Case Management
in Various National Elderly Assistance Systems

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Integrated Report of the ISG Sozialforschung und Gesellschaftspolitik GmbH

In the Framework of the International Co-operation Project
"Co-ordination of Complex Assistance for the Elderly:
Case Management in Various National Elderly Assistance Systems"

Developed by the Bundesministerium für Familie, Senioren, Frauen und Jugend

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1 Introduction

With increasing age, many people are no longer in a position to manage daily life on their own, but depend upon the assistance and care of others. Family members and social networks then provide diverse support. This assistance is, however, often not sufficient if the need for assistance and care of the elderly person exhausts the relatives, or if the elderly persons become self-reliant due to move or death of a family member. Especially in cases in which a high degree of assistance or care is necessary, but also in acute crises (when, for example, after treatment in hospital, the question arises under which conditions a return to the private home is possible) for which additional support through professional care services and volunteer assistants is required. But it is often too much for older people to obtain an overview of what assistance is available and to choose those means of assistance which are necessary and which make sense for them. A qualified Case Management can assist in this situation to sound out the concrete assistance and care needs of the older person and to optimally tailor the offer of professional and volunteer assistance to his personal needs, his social situation and his living conditions.

These problems are faced by elderly people in various countries in a similar way; but the forms of professional and volunteer support are varied, as are the national and local experiences of how the available assistance resources can be tailored to the individual case according to need. The Federal Ministry of Family, Senior Citizens, Women and Youth (*Bundesministerium für Familie, Senioren, Frauen und Jugend - BMFSFJ*) of the Federal Republic of Germany proposed, within the scope of the "International Year of Senior Citizens 1999", to compare model experiences in the consultation and mediation of services for older people in need of assistance in several countries. The ISG Sozialforschung und Gesellschaftspolitik GmbH appointed to direct and scientifically analyse this co-operation project:

The significance of this co-operation project for the Bundesministerium für Familie, Senioren, Frauen und Jugend was expressed by the representative Mrs. Dr. Gorges at the project's inauguration as follows:

"1. The need for providing services in the elderly assistance sector, as in general, is more and more orientated at the tendency of 'ambulatory prior to stationary services' - which firstly corresponds with the needs of the persons concerned, and secondly, is less cost-intensive.
2. People in the Federal Republic of Germany believe that the persons concerned have a legal claim for specific individual consultation in a

situation of crisis; thus, practice has to clarify which aspects have to be fixed by law.
3. In a situation of crisis, the citizen needs to know which central consultation office he has to address; yet practice has to prove whether this has to be his community or can be another institution.
4. Common or similar infrastructures have a positive effect on a growing together of Europe - so let us compare the situation in other countries."

The co-operation project brought together the responsible persons of the different Ministries ("national representatives") and the specialists ("evaluators"), in order to compare the various national systems of Case Management in the elderly assistance and care to the international system. Following countries could be won to participate in the project:

Country	*National Correspondent*	*Evaluator*
• Belgium	Rita Baeten	Dr. Christiane Gosset
		Dr. Cécile de Froidmont
• Spain	Teresa Sancho Castiello	Dr. Lluisa Marrugat
• Israel	Miriam Bar-Giora	Dr. Ariela Lowenstein
• Italy	Dr. Natalia Nico Fazio	Dr. Luisa Bartorelli
	Dr. Raffaele Fabrizio	Dr. Aurelia Florea
• Luxembourg	Fernando Ribeiro	Dr. Jacqueline Orlewski
• The Netherlands	Dr. Jaap Poleij	Dr. Clarie Ramakers
• Austria	Dr. Alexandra Werba	Dr. Waltraud Saischek
• The United Kingdom	Raimond Warburton	Prof. Dr. David Challis
• Germany, *represented by the Länder:*		
– Baden-Württemberg	Dr. Konrad Hummel	Prof. Dr. Wolf Rainer Wendt
– Hamburg	Eckhardt Cappell	Lothar Voß
– Hesse	Dr. Hannes Ziller	Hermann Scheib

The basic conditions in these countries are comparable since the increasing number of elderly, especially very old persons, confronts the services which provide care and assistance for everyday life with new challenges. Moreover, several countries know the systematical division of the health and social sector, including its effect on communication problems between the medical and the social care professions. The concrete structures under which elderly assistance and care is organised in the various countries, thus differ from each other and determine the method that is adopted in the Case Management concept.

