revealed many different opinions about the ideal professional background of a Case Manager. Most responses pointed towards either public health nursing or social work. Those who favoured these professions as appropriate for a Case Manager position felt that the training received by them encompassed many of the core skills necessary for a Case Manager. Other respondents suggested that a Case Manager could come from an administrative background, as the core skills of Case Management were not specific to specialist health or social care training. However, the feedback in Phase Two strongly indicated that specialist training and experience was essential for Case Managers. This echoes the views of some of the leading authors in the area who have recommended that Care Management be seen as a new specialisation (Challis et al., 1998). Whatever the training involved, there is a consensus that staff whose sole or dedicated role is that of Case Management are essential.

The relatively recent development of Care and Case Management in Ireland provides a unique opportunity to challenge the dominant medical model of care. This comes at an opportune time, coinciding with investment in and development of the social work service.

**Key Prerequisite:**
The position of a Case Manager should be seen as a new specialisation with training courses open to all those with a qualification in a health or social care discipline and relevant work experience.

7.1.7 Staffing And Recruitment

Effective implementation of Case Management critically depends upon the availability of a wide range of services that can offer real choice to older people and their informal carers. Case Managers cannot design tailored packages of care if the options available are limited to one or two services. Investment in the community sector must become a priority. Additionally, the development of innovative approaches to staff recruitment and retention and a reduction the bureaucracy associated with recruitment and promotion policies in statutory provision need support. A recently completed report by the Department of Health and Children on the current and future supply and demand for specific professionals highlighted the problems that will have an impact on achieving comprehensive Care Management. For example, the report proposes an increase in physiotherapy, occupational therapy and speech and language therapy posts from the current 3,188 to 5,338 posts by 2015 (i.e. an increase of sixty-seven per cent) (Bacon, 2001). In addition to creating new service posts, existing community service provision should be extended to include weekends and after hours working. For example, the usefulness of a home help service that is only available from Monday to Friday between
the hours of 9 to 5 is very limited. Home help services should be available twenty-four hours a day, seven days a week.

**Key Prerequisite:**
*Proactive steps should be undertaken to ensure adequate numbers of qualified professionals are available to staff a comprehensive Care and Case Management Programme. This can be achieved by:

- producing greater numbers of highly qualified graduates in relevant disciplines such that sufficient numbers are available and can be attracted to work with older people
- providing incentives such as flexible working conditions and clear and attractive promotional strategies to help maintain experienced professionals in the public sector. Specific actions include:
  - providing more places on training courses for health and social service professionals
  - providing challenging and attractive work settings to encourage graduates to work in services for older people
  - providing incentives for continued professional development in services for older people (such as grant schemes, scholarship schemes and rewarding placements during training)
- recruitment procedures for health and social service professionals should be made more efficient by reducing the length of time between application, interview and commencing employment and by increasing pay levels to reflect the skills, workload and responsibility of the workforce.

**7.1.8 Education And Training**

Education and training for professionals which challenges them to question their own assumptions about care of older people is essential to ensure that the service user is truly empowered and able to participate fully in the decision-making process. Education should be based both on the principles underpinning Care Management and the core skills of both Care and Case management. Courses could be set up as part of continuing professional development for workers both in the health and social care sectors. (For an example of one such course, see Appendix J regarding the graduate certificates and diplomas in Case Management run by the University of Melbourne, which cover the managerial and policy aspects of the role.) Typically, these courses are designed for those who have obtained an undergraduate qualification in a health or social discipline, and can demonstrate sufficient work experience (University of Melbourne, 2001). However, in addition to these managerial aspects of training, it is recommended that topics such as counselling, inter-personal skills, conflict resolution skills and holistic aspects of care be considered.
In planning these specialist courses, a continuum that builds on the basic professional training of a variety of health and social service disciplines should be developed. Each of the various disciplines should also be encouraged to provide an introduction to Care and Case Management within their own training and to promote anti-ageism in all service delivery. In an evidence-based culture, professional training must include evaluation as a core component of the course (this is discussed in more detail on page 179).

**Key Prerequisite:**
A multi-level training system for Care and Case Management should be developed and incorporated into general training and promotional considerations. Training should be built on the principles of Care Management and incorporate evaluation skills as a core component.

### 7.1.9 Assessment

Assessment procedures and measures need to be standardised to enable evaluations to be conducted across projects or health boards. It is essential that the standardised assessment adopted or developed be structured and based on a holistic view of the care recipient, in order to ensure the development and implementation of an individualised, appropriate and comprehensive care plan.

**Key Prerequisite:**
The development of a standardised generic assessment tool should be made a priority with a view to its implementation as a pilot project.

### 7.1.10 Targeting

If Care Management is viewed as part of the ongoing continuum of care, when Care Management should begin to intervene depends heavily on the wishes of older people themselves and their caregivers. From the viewpoint of the service planners, the question of who should be targeted for Care Management services becomes a complex issue, especially if the goals of equity in the system are considered. The recommendations of the Audit Commission (UK) provide one such guide for determining which older people could be monitored. Those older people at risk of entering long-term care unnecessarily and against their wishes, those in need of rehabilitation after a period of acute illness, those who wish to return to the community from a long-stay facility or those whose primary carers are highly stressed are identified as those most likely to benefit from a Care Management intervention. Additionally, the assumption that everyone should stay at home should not go unquestioned. Ongoing assessment and review is essential to make sure that Case Management remains the most appropriate form of care as the needs of the care recipient and their carers change.
Key Prerequisite:
Care and Case Management for people with specific needs such as those with dementia should be designed in consultation with specialised care teams. The Case Manager should have specific training and experience in working with such groups of people.

