L'INFERMIERE CASE MANAGER NELLE RESIDENZE PER ANZIANI

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IL CASE MANGER

- **E' il professionista** che provvede all'assegnazione e al coordinamento dei servizi socio-sanitari destinati alla gestione clinica di un determinato target di utenti.
- Si occupa della creazione di un particolare **processo assistenziale** tarato sul singolo paziente che viene seguito in tutte le fasi, dall'ammissione alla dimissione.

MANAGEMENT

Infermiere Case Manager, un importante agente di cambiamento

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IL CASE MANAGER

- **IL SUO RUOLO È DI MIGLIORAMENTO DELL'EFFICACIA E DELL'EFFICIENZA DELL'ASSISTENZA SANITARIA, BASATO SULLA LOGICA DI COORDINAMENTO DELLE RISORSE DA UTILIZZARE PER LA SPECIFICA PATOLOGIA.**

Paolo Chiari e Antonella Santullo

IL CASE MANAGER
LA FORMAZIONE

- **alta formazione universitaria**, **Master di I livello**,

- l'Infermiere Case Manager acquisisce e affina competenze che gli consentono di:
  - **coordinare l'assistenza, destinata a singoli o a gruppi di popolazione, lungo un continuum che ingloba la gestione di prevenzione, fase acuta, riabilitazione, dimissione e cure a lungo termine.**

IL CASE MANAGEMENT
Un modello assistenziale

- Prevede **la presa in carico** del paziente e della sua famiglia attraverso percorsi assistenziali più o meno complessi, a seconda dei casi, per agevolare il rientro al domicilio o l'inserimento presso strutture sanitarie di lungodegenza di riabilitazione o residenziali.

- è un sistema che **FAVORISCE** il **governo dell'intero processo**, permette all'ICM di **coordinare** varie professionalità e risorse, **garantendo** un'assistenza personalizzata e **favorendo** la massima autonomia residua possibile all'utente.

La prevalenza oggi di malattie croniche che evolvono nel tempo presentando fasi differenti, richiede nuove "forme organizzative" che integrino i luoghi e i diversi professionisti coinvolti.

Sistema integrato per la gestione del percorso del paziente fragile

Inf.CASE MANAGER Francesca Bonci
Unità di Cure Post-Acuzie - Fano

LA PRESA IN CARICO

- ***PRENDERE IN CARICO SIGNIFICA SEGUIRE NEL TEMPO I PROBLEMI DEI PAZIENTI, GARANTIRE LA CONTINUITÀ TRA OSPEDALE E TERRITORIO (CONTINUITÀ DI ASSISTENZA E DI INFORMAZIONE), FARSI CARICO ANCHE DEI PROBLEMI EMOTIVI E NON SOLO DI QUELLI CLINICI, FORNIRE UN RIFERIMENTO CONTINUO.***

[Haggerty 2013]

COMPETENZE

- **CLINICHE**
- **MANAGERIALI**
- **FINANZIARIE**

Morales-Asencio *et al. BMC Health Services Research* 2010, **10**:324
http://www.biomedcentral.com/1472-6963/10/324

BMC
Health Services Research

STUDY PROTOCOL **Open Access**

Design of a case management model for people with chronic disease (Heart Failure and COPD). Phase I: modeling and identification of the main components of the intervention through their actors: patients and professionals (DELTA-icE-PRO Study)

Jose M Morales-Asencio[1*], Francisco J Martin-Santos[2], Juan C Morilla-Herrera[2], Magdalena Cuevas Fernández-Gallego[2], Miriam Celdrán-Mañas[3], Francisco J Navarro-Moya[4], Maria M Rodríguez-Salvador[5], Francisco J Muñoz-Ronda[6], Elena Gonzalo-Jiménez[3], Almudena Millán Carrasco[3]

Abstract

Background: Chronic diseases account for nearly 60% of deaths around the world. The extent of this silent epidemic has not met determined responses in governments, policies or professionals in order to transform old Health Care Systems, configured for acute diseases. There is a large list of research about alternative models for people with chronic conditions, many of them with an advanced practice nurse as a key provider, as case management. But some methodological concerns raise, above all, the design of the intervention (intensity, frequency, components, etc).