In order to detect and understand these national contexts and conceptional types, the project was initiated by a workshop - held in February 1999 - to exchange national conditions and specific understanding. In the framework of the co-operation project, all participating countries had to choose one or two projects and use these examples to illustrate the national comprehension, the national framework, and the concrete method of Case Management for the elderly. In order to prestructure these studies, an evaluation scheme was set up in the initial approach, and discussed by the participants in the workshop. The evaluation aimed at an instructive analysis of national methods and experiences in the fields of Case Management for the elderly. This analysis should transmit ideas and improve the international distribution of successful solutions and structures.

During the following months, the evaluators visited their selected projects, held talks with the Case Managers there, and discussed the Case Management process on the basis of concrete examples. Between August and October 1999, the ISG received all reports of the national evaluators. There, an integrated analysis of the individual national reports (see part 2 of the present report) was made.

In November 1999, the evaluators and national correspondents met for a final workshop to present and discuss the individual evaluation reports and the integrated evaluation of the ISG. The reports of the evaluators as well as the outcomes of the discussion will be published in a separate volume. The final report presented here documents the individual reports in short summaries (see part 3), which were co-ordinated with the evaluators. Part 4 of this report defines - on the basis of the gained experiences - recommendations for a conceptional development and practical implementation of Case Management.

Many thanks to everyone who helped to make the international project a success by their engagement, their evaluation and their participation in the final discussion.

2 Integrated Evaluation of the National Reports

The Conception of the Evaluation

The international linkage of experiences in the Case Management should not be confined to professional discussion but include the concrete experiences of practice. Thus, one or more projects were selected on national level which gained some experiences in Case Management since quite some time. The national evaluators had the task to visit and personally make contact to a concrete Case Management office. This Case Management office should be described with regard to questionnaires (case examples on structural level). Then, the process of consultation should be explained by means of some examples on the Case Management for the elderly (case examples on clients' level).

The comparison of various Case Management offices is orientated by following four crucial questions:

(a) In which context does Case Management stand? (framework)
(b) Who works in a concrete Case Management office, under which basic conditions? (personnel and organisational structure)
(c) How and with what instruments does the Case Management office work? (methods)
(d) What does Case Management offer? (service structure, concrete conditions, outcomes)

The evaluators integrated these questions into an evaluation scheme which included following questions:

(a) National Context

- How can the situation of an elderly person in need of care be described in your country? (*short description of the demographic situation and the care infrastructure*)
- How is Case Management for the elderly in need of assistance understood in the national professional discussion, and in what forms is it developed in practice?
- Which position does Case Management for the elderly take within the political planning of structures for the elderly assistance and care?

(b) Structural Requirements: Qualification of Employees, Technical Resources and Institutional Structure

- How many employees participate in Case Management?
- Which qualifications do these employees have?
- In what form are the division of labour and team meetings practised by these employees?
- To what extent are volunteer workers included in the Case Management, and in which areas of activity are they engaged?
- Which technical resources (office equipment, electronic data processing, telephone with answering machine etc.) are employed, and which material and spatial resources are available to Case Management?
- Which financial resources are available for the implementation of a qualified Case Management?
- When can the Case Management office be reached by phone; when can personal talks be held?
- In what institutional structure is Case Management organised; to which institutions is it linked?
- What are the consequences of an institutional linkage regarding certain aspects of work?