7.1.11 Caseloads

The total number of people on care plans that any one Case Manager is responsible for must be limited to a manageable size. Case managers must have the time to develop an empowering relationship, to respond to changes in the needs of the older person in a timely manner and to allow for flexibility in care plans. If caseloads become too high, Case Managers’ time will become increasingly taken up with assessment and eligibility and leave little room for other, equally important aspects of their role. One person providing feedback in Phase Two reiterated this concern:

‘It is essential that a particular Case Manager has a reasonable caseload and is not overburdened with large numbers of people. Obviously they would cease to be effective if this should occur.’

Key Prerequisite:
Caseload sizes should be maintained at a level which enables the core tasks of Case Management to be carried out effectively.

7.1.12 Inter-Agency Collaboration And Multi-Disciplinary Team Working

Ross and Tissier (1997:159) have pointed out that ‘... older people’s needs are frequently varied and seldom fall neatly within the remit of any one of the caring agencies. The importance of co-ordinating flexible care and sharing information is therefore critical to avoid duplication.’ Current care provision for older people in Ireland is, like many other areas of care, heavily oriented towards the medical model. Public health nurses have traditionally been involved in many areas of care which in other countries would fall under the social work/social services remit (Blackman et al, 2001). As a result of this, links between health and social services agencies are relatively weak. These need to be strengthened if a truly holistic approach to care is to be achieved and service duplication avoided. However, this weakness in the care system has been recognised and changes, such as the development of meetings with local county councils or corporations and the creation of more social work posts, are now attempting to address it.
7.1.13 Reporting Relationships

The problem of underdeveloped links between health and social agencies is compounded by the fact that separate disciplines within agencies have their own reporting structures and professional boundaries. Ross and Tissier have documented the difficulties this can pose for a Case Manager:

‘The tensions along the boundary of health and social care services are important issues in the working relationship of the social worker and the district nurse. It is interesting that despite the overlapping elderly client group that the number of referrals from social services to the district nursing team was small ... These boundary problems were reflected in the reluctance demonstrated by some sections of social services to accept the authority of the district nurse in the Care Manager’s role. For example, the occupational therapy manager requested social worker endorsement before accepting a district nurse referral. There was also some resistance by home care staff and hospital social workers. This may reflect the fact that the district nurse was unable to make a substantial contribution to developing the care management role because of resource constraints.’

(1997:159).

This case from the UK illustrates a situation where the social worker in fact holds the balance of power over the district nurse. In the Irish care system, the public health nurse is regarded as a key service provider, while social workers for older people, especially in the community, are almost non-existent (although being developed). However, it provides an example of the tensions that arise with unequally distributed power among disciplines and personnel. Whatever the situation, any Case Manager, whether coming from an administration, health or social services background, will have to overcome the tensions and communication gaps that exist between health, psychological and social services. It is also essential to recognise the dual commitments assigned to many health professionals; they often report to an immediate superior or line manager, while also maintaining other responsibilities to different personnel with different status. An example of this is a hospital-based physiotherapist working as part of a multi-disciplinary cardiac care team. This individual is managed by the consultant cardiologist, while at the same time reporting to the senior physiotherapist in the hospital. This can pose a number of challenges for health and social professionals, but is already in operation in Irish health care settings.
Care Management will inevitably entail the introduction of a new system of management and reporting on top of existing structures. It is essential that the ‘best fit’ be made between the current organisational structure and the new arrangements required by Care Management. One possibility is to make the Co-ordinators of Services for Older People and the Area Managers of Services for Older People key professionals in the administration of Care Management. Additionally, their expertise in service liaison, co-ordination and development can inform the implementation of Case Management at the front line.

**Key Prerequisite**

The roles and duties of Care and Case Management, and the reporting relationships required, should be clearly defined. Existing reporting relationships should be considered in relation to this plan and a consultation process carried out to address areas of potential conflict before Care or Case Management is implemented on a larger scale.

### 7.1.14 Devolved Budgets

Health and social services in Ireland operate according to a mixed budgetary system. Within the health boards the services of staff are theoretically available to be accessed without the need for a separate budget to purchase their time. However, services provided through the voluntary and private sectors are not administered by the health board and therefore have to be purchased or ‘bought in’. Until recently these arrangements were relatively informal (Blackman *et al.*, 2001). One consequence of this situation is that there has been little or no emphasis on itemised costing of services or packages of care. One project in progress that aims to provide new information on costing packages of care is the ‘Home First’ pilot project in Beaumont Hospital.

In a UK study published in 1997, Griffen found that none of the ten Case Managers interviewed held budgets ‘... other than one who managed 22 social workers and three team leaders’. However, Austin (1992:64) believes that ‘the extent of Case Manager’s authority over the allocation of service resources is a critical variable ... when a Case Manager not only co-ordinates services but also co-ordinates multiple funding sources, individualised care plans can be tailored based solely on client need’. It remains to be seen whether this view of the necessity of Case Managers to have direct budgetary control in order to operate effectively can be resolved in an Irish context once Care and Case Management initiatives have been in place for some time and evaluated accordingly. However, the suggestion made in Phase Two that budgetary control be devolved to the Care Manager, or co-ordinators of services for older people in Ireland,

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15 This was a qualitative study of occupational therapists who went on to work as Case Managers.
appears to be a sensible starting point from which to move forward. Any move towards implementing Care Management in Ireland needs a flexible budget and sufficient access to obtain resources in a timely manner.