Methods/Design: *Objectives*: General: To develop the first and second phases (theorization and modeling) for designing a multifaceted case-management intervention in people with chronic conditions (COPD and heart failure) and their caregivers. Specific aims: 1) To identify key events in people living with chronic disease and their relation with the Health Care System, from their point of view. 2) To know the coping mechanisms developed by patients and their caregivers along the story with the disease. 3) To know the information processing and its utilization in their interactions with health care providers. 4) To detect potential unmet needs and the ways deployed by patients and their caregivers to resolve them. 5) To obtain a description from patients and caregivers, about their itineraries along the Health Care System, in terms of continuity, accessibility and comprehensiveness of care. 6) To build up a list of promising case-management interventions in patients with Heart Failure and COPD with this information in order to frame it into theoretical models for its reproducibility and conceptualization. 7) To undergo this list to expert judgment to assess its feasibility and pertinence in the Andalusian Health Care. *Design*: Qualitative research with two phases: For the first five objectives, a qualitative technique with biographic stories will be developed and, for the remaining objectives, an expert consensus through Delphi technique, on the possible interventions yielded from the first phase. The study will be developed in the provinces of Almería, Málaga and Granada in the Southern Spain, from patients included in the Andalusian Health Care Service database with the diagnosis of COPD or Heart Failure, with the collaboration of case manager nurses and general practitioners for the assessment of their suitability to inclusion criteria. Patients and caregivers will be interviewed in their homes or their Health Centers, with their family or their case manager nurse as mediator.

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BMJ Open

Using comprehensive geriatric assessment for quality improvements in healthcare of older people in UK care homes: protocol for realist review within Proactive Healthcare of Older People in Care Homes (PEACH) study

Maria Zubair,[1] Neil H Chadborn,[1] John R F Gladman,[2,3] Tom Dening,[4] Adam L Gordon,[1,5] Claire Goodman[6]

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ABSTRACT

Introduction Care home residents are relatively high users of healthcare resources and may have complex needs. Comprehensive geriatric assessment (CGA) may benefit care home residents and improve efficiency of care delivery. This is an approach to care in which there is a thorough multidisciplinary assessment (physical and mental health, functioning and physical and social environments) and a care plan based on this assessment, usually delivered by a multidisciplinary team. The CGA process is known to improve outcomes for community-dwelling older people and those in receipt of hospital care, but less is known about its efficacy in care home residents.

Methods and analysis Realist review was selected as the most appropriate method to explore the complex nature of the care home setting and multidisciplinary delivery of care. The aim of the realist review is to identify and characterise a programme theory that underpins the CGA intervention. The realist review will extract data from

Strengths and limitations of this study

- ► To our knowledge, this is the first review of the use of comprehensive geriatric assessment (CGA) in the care home setting (long-term care residence).
- ► The review will develop and refine realist programme theories about the practice of CGA in care homes using evidence from literature and professional bodies and experts within the field.
- ► A potential limitation will be the availability of relevant evidence for the care home setting. This will be mitigated by a realist theory-driven approach to evidence review.
- ► Public involvement in studies of CGA has been limited and it is difficult to ascertain views from care home residents with frailty and/or dementia as to their personal experience of CGA.

Committee. The study protocols have been reviewed

Conceptualization of the Chronic Care Model

Implications for Home Care Case Manager Practice

Garland-Baird, Lisa, RN, MN; Fraser, Kimberly, PhD

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Feature

BUY

Abstract | Author Information | Article Metrics

One of the greatest challenges for healthcare systems is the management and prevention of chronic diseases. Wagner's Chronic Care Model aims to transform the daily care of patients with chronic illnesses from acute and reactive to proactive, planned, and population-based. The purpose of this article is to provide a review of the available research relating to the Chronic Care Model and consider the implications for Home Care Case Management practice. A total of 18 research studies (5 qualitative and 13 quantitative) were reviewed. A thematic content analysis approach was used. The findings included three themes: Chronic Care Model and positive chronic illness health behaviors and outcomes; Chronic Care Model and delivery of quality chronic illness care; and the importance of the supportive role of the home care nurse in the role of Home Care Case Management. Gaps and limitations of the Chronic Care Model in relation to Home Care Case Management were identified and discussed in relationship to partnership building and reciprocal trust between patients, family caregivers, and the Home Care Case Manager. Finally, implications for the use of the Chronic Care Model in Home Care Case Manager practice, policy development, and future research were presented.

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Home Care Case Managers' Integrated Care of Older Adults With Multiple Chronic Conditions: A Scoping Review.

Baird, Lisa Garland RN, MN; Fraser, Kimberly PhD

[Article] *Professional Case Management*. 23(4):165-189, July/August 2018.