(c) Methods

- In which form is an assessment of health, care and socio-cultural aspects carried out in order to determine the concrete assistance and care needs as well as the life context of the client?
- Which instruments are brought in to carry out the assessment?
- Which methods of consultation are applied, and which points are taken into consideration thereby?
- In what way is the local medical care and assistance system (care services, household assistance services, possibilities of geriatric rehabilitation, day care and short-term care, care by the family doctor or through a clinic, availability of assisted living arrangements, nursing home placement - if necessary, etc.) recorded? Are these capacities recorded in a computer system and then continually updated?
- Are the experiences of the Case Management offices (for example, regarding too low or too high capacities in the individual sectors of the service system) taken into consideration when planning the care structures?
- How is an individual assistance plan drawn up, taking into consideration the situation of the client and the available assistance resources?
- Is this assistance planning examined after a certain time, regarding: what targets were achieved, which ones were not, and which aspects of the assistance plan have to be modified?

- Which steps are taken to mediate the required assistance?
- What possibilities of co-determination in planning and organising the assistance services does the client or his family members have?

(d) Service Profiles and Outcomes of Case Management (to be answered on the basis of individual examples of clients, if possible)

- How can one continue to lead as independent a life as possible in a private household, even after a hospital stay or an acute decline in one's state of health?
- Which measures for change must be undertaken (such as the organisation of household assistance, mediation of a care service, technical alterations in the home itself, assistance with moving into an assisted living arrangement or a nursing home, etc.)?
- Which concrete needs for assistance or care does the client have?
- Which family and neighbourhood support systems can assistance him to fulfil these needs?
- Which professional and volunteer resources can contribute to this support?
- In what way can one combine family and neighbourhood, professional and volunteer resources with one another in order to organise assistance adequate to the client's needs, taking into consideration the social situation and living conditions of the client?
- Which concrete steps are required in order to realise an individually-tailored package of assistance services?
- Are the proposals for solutions worked out by the Case Management compatible with the client's subjective estimation of his need for assistance, or must acceptance problems be clarified in a consultation session?
- Which local support structures, such as assisted living, hospital transition, local care support services, etc. are available?
- Which social exponents (e.g. charity organisations, privately-owned services, volunteer organisations, community or government assistance structures) are active in this care service field?
- Which influence does the living situation of elderly persons have on the possibilities of achieving a needs-based solution?

The reports on the projects by the individual countries more or less followed this evaluation scheme - although not all aspects were applicable to each of the selected projects. Yet the integrated evaluation of the national evaluation reports in the following is orientated at this structure in many points.

2.1 National Contexts

Sketch of the Demographic Situation and the Care-Giving Infrastructure

Age Structure

The demographic structure of the model regions differ extremely: While the percentage of elderly population is very high in some regions (persons aged 60 or more rank 26 % in Emilia Romagna; 22 % in Northern Hesse - 15 % for persons aged 65 or more, respectively -; 22 % in Belgium, and 20 % in Austria.), a lower quota is found in other participating countries or regions (e.g., 9 % of Israel's population is aged 65 or more). All countries report a strong tendency towards an increase of the elderly population (Sabadell/ Spain: the quota of persons aged 65 or more increased from 13 % to 16 % within three years; Austria: an estimated growth of population aged 85 or more by 100 % until 2030). All participating countries regard the elderly assistance as primary problem, simply the development towards this situation varies in time.

Migration

The relevance of migration problems differs as well. While in Germany only a small number of the population consists of elderly migrants, the enormous number of elderly migrants in Israel cause problems in language and in cultural integration for some of the elderly clients. The elderly migrants possess a different cultural background, often combined with low education and distrust towards changes.

Systems of Health and Social Assistance

All participating countries reported a common problem that contributed to the development of the Case Management concept: The fundamental distinction between the health system and the social system which is found especially in Southern or Western European countries and in Israel[1]. A detailed description of each project demonstrates that the initial situation was marked by activities of employees in both systems which did not correspond. Thus, Case Management was introduced to concert actions. The

[1] A comparison of various systems of the health and social services, as well as the financing structure linked to them, is provided by B. Schulte, Altenhilfe in Europa, Schriftenreihe des Bundesministeriums für Familie, Senioren, Frauen und Jugend Vol. 132.1, Stuttgart 1996, especially Pages 141 f.

success of the Case Management offices mainly depends on how far such an integrated working was accomplished.