**Key Prerequisite**

The process of devolving budgetary control down the health board hierarchy should be continued to the appropriate level.

### 7.1.15 Information Dissemination And Information Quality

Many health professionals recognised that information regarding health and social services is hard to access, sometimes not available at all, and certainly not disseminated proactively. Yet, accurate information is a prerequisite for effective health and social care. Simply producing accurate information, however, is not sufficient; it must also be disseminated in a proactive fashion, using multiple modalities and with multiple points of access such as booklets, advertising and local radio and television.

In a study carried out by the Southern Health and Social Services Board (Northern Ireland) (Halliday *et al.*, 1996), eighty-eight per cent of service users and eighty-one per cent of carers said that they had never received leaflets containing information about community care services. Accurate, accessible and timely information on Case Management is essential if older people are to be aware of it, if they are to utilise it and if Case Managers are to achieve a person-centred, empowering approach.

The forthcoming Health Information Strategy indicates a recognition that the availability of information on health for clients will help empower them to have a more active role in their health care and promote self care. Service users must have knowledge regarding their access to and the quality of the health services which they use. The launch of this strategy is welcomed; however, it is key that the aspirations of the strategy are paralleled by an active implementation framework to ensure that the problems that beset current information policies are effectively addressed.

Any information provided about Care and Case Management should aim to answer the following questions:

- what are Care and Case Management?
- what is the process of care?
- who is it for?
- how is it accessed?
who pays for it?

what happens if something goes wrong?

who do I contact and how?

**Key Prerequisite:**

*Health information systems should be developed to meet the complex information management requirements of Care and Case Management. Systems need to facilitate service co-ordination and evaluation.*

*The development of a Unique Patient Identifier to track clients across different health care settings is one such necessity. The forthcoming Health Information Strategy should provide the basis for this system.*

### 7.2 Evaluation

Due to the complexity of the issues arising from the literature about evaluation, the lack of a coherent and consistent evaluation framework and the lack of consensus around key evaluation issues, there is a need to form an external working group to fully develop an evaluation system for Care Management in Ireland. Ideally, this group would consist of both professionals and lay people who are knowledgeable and committed to the philosophy and development of Care Management. Perspectives of those with intimate working knowledge of evaluation should be sought and include those involved with pilot projects and ‘experts’ in Care Management evaluation. Various levels in the health and social service hierarchy, from senior management to front-line workers, should be represented, as all have a significant role to play in the development and implementation of such a project. Service users, including informal and primary caregivers, must be included and should not be represented in a ‘token’ manner.

The goal of the external working group would be to arrive at a consensus as to how evaluation efforts should proceed so that each health board or project is using the same criteria, methods and procedures. This is to enable direct comparisons across the projects and allow easier transition to more complex evaluations over time (such as outcome or cost evaluations). More specifically, the working group needs to determine:

- the type of evaluation they will undertake
- the method they will use to evaluate the programs
• the key indicators or measures that will be used

• the key professionals who will take part in evaluation efforts and their roles

• what resources need to be in place to carry out the evaluations

• the timeline.

**Key Prerequisite:**

An external working group should be formed to develop a working plan for a programme of evaluation. The working group should ensure comparability in evaluation methods across programmes.

The type of evaluation should be selected on the basis of the specific purposes for which it will be used. As described previously, evaluations can be used for descriptive purposes and to inform budgeting and planning; reviewing programmes to justify continued funding or evaluating the impact of the change to aid in choosing between two alternatives. The availability of key resources needed to carry out the evaluation may be a limiting factor in the decision. A simpler, more practical type of evaluation, such as a descriptive evaluation, may be more feasible given the finding that resources, and in particular information management systems, are lacking. Regardless of which type of evaluation is selected, the evaluation should include, at the minimum, some measure of the service user’s perspectives. Service users must be consulted during the development and planning of those aspects of the evaluation. Some evaluation of the costing should also be included.

**Key Prerequisite:**

The type of evaluation selected should include, at the minimum:

a) some measure of the service users’ perspectives of the Case Management services provided to them. Service users must be consulted during the development and planning of those aspects of the evaluation

b) costing information on any system alterations required to implement a Care and Case Management programme.

The method and types of key indicators which need to be identified are somewhat dictated by the type of evaluation selected. The method should be transparent to all in the hierarchy, so that everyone involved in the process understands why certain data collection procedures must be followed. Those involved in delivering the service of Case Management must also be the ones overseeing and taking prime responsibility for the evaluation of the programme. If the information generated is not of relevance as to how
they conduct their job on a daily basis, the evaluation task becomes meaningless and the quality of the evaluation will suffer as a consequence. The evaluation method must also be selected so that it is easily integrated into established routines and other job duties, with clear links established between the functions of planning, evaluation and quality assurance. Key indicators must be consistent with goals of evaluation, easy to administer, valid and reliable.