(Format: HTML, PDF)

Purpose of Study: The purpose of this scoping review was to explore peer-reviewed research and gray literature to examine the extent, range, and nature of available research that describes how home care case managers (HCCMs) provide integrated care for older adults with multiple chronic conditions (MCCs); identify how case management standards of practice correspond with functions of integrated care; identify facilitators and barriers to case management and integrated care delivery; and propose a framework to describe how HCCMs can use case management standards to provide integrated care to older adults with MCCs.

Primary Practice Setting: Community, home care settings.

Methodology and Sample: Scoping review; older adults older than 65 years with MCCs, case managers and health care professionals who provide care for older adults with MCCs.

Results: The study findings demonstrated that HCCMs consistently used the case management standards assessment, planning, implementation, and evaluation to provide all professional and clinical integrated care functions, and were least likely to use the standards of identification of client and eligibility for case management and transition to provide professional and clinical integrated care functions. In addition, HCCM use of professional and clinical integrated care functions was inconsistent and varied based on use of case management standards. All case management standards and integrated care functions were found to be both facilitators and barriers, but were more likely to facilitate HCCM work. Interestingly, the standards of assessment, planning, and implementation were more likely to facilitate functional integration, whereas the integrated care functions of intra- and interpartnerships, shared accountability, person centered of care, and engagement for client self-management were more likely to facilitate normative integration. We also found that HCCMs use case management standards and integrated care functions to provide care for older adults with MCCs at the professional (meso) and clinical (micro) levels.

Implications for Case Management Practice: Variations in HCCM practice may impact the delivery of case management standards when caring for older adults with MCCs. This has implications for the comprehensiveness and consistency of HCCM practice, as well as interdisciplinary health professional and the client's awareness of the HCCM role when providing integrated care to older adults with MCCs within home settings. The greatest facilitators and barriers to integrated care are those case management standards and clinical and professional integrated care functions that focus on partnerships, collective and shared responsibility and accountability, coordinated person centered of care for clients, and ensuring engagement and partnership in self-management. This indicates the need for development of case management policies and programs that support the work of HCCMs in the delivery of seamless and collaborative case management and integrated care functions that foster collaboration and partnership-building efforts. The development of a new case management and integrated care conceptual framework that includes case management standards, professional and clinical integrated care functions would guide HCCM integrated care practice, policy and research to support client and family-centered care, and foster shared values for sustainable partnerships across care settings.

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IL CASE MANAGER IN RSA

- **CONTINUITA' ASSISTENZIALE**

  - FORTE INTEGRAZIONE TRA OSPEDALE E TERRITORIO
  - PRESA IN CARICO
  - ALLEANZA TERAPEUTICA
  - EDUCAZIONE SANITARIA
  - IDENTIFICAZIONE DEL PERCORSO IDONEO ALLA DIMISSIONE

IL CASE MANAGER IN RSA

- **Accogliere** l’Ospite, prenderlo in carico, effettuare lo screening de problemi ed accertare eventuali rischi;
- **Accertare ed identificare** i problemi e sviluppare il piano assistenziale;
- **Implementare** il piano di assistenza;
- **Coordinare, facilitare e gestire** l’assistenza;
- **Pianificare** le transizioni fra le varie fasi e coinvolgere gli altri professionisti;
- **Effettuare** le rivalutazioni periodiche e il follow up dell’Ospite

IL CASE MANAGER IN RSA

- **Educare** l’Ospite e la famiglia riguardo i bisogni di assistenza sanitaria e i cambiamenti dello stile di vita;
- **Monitorare** e valutare le attività assistenziali;
- **Supportare** l’Ospite e la famiglia nei bisogni di salute;
- **Formare e supportare** lo staff e condurre sessioni di educazione continua;
- **Documentare** tutta l’attività svolta, i risultati, scrivere report e fornire feedback ai soggetti;
- **Sviluppare e valutare** il programma di case management;

CONCLUSIONI

- CASE MANAGER COME AGENTE DI INTEGRAZIONE
- EFFETTIVA RISPONDENZA AI BISOGNI DEL PAZIENTE
- COORDINAMENTO DEI DIVERSI TIPI DI ASSISTENZA
- DE – ISTITUZIONALIZZAZIONE
- COMUNICAZIONE CONTINUA E COLLABORATIVA
- FIGURA DI RIFERIMENTO

CASE MANAGER
O
CARE MANAGER?

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