A basically different system of health and social services is typical for the Scandinavian countries; here, a service system based on primarily governmental funding brought out a uniform structure on communal level.[2] More differences can be found in the socio-political background in the United Kingdom, especially regarding the tasks and history of the so-called "Care Management". There, this form of service organisation was not a reaction on badly co-ordinated and intransparent service systems but an attempt to arrange suitable service packages *within limits of the budget*.[3]

Comprehension and Type of Case Management

Comprehension of Case Management

To fully comprehend Case Management, it has to be pointed out that the expression "case" does not refer to the client but to a critical situation in which further resources of assistance have to be mobilised. Thus, it is not a person who is "managed" but a crisis.

The definition of Case Management is similar in different sectors. In Spain, "Case Management" is understood as co-ordination of services for elderly persons in need of care and their families, realised by individually tailored services and cost control in one. In Israel, "Case Management" is a mullet-dimensional method including managerial, co-ordinative and medical functions. "In Germany, Case Management is seen in the context of reformatory efforts that stress co-ordination and connection, efficiency in serving the citizens, and enhanced active participation of the citizen in handling social problems and tasks" (*Land* Baden-Württemberg). The definitions made by other evaluators point in similar directions.

The definition of Case Management should not be confined, but express the various types of Case Management. Such a definition should

- announce a self-reliant living for elderly persons as purpose of Case Management,

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2 Since the contact made on national level was not handed down to the communal level that is in charge of the elderly assistance, the system could not be included in the project documented here.

3 See Schulte, Altenhilfe in Europa, etc. Page 108 f.

- include following functions (medical and socio-cultural): assessment, assistance planning, mediation of assistance, evaluation, as well as adaptation of the assistance plan to needs,
- refer to the client's typical situation (as for example, discharge from hospital, increased need of assistance in private households, as well as need for stationary care due to neglect),
- explain the difference between Case Management as procedure and Case Management as organisational structure; and finally
- express the organisational linkage of Case Management (to the community, to the hospital, as independent consulting office, to the assisted living arrangement etc.).

Realisation of Case Management

The realisation of Case Management shows a broad spectrum of models and versions. First, the structural development is different: the examples show different types of Case Management reaching from Case Management in addition to one's regular duties (the Roman model), to part-time engagement (in various offices), up to a comprehensive capacity performed by interdisciplinary teams (in Spain). Second, the integration of Case Management into the systems of care and assistance differs depending on whether they are tested in models or already part of the general provision (Emilia Romagna). In countries with a divided health and social system - by structural organisation -, the localisation of Case Management within one of those systems requires a strong emphasis in its contents as well as the mediation of problems to the other system.

Position of Case Management within the Political Planning of Structures for the Elderly Care and Assistance

The pioneer in the development of Case Management concepts is the United Kingdom; the "National Health Service and Community Act", enacted in 1993, was the basic legislation. Shortly after, at the end of 1993, Case Management was integrated into the regular system of care and assistance in Emilia Romagna by the law "Tutela e valoriz-zazione delle persone anziane. Interventi a favore di anziani non autosufficienti". Since the beginning of 1999, the Care Insurance in Luxembourg is bound to perform Case Management as well; although practical experience still has to prove whether the responsibility of a realisation of care according to needs is taken in terms of a Case Management process, or if it merely remains a theoretical claim (as reported from Israel, and confirmed by experiences of the German Care Insurance).

In other participating countries, the basic legislation for the right to receive Case Management is not very well-developed; the socio-political importance of this concept becomes evident in the governmental programs to further promote this concept.