**Key Prerequisite:**
The key indicators should be selected on the basis of their relevance to the goal of the evaluation and the philosophy of Care Management, while also being seen to be of apparent relevance to those conducting the evaluation. The procedures of the evaluation should be integrated into the daily work routine of the service providers.

Phase two evidence suggested that at least some professionals lack knowledge about evaluation methods and procedures. Training which focuses specifically on these topics may be necessary for them to participate in an evaluation process. Training should be standardised, so that all personnel involved in the evaluation process approach the task with the same background knowledge and understanding of how to conduct the evaluation.

**Key Prerequisite:**
Evaluation skills should be included as a core component of any training system for Care and Case Management.

Key resources must be ring-fenced for evaluation efforts with a strong commitment to the goals of evaluation shown by administrative staff. As stated previously, all evaluation efforts require a minimum set of resources and information to be completed successfully. Resources that should be considered include dedicated and trained personnel, funding, time and appropriate computer and analysis infrastructure.

**Key Prerequisite:**
Key resources should be ring-fenced for evaluation efforts, including personnel, funding, time and appropriate computer and analysis infrastructure.

Finally it is important that regular review of the progress on the findings and recommendations of this study be undertaken in order to ensure that concrete steps are taken towards the implementation of Care and Case Management on a national basis.
Key Prerequisite:
Progress on the recommendations of this study should be monitored on an ongoing basis by a working party on Care Management. This group should establish a monitoring mechanism to include key stakeholders such as health board managers, health and social service professionals, members of the community and voluntary sector, and representatives of carers and older people. The working party should produce a report summarising progress within five years from the initiation of an implementation plan for the introduction of Care (and Case) Management.
References
References


Care and Case Management for Older People in Ireland


Meenan, R. Mason, J. 1994. AIMS2 user's guide (revised). Boston, MA: Boston University School of Medicine, Boston University Arthritis Center and Department of Public Health.


North-Western Health Board. 1999. *A Strategy for Health and Social Gain for Older People*. Manorhamilton: North-Western Health Board.


Appendices
Appendix A – List Of Participating Voluntary Organisations And Expert Consultants

Carnew Community Care*

Dementia Services Information and Development Centre

Drogheda Community Services

Dundalk Social Services Council

The Alzheimer Society of Ireland

The Carers Association*

The Irish Association for Older People

The Volunteer Stroke Scheme

Professor David Challis (Personal Social Services Research Unit, University of Kent at Canterbury)

Dr Michael Donnelly (Department of Epidemiology and Public Health, The Queen’s University of Belfast)

Ms Brigit Smith (Area Co-ordinator for the Elderly, North-Western Health Board)

* These organisations acted in a consultative capacity to the study.
Appendix B – Models A And B – Organisational Structure

- Community Care Area
- Co-ordinator of services, for example Area Managers
  - Case Manager + case load
  - Case Manager + case load
  - Case Manager + case load
  - Multi-disciplinary team for consultation
  - GP and Public Health Nurse or Social Worker
  - Specialist Support
- Intensive home-focussed health and social care
<table>
<thead>
<tr>
<th>Topic – Name of Measure</th>
<th>Description</th>
<th>Author (Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Well-Being</td>
<td>Brief, 14-item assessment of anxiety and depression. Is able to detect cases of psychiatric disorder.</td>
<td>Zigmond and Snaith (1983)</td>
</tr>
<tr>
<td></td>
<td>Self-administered screening measure for psychiatric illness. Most widely applied measure of psychiatric difficulties in the UK. Several versions exist, including a 12-item and 60-item version.</td>
<td>Goldberg (1978); Goldberg and Williams (1988)</td>
</tr>
<tr>
<td></td>
<td>A 9-item measure of cognition, specifically orientation and memory. Has been used with community-dwelling older people.</td>
<td>Pfeiffer (1975)</td>
</tr>
<tr>
<td>Functional Ability</td>
<td>Measures functional ability (e.g., bathing, eating, dressing) in order to determine the amount of nursing care required. The 10 activities are rated by a nurse or another observer.</td>
<td>Granger, Albrecht and Hamilton (1979)</td>
</tr>
<tr>
<td></td>
<td>Measures the persons’ independence in performing activities of daily living (similar to above) on a 3-point scale.</td>
<td>Katz et al., (1963)</td>
</tr>
<tr>
<td></td>
<td>Self-administered measure of 9 components of functional ability. Includes items such as pain, drug toxicity, costs and discomfort. It has been extensively tested for validity and reliability.</td>
<td>Fries et al., (1980)</td>
</tr>
</tbody>
</table>

