# INTEGRATED APPROACH TO PATIENT CARE IN COMMUNITY NURSING
# CASE MANAGEMENT - GENERAL METHOD IN SOCIAL AND MEDICAL COMMUNITY SERVICES

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***Keywords:*** *community intervention plan, community medical/social assistance, medical/social diagnosis, integrated approach to patient care on a community level*

***Abstract:*** *Case management is an integrated coordination method for social and medical community services including medical/social services and home based care. It implies identifying all of the beneficiaries' needs at a community level, prioritizing them, planning specific interventions, coordinating and monitoring the implementation of the interventions depending on available resources, and evaluating the results. The purpose of these stages is the satisfaction of all medical and the social needs and social and professional reintegration.*

***Cuvinte cheie:*** *plan de intervenţie comunitara, asistenţă medico-socială comunitară, diagnoză medico-sociala, abordarea integrată a pacientului la nivel comunitar*

***Rezumat:*** *Managementul de caz este o metodă de coordonare integrată a serviciilor medico-sociale comunitare incluzând servicii medicale, sociale, îngrijiri la domiciliu şi constă în identificarea tuturor problemelor de dependenţă ale beneficiarului la nivel comunitar, prioritizarea acestora, planificarea intervenţiilor specifice, coordonarea şi monitorizarea implementării intervenţiilor centrate pe beneficiar, în funcţie de resursele disponibile şi evaluarea rezultatelor obţinute. Scopul acestor etape constă în satisfacerea tuturor nevoilor medico-sociale în mediul de viaţă cu reintegrarea socio-profesională.*

## INTRODUCTION

The fundamental principle of the community nursing process is the fact that the beneficiary (individual, family, community) is in the centre of the whole process; allocating material and human resources efficiently leads to the expected results in the planning process.

The efficiency of case management is analyzed relating to:

- Allocating human and material resources according to the needs of each beneficiary;
- The degree of coordination between integrated community services (medical, social and home-based care), so that all the needs of the patient/beneficiary can be met;
- The efficiency of the "low cost for community services"/ "expected results for the beneficiary" ratio.

Case management at community level as a work method is defined as an evaluation of the needs, a certain individual, his family, his community or his social environment may have and it functions in parallel with the medical and social service network available at community level (family doctor, community nurse, social worker, home nurse, Roma mediator); an individual intervention strategy is drawn up. This strategy is centred on the beneficiary himself, on immediate needs and available resources. What sets this work concept for the community intervention team apart is that the specific service provider is not focused on selecting eligible beneficiaries for a certain service/intervention but rather on identifying multiple complex issues of the beneficiary (healthy or ill) and the resources (services and material resources) from the community network that could efficiently solve these problems.

In community nursing, case management implies granting and coordinating interventions that are necessary for the beneficiary by the case manager or another official, which, in this case, can be the family environment, community nurse, social worker or Roma health mediator, depending on the problem, the identified needs and the necessary professional abilities.

The case manager is a professional on a community level that coordinates nursing activities, social assistance and combined activities carried out through the specific activities of the multidisciplinary teams (community teams); the manager, along with the community service providers (primary medical care, social assistance, home-based care) determines the eligibility criteria for the access to certain services by the beneficiary, facilitates interaction between the members of the community team from different fields of activity implicated in the care process.

Each complex case, with its specific medical/social issues, can benefit from the activity of a case official, who can be delegated certain authorities by the manager, in order to coordinate specific activities and implement specialized medical / social interventions - the individualized medical intervention plan, the social / professional assistance plan, the primary / secondary / tertiary prevention plan, the safety and risk evaluation plan, etc.