- In Belgium, the tradition of promoting Case Management models is very distinct: The project of a "Référent Hospitalier" to guarantee continuous care (1998 – 1999) is the third following two model projects, namely the "Case Management and Care for Psycho-Geriatric Patients and Their Family" (1994 – 1996) and the "Case Management in Belgium Hospitals" (1996 – 1998). A follow-up project emphasising the ambulatory sector is already planned (1999 – 2000).
- In Baden-Württemberg, the promotion of Case Management results from two traditional lines: First, a comprehensive system of "information and mediation offices" was established to consult and support persons in need of care and their family members. Second, the citizens' engagement was enhanced in various model projects. The Case Management project in this case combines elements of both.
- Since 1998, a comprehensive system of consultation and co-ordination offices financed by the *Land* and the community is set up in Hesse. A pilot project called "social and ergo-therapeutic team" that tested the typical elements of Case Management was launched previously in the region of Northern Hesse (1993 – 1996).
- In Spain, different programs for handicapped or chronically ill persons were launched, especially in Catalina the so-called "Vida a los Años" (fulfilled years, 1986). For the first time, a program was directed specifically for the elderly; before, selective assistance was offered merely by hospitals or care centres etc.; however, no integrated medical, social and familial assistance for the elderly person in private households could be found. Comprehensive and individually tailored assistance is essential, as well as avoidance or delay of hospitalisation and the establishment of social-health centres for persons in need of care and assistance.

A line has to be drawn between Case Management as element of a basic provision with care and assistance (e.g., Britain and Emilia Romagna; Belgium might start soon) and the development within the scope of a model project (as, e.g., in Innsbruck, Rome, *Land* Hamburg). The better Case Management is established within the structure of care and assistance, the sooner the co-operation partner will accept and integrate it into his own operations (the Spanish report compares two different models that demonstrate this).

2.2 Structural Requirements: Qualification of Employees, Technical Resources and Institutional Structure

Number of Employees in Case Management

The structures of the evaluated Case Management projects differ especially regarding the definition of the employee's role: either as a full time position or a part-time function within a larger team. The number and qualification of Case Managers depend, in the first case of an independent Case Management office, on all employees; in the second case, on the amount of work done for Case Management by each team member.

A closer look reveals the limited capacity of employees for Case Management. Various types follow:

- an employee allocated 20 hours per week (half of a full time position) might either be responsible for the Case Management in an independent Case Management office (in Hesse), or in connection to a clinic (in Belgium).
- a Case Manager (in a full time position) can additionally allocate a proportion of 20 % of a social worker's work load; an amount that usually accounts for community field work (Austria).
- Two Case Managers (a general and a psychiatric specialist) are allocated 24 hours per week taking care about 40 inhabitants of an assisted living arrangement (the Netherlands). A comparative job is done by two workers allocated 10 hours per week (a quarter of a full time position), each responsible for 15 clients (Israel; here the Long Term Care Insurance appoints one Case Manager to 350 cases which obviously makes a qualified Case Management impossible).
- A team of six specialists (plus administrative staff) is appointed to various medical and social aspects of Case Management (shared work load that accounts for about 10 % of the total working hours), as well as to additional services (Spain).
- Within the framework of a pilot project, several units are involved in the entire process with two Case Manager (one social worker and a household nurse) appointed to 200 selected cases (Rome, Italy).

The capacity of personnel in Case Management depends highly on the institutional integration of the Case Management office into the entire structure of care and assistance, and on the amount of related fields of work. In Emilia Romagna, various Case Management offices exist (usually occupied by social workers); they, however, can rely on a specially developed institution (Geriatric Assessment Unit - UVG) in cases of an assessment of a per-

son in need of care. Same as the project in Rome, several units are involved in the entire Case Management process.

> Not directly comparable are the experiences of Luxembourg: when introducing the Care Insurance Law here, an evaluation and orientation office was established to integrate Case Management. This office assigns 16 employees with different qualification. In the initial phase of the Care Insurance, these employees do not perform tasks of Case Management but are solely responsible for assessing the need of care of all inhabitants of Luxembourg who applied for services.

The Required Qualifications

In Spain and Luxembourg, all qualifications provided by the team are included in Case Management, based on division of labour. Most other Case Management projects, however, stress competencies in social work as major qualification. Notwithstanding, additional professional and personal qualification play an important role.