**ADL: The Index of Activities of Daily Living**

**HAQ: The Stanford Arthritis Center Health Assessment Questionnaire**
<table>
<thead>
<tr>
<th>Topic</th>
<th>Author (Year)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIMS2: The Arthritis Impact Measurement Scales – Revised</strong></td>
<td>Meenan and Mason (1994)</td>
<td>A 78-item self-administered questionnaire primarily of health and functional mobility. Also incorporates items about work, social support and satisfaction with function. Respondents can also indicate areas of priority for improvement.</td>
</tr>
<tr>
<td><strong>Broad Health Status</strong></td>
<td></td>
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</tr>
<tr>
<td>The Nottingham Health Profile (NHP)</td>
<td>Hunt and McKenna, (1991)</td>
<td>Developed in the UK. ‘Yes’ or ‘no’ responses are required for 38 simple statements (e.g. I’m tired all the time) which reflect lay rather than professional definitions of health.</td>
</tr>
<tr>
<td>The McGill Pain Questionnaire (MPQ)</td>
<td>Melzack (1975)</td>
<td>Focuses specifically on pain. Provides 78 words which patients endorse to yield a description, location and severity of their perceived pain.</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
<td>Author (Year)</td>
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<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Goal Attainment Scaling</td>
<td>Used as a measure of clinically important change in nursing home patients</td>
<td>Gordon, Powell and Rockwood (1999)</td>
</tr>
<tr>
<td></td>
<td>with professionally established goals. Developed for use with older people</td>
<td></td>
</tr>
<tr>
<td>Quality of Life</td>
<td>A 20-item scale developed and used with older populations. The aim is to</td>
<td>Neugarten et al, (1960)</td>
</tr>
<tr>
<td></td>
<td>measure general feelings of well-being to identify successful ageing.</td>
<td></td>
</tr>
<tr>
<td>Caregiver</td>
<td>Assesses the stressors experienced by the family caregivers of elderly and</td>
<td>Zarit et al, (1980)</td>
</tr>
<tr>
<td></td>
<td>disabled persons. The 22-item scale asks about the impact of the patient's</td>
<td>Nolan, Grant and Keady (1996)</td>
</tr>
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<td></td>
<td>disabilities on their life. Scoring ranges from 'never' having felt a certain</td>
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<td></td>
<td>way to feeling it 'quite frequently' or 'nearly always'.</td>
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<td></td>
<td>The CADI presents in checklist form a list of key sources of stress for</td>
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<td></td>
<td>caregivers, the CASI is designed to complement the CADI by identifying key</td>
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<td></td>
<td>sources of reward and gratification in caregiving.</td>
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<tr>
<td>Topic</td>
<td>Author (Year)</td>
<td>Description</td>
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</tr>
<tr>
<td><strong>Multi-dimensional Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SELF: Self-Evaluation of Life Function Scale</td>
<td>Linn and Linn (1985)</td>
<td>A 54-item self-report scale to measure physical, emotional and social function. Used as a comprehensive, relatively short self-report measure for clinical or research purposes.</td>
</tr>
<tr>
<td>The OMFAQ: OARS Multidimensional Functional Assessment Questionnaire</td>
<td>Older American’s Resources and Services, Duke University (1978)</td>
<td>Measures the overall functional status (Part A) and service use (Part B) of older people. Part A includes 120 items covering: basic demographics, physical health, mental health, social resources, economic resources and activities of daily living. Part B, the services assessment questionnaire, covers 24 categories of services. A trained interviewer can complete the entire questionnaire in 45 minutes.</td>
</tr>
<tr>
<td>The QUOTE: Quality of Care Through the patient’s Eyes</td>
<td>Sixma et al, (2000)</td>
<td>Measures quality of health care provided from the perspective of health service users, including older people. A 32-item scale assessing problem frequency and importance scores for a set of process quality (e.g. courtesy, autonomy, independence), structure quality (e.g. costs, continuity of care), and category-specific quality (e.g. accessible transport).</td>
</tr>
<tr>
<td>Topic</td>
<td>Author (Year)</td>
<td>Description</td>
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</tr>
<tr>
<td>The Camberwell Assessment of Need for the Elderly (CANE)</td>
<td>Walters <em>et al</em>, (2000)</td>
<td>Assesses 24 domains of need related to the older person and 2 domains related to the carer. Needs are identified as either ‘met’ or ‘unmet’. One of the few measures that seeks the perspectives of multiple people, including the older person themselves, their carer(s) and their main health professional in order to allow direct comparisons of the different perspectives.</td>
</tr>
<tr>
<td>InterRAI: Resident Assessment Instrument – Home Care (RAI-HC)</td>
<td></td>
<td>A package of instruments that constitute a minimum data set for a consortium to improve the care of older persons. The assessment component of 30 items covers physical function, health, social support and service use. Problems identified are assessed in more depth. It has been used internationally and has good reliability. It is client-based, multi-disciplinary, supports care planning, allows cross-system comparison and forms a basis for indicator measures.</td>
</tr>
<tr>
<td>Satisfaction with Services</td>
<td></td>
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<tr>
<td>Home Care Satisfaction Measure (HCSM)</td>
<td>Geron, 1999</td>
<td>Developed by service users, the measure covers five different social care services, including home care services and meals services, and provides an overall satisfaction score. Respondents indicate their agreement with a series of statements on a 5-point scale. It can be used to examine changes in satisfaction over time or identify differences between service providers.</td>
</tr>
<tr>
<td>Topic</td>
<td>Author (Year)</td>
<td>Description</td>
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<td>-------</td>
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</tr>
<tr>
<td>Client Satisfaction Questionnaire (CSQ)</td>
<td>Larsen et al., 1979</td>
<td>Has been used with older people in both long-term care and health settings. Developed from the perspective of older people (non-institutionalised), it measures satisfaction with care. The 32 items refer to ‘process’ and ‘structure’ aspects of the care, rather than outcomes, and take into account expectations.</td>
</tr>
<tr>
<td>QUOTE-Elderly (Quality of Care Through the patients’ Eyes)</td>
<td>Sixma et al., (2000)</td>
<td>Has been used with older people in both long-term care and health settings. Developed from the perspective of older people (non-institutionalised), it measures satisfaction with care. The 32 items refer to ‘process’ and ‘structure’ aspects of the care, rather than outcomes, and take into account expectations.</td>
</tr>
</tbody>
</table>
How does an older person get access to services?
What are the criteria for eligibility?
What type of information do they receive?