**The case manager:**

- Coordinates community nursing activities, ensuring that the stages of case management are followed;
- Elaborates the individualized intervention plan;
- Determines the structure of the multidisciplinary community team;
- Ensures communication with all medical/social service providers;
- Coordinates the case official, facilitates his/her communication with other suppliers involved with the interventions;

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- Elaborates plans for evaluating risks and preventing complications;
- Communicates the decision to solve problems after evaluating the interventions;

**The case official:**

- Ensures the implementation of the individualized intervention plan;
- Ensures that the necessary medical/social services for dealing with certain issues and satisfying the beneficiary's needs are provided;
- Ensures that all the decisions and medical/social services which target the beneficiary are communicated;
- Ensures that the beneficiary receives information which he can understand regarding all that is done to solve the respective problems;
- Ensures communication between all the service providers involved in the resolution of the case (ensures inter-family mediation and collaboration with the community health teams, monitors the implementation of medical/social services and interventions).

**The stages of case management:**

- Initial evaluation - data collection and problem prioritizing;
- Medical/social diagnosis depending on the problems or the needs which are identified;
- Elaborating the intervention plan;
- Applying and implementing specific medical, social and home-care related interventions from the individualized plan;
- Evaluating the results of the interventions and the beneficiaries' opinion.

In community nursing, solving a complex medical/social case means applying a certain algorithm, undergoing a variety of stages that are meant to fully or partially satisfy the identified needs, according to the following scheme:

**A. INITIAL EVALUATION - DATA COLLECTION**

Signalling or identifying a certain medical or social situation in the case of a beneficiary (patient) from a community implies an initial evaluation to determine the existence of medical/social problems or unsatisfied needs. In order to offer aid as part of integrated community services depending on medical, social, and home-based service providers, an initial evaluation is necessary in the community intervention team. All the necessary data are gathered and all the problems that require an intervention are identified.

This complex evaluation implies knowing all the problems and resources of the beneficiary in order to elaborate an intervention plan. In order to have a correct evaluation, the members of the multidisciplinary team need to understand how various elements relating to social, familial and individual context affect the patient's state of health and social situation.

In this stage it is also necessary to prioritize the beneficiary's problems depending on gravity and available resources. For this purpose, the members of the multidisciplinary teams have the following data collection methods:

- INTERVIEW/ ANAMNESIS from direct sources (patient) or indirect sources (the patient's family or medical documents)
- CLINICAL EXAMINATION/ PARACLINICAL EXAMINATIONS/ LABS - physical examination, results from other examinations and lab tests
- COMPLEMENTARY EXAMINATIONS/EVALUATING LIFESTYLE - social investigation, epidemiologic evaluation, risk evaluation, family environment evaluation

It is important for the members of the multidisciplinary team but especially for the case official to get close to the patient and his/her family by:

**Examining the patient/beneficiary and the care/intervention plan**

- Emotional aspects;
- Intellectual aspects (how well the patient is acquainted with the disease, its complications and various legal implications);
- Economic aspects.

**Examining the family environment**

- The relationship between family members;
- The structure of the family;
- Various medical/social situations other family members were involved in;
- How medical recommendations were followed and how social aids were used.

**The beneficiary's position in the community**

- Appurtenance to certain social groups;
- Responsibilities in the community.

**B. MEDICAL/SOCIAL DIAGNOSIS AND ESTABLISHING INTERVENTION OBJECTIVES**

After the initial evaluation (there has to be a very small delay between signalling a social/medical situation in the community and analyzing the case, according to its gravity and urgency), a case manager is named from among the members of the multidisciplinary team. Depending on the nature of the problem (medical or social) and on the area of expertise of the team members, the case manager can be a family doctor, social worker, community nurse etc.

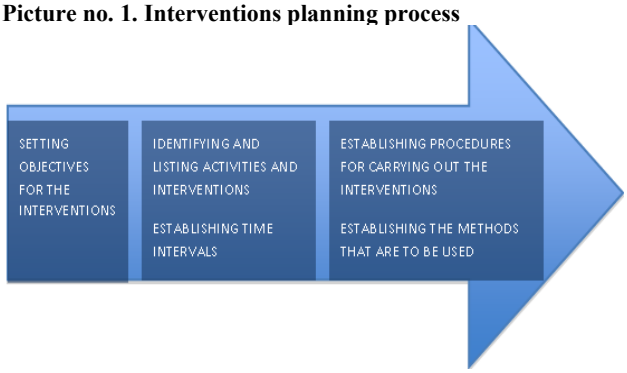
The individualized intervention plan will be based primarily on establishing intervention objectives i.e. the changes that are necessary for improving the patient's health or for solving certain social problems.