- In some projects, a multiple qualification is expected from the Case Manager: In Hesse, the Case Managers possess the qualification of both a social pedagogue and an examined nurse; the Case Managers in Austria are nurses with diploma and an additional social-medical education; in addition, they have expertise in ambulatory and stationary elderly assistance (through work experience, or practical courses), and in some cases experience in consultation offices or through “social competence”.

The Israeli report explicitly points out the necessity of professional and personal qualification: Case Manager are social workers who moreover require

- knowledge of the needs of the relevant target group
- knowledge of the corresponding service providers
- knowledge of the available community resources
- close co-operation with the service providers, volunteer agencies and other community services
- expertise in information and referral activities
- expertise in interviews, data collection and assessment
- general expertise in elderly assistance, including its basic legislation.

Thus, some projects aim at a combination of different professional qualification within one person; others distribute the competencies on a multiprofessional team that performs every step of Case Management in cooperation. Various reports, however, point out the significance of personal expertise and “social competence” of the Case Manager (e.g. Austria, Israel, Hesse).

Division of Labour and Team-Meetings

The projects performing Case Management within a team have clear regulations on division of labour, as well as regular team discussions on daily work. The functions of the team meetings, however, differ: in some cases, a comprehensive exchange of experience is given, and in others, certain elements of Case Management (e.g., the development of a care plan) are discussed.

- In Spain, an assessment based on division of labour is the basic element for setting the outcome of assistance and developing a care plan during the course of a team meeting (latest one month after the first visit). Likewise in Italy and Belgium, the care plan is set up by an interdisciplinary team that meets regularly.
- In Luxembourg and Austria, regular meetings are organised to discuss complex themes as well as especially difficult cases. The team meetings guarantee the interdisciplinary treatment of the various needs of a person applying for assistance.
- The purpose of the weekly meetings of Case Manager with Case Manager from other city districts (in Austria) is to exchange experience; moreover, once every two weeks the Case Managers meet all employees of the elderly assistance of the Social Service Bureau to discuss – as specialists – individual clients and organisational problems (in Israel).

These internal team meetings, however, have to be distinguished from regular meetings and contacts to other service institutions (e.g., visits to hospitals or day care centres, co-operation in regional care conferences).

Integration of Honorary Assistants

The question of including honorary or voluntary workers differs to a high degree within the various examples of Case Management. Several projects co-operate with voluntary organisations; an example from Germany demonstrates that the honorary staff is integrated into the structure of Case Management itself.

- In Haifa, close co-operation with the Voluntary Assistance Centre: Case Managers train voluntary staff and inform about persons in need of care (Israel).
- In Sabadell (Spain), voluntary assistance - such as paying visits in case of loneliness as well as accompanying to pensioner clubs, physicians, or authorities – is integrated in the Case Management.

- Within these model examples, much significance to the systematic integration of volunteers is given in the Case Management project in Baden-Württemberg. The honorary staff has certain functions, such as: organising meetings for the elderly, consultation on housing, guidance for relatives of the mentally infirm, and services to relieve care-giving relatives.

In all these cases, the voluntary assistants perform tasks which supplement the professional care. This kind of services cannot be financed as professional services and would be missing without the engagement of voluntaries. The report of Baden-Württemberg further points out the necessity of "small-talk" with the honorary to allow confidential talks on the burden of the care situation as well as on unsatisfactory professional care. This critical function represents an individual service that is independent from professional structures.

Voluntary assistance, however, is not included in all Case Management projects. In Austria, honorary assistants of *Sprengel* (a territorial authority) are momentarily not appointed due to a lack in the organisational structure. The example of Hesse, likewise, indicates that the time capacity to mobilise and train voluntaries is not sufficient. Yet in both cases, informal assistance is only included if it is available in the family or neighbouring environment of the client; a stronger systematically integration of honorary staff is planned (for the future). No voluntary assistance is systematically integrated in Italy, Belgium, Luxembourg, the Netherlands and Hamburg.