How are services co-ordinated?
What types of staff are required?

Self-care and family assisted care until older person decides to notify

How long do they have to wait for services?

Meets with care recipient and family

What types of services are available to them?
How intense are they?
Where are services delivered?

What is the total cost?

Community-based services and additional services

Case manager, care recipient and family
On-going implementation and re-assessment of plan

Care Plan

Specialist Services

GP and PHN/Social Worker

Appendix D: Evaluation – Sample Of Structural Components
Appendix E: Evaluation – Sample Of Process Components

Co-ordinator of services notifies self-care and family assisted care until older person decides to notify.

Community-based services and additional services notified to case manager, care recipient and family.

Case manager, care recipient and family notified of on-going implementation and re-assessment of plan.

GP and PHN/Social Worker meets with care recipient and family.

Care Plan meets with care recipient and family.

Specialist Services notified of on-going implementation and re-assessment of plan.

How responsive is the system?

How are the older person and family involved in the decision-making process?

How comprehensive is the treatment plan communicated to the other professionals?

How comprehensive is the care plan?

How appropriate is it?

What are the feedback mechanisms?
Appendix F: Evaluation – Sample Of Outcome Components

How are the older person and their carers functioning before the care plan is implemented?

How are the older person and their carers functioning after the care plan is implemented?

Co-ordinator of services

Self-care and family assisted care until older person decides to notify

Co-ordinator of services notifies

Care Plan

GP and PHN/ Social Worker

Case manager, care recipient and family

Specialist Services

On-going implementation and re-assessment of plan
Appendix G: Types Of Evaluations

Descriptive Evaluations

The purpose of a descriptive evaluation is to better understand the nature of the service that is being provided. Key ‘indicators’ need to be developed in order to describe how Care Management is being practised through a Case Management service delivery model. These indicators can be either quantitatively or qualitatively based. An example of a quantitative indicator is the number of weeks that elapse between an individual’s referral to a Care Manager and the completion of their initial assessment. If, for example, the time elapsed is two months, that may be deemed ‘too long’ a time for an older person to wait for the service. A qualitative approach to evaluating the same indicator might be a few questions embedded in a larger interview with the key participants (e.g. the Care Manager, the recipient of care, the family or caregiver, etc.) about the timeliness and adequacy of the referral to assessment process. Here, given the context and complexities of the situation, it may emerge that a two-month wait was not inappropriate and was satisfactory to all involved.

Developing key indicators for a descriptive evaluation can be relatively straightforward. Many times organisations find that the information that they will need to describe their efforts is already being routinely collected, such as the numbers of people served, the service provided, etc. What is required, however, is an adequate information system that can receive, tabulate and analyse the information needed in a systematic way. Again, descriptive evaluation efforts can effectively document and describe the activities of a programme, but they do not by themselves indicate the effectiveness of a programme. They do, however, provide a good basis for the other types of evaluations.

Programme Review Evaluations

A systematic review of the quality of care provided by a programme is the objective of programme review types of evaluations. The development of use of a ‘best practice’ model of care is necessary in order to determine if the activities of the programme constitute ‘quality’ care. The best practice model serves as a ‘yardstick’ to compare various aspects of a programme to professional standards. Of course, pre-existing professional standards need to be identified.

One example of how a programme review might be achieved is to form an external panel of independent experts on Care Management. This group of experts (typically comprised of professionals, but not necessarily so) could then conduct a type of audit of
the programme by reviewing care plans, for example. Initial assessments of the care recipients could be reviewed, with a focus on how well the care plan reflects and addresses the problems identified in the assessment. This type of evaluation may also serve a feedback/supervisory function for Case Managers. For example, it may identify Case Managers that tend to neglect mental health problems – perhaps depression is identified at the initial assessment, but its identification does not link to any specific action in the care plan. Further, programme review evaluations can serve to improve the overall comprehensiveness of Care Management programmes. One drawback of these ‘paper-only’ types of evaluations is that the paperwork does not adequately capture the complexities of the situation and does not reflect the dynamics of working in an interpersonal system.

Another example of programme review again involves a panel of experts, but in this case, the experts work in parallel with the Care Managers for a select number of cases or activities. For example, an expert may accompany a care worker during an initial assessment session and complete an assessment independently. The two assessment can then be compared and feedback provided to the Care Manager about their ability to conduct a comprehensive, quality assessment. This type of evaluation may prove beneficial for projects that have Care Managers of varying backgrounds and be used as a training technique. For example, it may identify a social worker who is less skilled at identifying specific medical conditions, and likewise, a nurse who may tend to neglect non-medical issues. A ‘paper-only’ audit as described above is less likely to uncover these sorts of shortcomings in providing a quality service. This type of evaluation, however, tends to be more time and cost intensive with professionals working more ‘in the field’. All programme reviews, no matter how they are conducted, require the consensus of the ‘experts,’ the development of ‘best practice’ models or the establishment of professional standards.