**C. PLANNING INTERVENTIONS**

In order to make interventions efficient, planning has to involve the participation of the patient/beneficiary.

The following factors are at the foundation of the individualized intervention plan:

**Picture no. 1. Interventions planning process**




**D. IMPLEMENTING THE COMMUNITY INTERVENTION PLAN**

The intervention is the most "visible" part of the community medical/social assistance plan. An intervention plan has no real practical value if there isn't a clear understanding regarding the means by which it will be implemented.

Along the course of implementing and carrying out planned activities, the members of the multidisciplinary team, especially the case manager or case official must monitor the process of implementation. Depending on the results of the interventions in dealing with the patient's/beneficiary's medical or social problems, the actions in the community intervention plan can be continued or modified to a certain degree.

Monitoring also implies checking the way in which

resources are used and how this has effects on the patient/beneficiary.

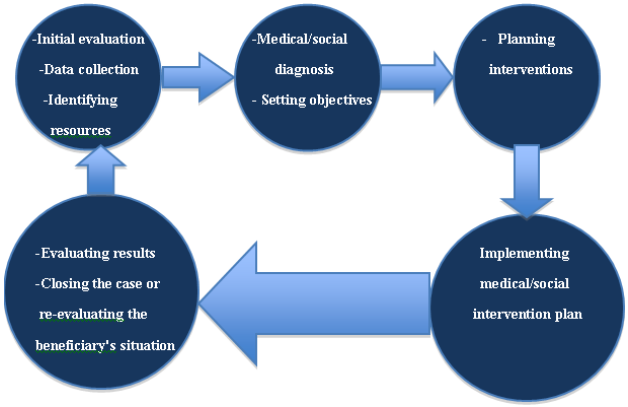
The main purpose of monitoring is to know whether the medical or social interventions are concordant with the patient's needs, but also to allow modifications to be made according to various results and the evolution of the patient in question.

**E. EVALUATING THE RESULTS**

Personalized interventions in community assistance need to prove their effectiveness by reaching their goals. Also, when providing medical/social assistance on a community level, the members of the multidisciplinary team and especially the case manager need to evaluate the performance of the various methods used for solving a case and also need to be able to make adequate changes for improving the quality of the services.

The degree of patient/beneficiary's satisfaction will be established by evaluating the patient's opinion regarding the results of the interventions, but also the services he has benefited from. (Feedback)

**Picture no. 2. Community intervention integrated process**




## BIBLIOGRAPHY

1. Cojocaru Ş. Metode aplicative în asistența socială, Editura Polirom 2005.
2. De Peretti A, Legrand JA, Boniface J. Tehnici de comunicare, Polirom 2001.
3. De Lassus R. Analiza tranzacțională, Ed. Teora 1999.
4. Irimescu G. Asistența socială a familiei şi copilului, curs IDD Editura universității "Al. Ioan Cuza" Iaşi 2003.
5. John Snow Inc., IHSM, Practice Management in Primary Health Care, 2002
6. Neamțu G, Stan D. Asistența Socială - studii şi aplicații, Editura Polirom 2005.
7. Olăroiu M, Mănoiu V. Îngrijiri paleative la domiciliu Editura Viața Medicală Românească 2004.
8. Reinke W. Health planning for effective Management New York: Oxford University Press 1988.
9. Szekely C. Nursing comunitar - curs Universitatea de Vest "Vasile Goldiş "Arad.
10. Zamfir C. Politicile sociale în România 1990-1998, Bucureşti, Editura Expert.
11. http://en. Wikipedia.org/wiki/Strategic planning