Material and Spatial Resources

The physical environment and the technical resources are restrict comparable. The basic equipment - such as an office (usually occupied by two employees), a telephone and an answering machine - is similar in all examples. Especially well equipped are the Case Management projects in Austria and Hesse:

- In Hesse, one Case Manager occupies an office (of 18 m^2), equipped with a desk, as well as a suite of armchairs and a settee, a telephone, an answering machine, and a personal computer. In addition, she has access to a copy-machine and a fax. For visits, an official car is available to her.
- In Innsbruck, a telephone, an answering machine, a fax, e-mail, and mobile phones are available; moreover, a computer with access to a "health information net" that informs about resources, capacities and utilisation in the ambulatory and stationary sector (access possible during consultation). In this case the Case Managers also drive official cars.

- In Luxembourg and Rome, Case Managers possess portable computers to enter and evaluate data on the spot.

More critical regarding the physical and technical equipment is the report from Israel: there is only room for two Case Managers and a telephone with answering machine; since there are not enough telephone lines, Case Managers often use the service of the Volunteer Assistance Centre. Although computers are available for general administrative purposes and baseline data on clients, no personal computers are available for Case Managers (so baseline data and further information on the Case Management process are handled separately).

Hours of Personal and Telephone Availability

Case Management often is required in critical situations, when decisions on possibilities of care and assistance have to be taken immediately; as for this, the "availability" of a Case Manager is important to the efficiency of Case Management. However, a distinction has to be made between the reception of a call that can be done by an answering machine or a call-centre, and the handling of a call, e.g. as information or consultation by phone.

- In some projects, Case Management is part of a comprehensive consultative organisation, including a call-centre. In Spain, the social-care centre can be reached by phone from 8 a.m. to 8 p.m., afterwards by an emergency-call service. In the assisted living arrangement in Nieuw Doddendaal (Netherlands) likewise, calls are first received by a call-centre; working hours are 8 a.m. to 11 p.m.. In both cases, general information is offered and appointments with Case Managers are arranged.
- However, Case Management offices with fixed office hours are easier to reach. Here, Case Managers can be visited or talked to directly. This certainly requires a sufficient capacity of personnel. In Israel, the Case Management office is opened from 8 a.m. to 3 p.m., once a week to 6 p.m.; in addition, a Case Manager is at hand "on-call" in cases of emergency.
- Another case is – as in Hesse – the example of a Case Manager who works independently (as part-time assistant), having no office with fixed working hours. Although the availability by telephone (or answering machine) is given here as well, no direct contact to the Case Manager is possible; the Case Manager in this case, lays emphasis on home visits while no regular consultation hours at the office are offered due to limited working hours.

Not relevant is the question of availability in cases that require an institutional access to the Case Management procedure, i.e. when clients who are found eligible are automatically directed to the Case Manager in cases of hospitalisation (Belgium), application for a home (various examples from the Netherlands), or care services (Luxembourg).

Institutional Structure and Financing of Case Management

The institutional structure of Case Management and its financing are usually connected. The different types reach from complete financing by the government (res. financing through the budget of the Care Insurance) to models of a mixed financing or clients' contributions. Some typical examples follow:

- models of "pure" governmental financing are found in Austria (financing by the *Land* and municipality) and, similar, in Spain (financing by Comunidad and municipality).
- In case of the Care Insurance being in charge of counselling and mediating assistance, it also represents the assessment or consultation offices (as in Luxembourg, Israel, Germany). It, however, remains unclear whether merely a classification of the care level is performed, or the typical steps of Case Management in assistance planning, service mediation and control are taken. (In Israel, this aspect led to the development of a Case Management model in addition to the Care Insurance.)
- In Hesse, the consultation office is financed by an interlocking system of service providers, churches and public funds.
- The example from the Netherlands shows a Case Management financed by an "assistance budget" that is re-financed through lump-sum contributions to which the inhabitants are entitled.