Impact Evaluations

When considering programme evaluations, impact evaluations are usually the first to be considered. This type of evaluation attempts to answer the question of whether the Case Management programme being implemented affects the individuals it serves differently than an alternative model of care. Do those with Case Management do better, worse or the same as those under the alternative model of care? It should be noted that the ‘alternative’ model that serves as the comparison can be another project, but it can also be the ‘old’ or existing model of service. The key is to be able to compare one group of older individuals who were served by a particular Care Management model to another similar group of older individuals who were a) not served...
in a Care Management model, or b) served through a different Care Management model. The first option (a) can evaluate whether or not the services delivered through Case Management are an improvement in the system of care, while the second option (b) can discriminate between differing models of Care Management.

Undertaking impact evaluation can be difficult and resource intensive. Designing the evaluation requires considerable planning and a certain amount of research expertise. Even tasks such as identifying an appropriate comparison group can be complicated. Implementation of the evaluation also requires substantial time and effort on the part of the service providers, not to mention their commitment to the evaluation process. Thus, although impact evaluation may be the most informative and beneficial type of evaluation to an organisation in the long run, it poses multiple challenges in implementation.
Appendix H – Semi-Structured Interview Schedule (Phase One)

Section A: Current strategy and practice

Community Care – organisation

How are services for older people in your community organised?

Discussion points:

- What are the aims of current service provision?

- Is there a key worker to co-ordinate services for individual clients, is this task carried out by a team or does co-ordination not take place?

- Is there an individual or group to oversee the key worker or team?

- Who controls funding? Is it central funding or are there devolved budgets for services/co-ordinators?

Access to services

How do people in need of care access the services in your area?

Discussion points:

- What are the procedures for identifying those ‘at risk’?

- What are the assessment and referral procedures?

- Are there eligibility criteria for both entry to and maintenance in care?

- What are they?

- At what point does someone leave the care system? Is it possible to re-enter the care system?
Components of care

What sort of services for older people are available in your area?

Discussion points:

- How well integrated are these services? How well do they communicate?
- Do these services include both health and social aspects of care?
- How well able are services to adapt to changing needs?
- The roles of care recipients and carers

How are recipients and carers involved with care services?

Discussion points:

- Are there guidelines for consultation with care recipients and carers?
- How are their preferences incorporated into planning/decision-making?
- How is information about access, eligibility, care decisions, and so on, disseminated?

Feedback and accountability

What measures to ensure accountability are in place?

Discussion points;

- Are there guidelines for receiving feedback from staff, care recipients and carers?
- Do you have grievance procedures in place if necessary?
- Is there any way of tracking the impact of current service provision on the target population?
- Are there criteria by which outcomes are measured? If so, what are they?
Incipient changes in strategy or practice

Are there any new developments in care services for older people about to come on-stream in your area? If so, could you tell me what these are?

Discussion point:

- What are the underlying aims of these developments?

Section B: Strengths and weaknesses in current practice

Strengths

What do you think works well in terms of current care provision in your area?

Discussion point:

- Are there any aspects that particularly work well? Why?

Can you think of any opportunities for improvement in your area?

Weaknesses

What do you think does not work very well at present?

Discussion point:

- Why are these elements not working well?

Can you think of any threats to ongoing service provision in your area?
Section C: Ideal systems of care

If you had all the necessary resources, what would your ideal approach to care in your area be?

Discussion points:

- Why would you like to see this approach implemented?
- Is it possible to map the underlying principles, structures and/or practices involved?

What factors would stop this situation from becoming a reality?

Discussion point:

- Which of these factors are to do with local issues within your health board, and which are to do with issues beyond your control, such as government policy or funding decisions?

Taking into account these constraints, how would you like to see current care provision improved?

Discussion points:

- Is it possible to map the underlying principles, structures and/or practices involved?
## Appendix I: Possible Multiple Perspectives On Evaluation Components

<table>
<thead>
<tr>
<th>Evaluation Components</th>
<th>Service User</th>
<th>Case Manager</th>
<th>Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure/Process/Outcome</strong></td>
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<tr>
<td>Structure</td>
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<tr>
<td>- Access to services</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Information</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Transportation</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Eligibility for services</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Timeliness of care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Location/Time care delivered</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Types of services available (choice)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Quantity/intensity of care</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Co-ordination of services</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Qualifications of practitioners</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>- Staffing patterns</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>- Cost</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
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<tr>
<td>- Procedures and courses of treatment</td>
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<td>X</td>
<td></td>
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<tr>
<td>- Number of individuals served</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Quality of care</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>- Appropriateness of care</td>
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<tr>
<td>- Comprehensiveness of care</td>
<td>X</td>
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<tr>
<td>- Involvement in decision-making</td>
<td>X</td>
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<tr>
<td>- Communication of care</td>
<td>X</td>
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<tr>
<td>- Feedback mechanisms</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Convenience</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>- Responsiveness</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

16 A carer’s perspective may also be sought for these same components
<table>
<thead>
<tr>
<th>Evaluation Components</th>
<th>Service User&lt;sup&gt;16&lt;/sup&gt;</th>
<th>Case Manager</th>
<th>Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client/Carer (Outcome)</td>
<td></td>
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<tr>
<td>- Psychological well-being</td>
<td>X</td>
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<td>- Physical status</td>
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<td></td>
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<tr>
<td>- Social support</td>
<td>X</td>
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<td>- Environment</td>
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<tr>
<td>- Current use of services</td>
<td>X</td>
<td>X</td>
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<tr>
<td>- Other unmet needs</td>
<td>X</td>
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<tr>
<td><strong>Case Manager (Definition-based)</strong></td>
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<tr>
<td>- Case finding</td>
<td></td>
<td>X</td>
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<td>- Screening for eligibility</td>
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<tr>
<td>- Assessing for care plan</td>
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<td>- Care planning</td>
<td>X</td>
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<tr>
<td>- Implementing care plan</td>
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<td>- Integrating care</td>
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<td>- Monitoring care plan</td>
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<td>X</td>
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<tr>
<td>- Advocating</td>
<td>X</td>
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<tr>
<td><strong>Philosophy-based</strong></td>
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<tr>
<td>- Integrated?</td>
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<td>- Needs focused?</td>
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<td>- Person focused?</td>
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<td>- Holistic?</td>
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<td>- Flexible?</td>
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<tr>
<td>- Builds self-respect and self-esteem?</td>
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<td>- Facilitates choice?</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>- Facilitates empowerment?</td>
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<td>X</td>
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<tr>
<td>- Promotes anti-ageism?</td>
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<td>- Promotes partnership?</td>
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<tr>
<td>- Maximises health and well-being?</td>
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</tbody>
</table>

<sup>16</sup> Indicates whether the component is included in the service user's evaluation.
Appendix J: Courses On Case Management Run By The University Of Melbourne

The School of Postgraduate Nursing at the University of Melbourne runs two courses on Case Management: a Graduate Certificate in Case Management and a Graduate Diploma in Case Management. Both courses are open to all health and ‘human service’ professionals including nurses, social workers, occupational therapists, physiotherapists, psychologists and general practitioners. Both courses use the internet as a teaching medium and are available in Australia and internationally.

Students can move between the Graduate Certificate and the Graduate Diploma. In terms of the distinction made between Case and Care Management in this report, the Certificate covers skills primarily associated with Case Management, and the Diploma covers the policy, organisational and information aspects associated with work at a Care Management level (although the University of Melbourne does not make this distinction in terminology).

Graduate Certificate Course Content

Case Management 1

This is an introduction to Case Management theory and practice. The initial sessions cover the main motivating factors contributing to the rise of Case Management as a model of service delivery. Other topics covered include principles and standards for Case Management; models of Case Management; the daily practice of Case Management; critiques of Case Management; evaluation and consumer rights.

Case Management 2

Two units run concurrently in this module – the theory of Case Management and practice of Case Management. The theory unit focuses on key Case Management skills and issues. The practice unit covers outreach (or case finding); intake; assessment; planning; implementation; monitoring and discharge. A range of other topics are covered including negotiation and conflict-resolution; working with clients from other cultures; safety; ethics; legal issues; record-keeping and working with a variety of different population groups.
Graduate Diploma Course Content

The Graduate Diploma in Case Management includes Case Management 1 and 2 as described above, along with four modules which focus on organisational and managerial issues which can be regarded as pertaining to the Care Management level of service planning.

Health policy

This module examines the local and global context of health and welfare policy-making. The rest of the subject focuses on the theoretical and practical foundations of public policy. Students undertake a policy case study as part of the course.

Information management

This subject emphasises both general knowledge and skills development with reference to working with databases; identifying information sources within the community; planning pathways of care; using information for management and evaluation; ethics and confidentiality. Design and implementation of information management systems is also covered. An analysis of the potential impact of information management on Case Managers, clients, organisations and society in general concludes the course.

Research and evaluation for practice

This subject is based on evidence-based practice. It aims to develop practitioners’ confidence and skills in critical analysis of research and evaluation reports. Topics covered include: evidence-based practice issues; approaches to research and evaluation and internet and library literature-search skills.

Organisational change

This module aims to help students to better understand processes of change in organisations; leadership; and the role of Care Managers as change agents. Major factors regarding the motivating factors for change; the conditions under which change can occur; factors in resistance to change, and best practice models of change implementation are also examined.
**Duration of Courses**

The Graduate Certificate lasts for one year and the Graduate Diploma is normally completed in eighteen months to two years.

**Entry Requirements**

Applicants are required to hold at least a three-year undergraduate degree in a health or social service discipline, or an equivalent qualification. However, if an applicant can demonstrate sufficient ability and relevant work experience, this condition may be waived.

See [www.nursing.unimelb.edu/gdem.htm](http://www.nursing.unimelb.edu/gdem.htm) for more information.
Terms of Reference

The National Council on Ageing and Older People was established on 19 March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:

   (a) measures to promote the health of older people;

   (b) measures to promote the social inclusion of older people;

   (c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

   (d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;

   (e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;

   (f) meeting the needs of the most vulnerable older people;

   (g) means of encouraging positive attitudes to life after 65 years and the process of ageing;

   (h) means of encouraging greater participation by older people;

   (i) whatever action, based on research, is required to plan and develop services for older people.
2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

   a) undertaking research on the lifestyle and the needs of older people in Ireland;

   b) identifying and promoting models of good practice in the care of older people and service delivery to them;

   c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;

   d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3. To promote the health, welfare and autonomy of older people.

4. To promote a better understanding of ageing and older people in Ireland.

5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.
Membership

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<th>Chairperson Dr Michael Loftus</th>
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<tr>
<td>John Brady</td>
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Director Bob Carroll