Institutional Integration and Main Aspects of Case Management

Regarding the organisation, various forms of integration of Case Management are found in the examined model examples. They can be differentiated by the degree of institutional independence. Advantage of such an integration into existing institutional structures is the shared use of technical resources and their notoriety, hence causing synergy-effects. Disadvantage of such an integration can be an insufficient independence of Case Management towards other consultation offices. The reports presented by the participating countries illustrate following forms:

- independent consultation office (Emilia Romagna, Hesse)

- integration into a district (Austria, Spain)
- pensioner's clubs and ambulatory services (*Land* Baden-Württemberg)
- administration by the Care Insurance (Luxembourg)
- municipal administration (Israel, Hamburg)
- hospital (Belgium, Rome)
- home for the aged or assisted living arrangement (the Netherlands)

The institutional integration influences the structure of clients and the priority in work. Some Case Management projects specialise in certain groups of clients and problem constellations.

- The Case Management offices that are institutionally integrated into a hospital concentrate on transfer after hospitalisation and seek to guarantee a continuity of care by maintaining contact to ambulatory services and relatives. This procedure of selecting and accompanying the client up to providing assistance after his return to the private home is explicitly mentioned in the Belgian report.
- Also very specific are the clients and the priority of work in the examples from the Netherlands. Some Case Management projects - placed at homes for the aged - are sketched in those examples; clients are selected during the process of application for a place in the home: alternatives to stationary care are examined here. – The example of the assisted living arrangement in Nijmegen is special such as defining the specific need of assistance, as well as providing the necessary service for a certain group of inhabitants (in a stage between complete self-reliance in the private household and the need for stationary care).
- While Case Management is orientated at the Care Insurance, the selection of eligible clients is determined by legal criteria for the need of care, either directly (in Luxembourg), or indirectly (in Israel, clients were selected according to these criteria at the beginning of the project, later the number of clients was increased.).
- Less restricted are the Case Management projects that either work as independent office or in co-operation with the social or health system of the municipality, the district, or the pensioner's clubs (e.g., Austria, Spain, *Land* Hesse). They basically include all elderly citizens in need of care who live in private households. The projects in Emilia Romagna take the next step: the Case Manager accompanies the person in need of care also when accommodated in a home.

2.3 Methods of Case Management

Assessment Instruments

Usually an assessment is performed at the home of the person seeking assistance, whereby health, care and socio-cultural aspects are the main aspects of the assessment. The advantage of assessing in the private household lies in the possibility to gain additional information besides the standardised data (e.g. impression of the environment, atmosphere between family members). The staff of Case Management projects positively pointed out the same aspects as interview results in Spain prove: The opportunity to learn directly about the environment and social surroundings of the client is seen as major advantage of Case Management.

Exceptions are those examples when first contact is established in a clinic (e.g. Belgium, Rome), or the systematically approach in Luxembourg where a home visit by the doctor is only paid when the client is incapable to see the evaluation office.

The first (non-medical) assessment is performed by the Case Manager himself; for multi-professional teams (as e.g. in Spain) the diverse aspects are assessed based on division of labour. In Italy, an additional assessment unit is appointed to complicated cases; it is asked for assessment by the Case Manager.

The assessment instruments include standardised questionnaires that can be analysed by computers as well as “discussion manuals” which allow a concentration on individual points of emphasis (e.g. Hesse). Usually, the aspects of assessment are orientated at medical and psychological diagnosis instruments, including scales to measure the daily competence (ADL, IADL). Depending on the emphasis laid by the Case Manager, accents are set differently:

- In Italy, the Case Manager assesses the general psychological and physical condition, the economic living situation, as well as the social and family situation of the person seeking assistance. In case the first assessment shows a multi-dimensional need for assistance, the second assessment unit (UVG) provides a multi-dimensional ability profile of the person seeking assistance with different levels of standard.
- In Spain, a two-level assessment process is carried out: in the course of a primary visit home, the client’s need for assistance is assessed, and he is informed in detail about Case Management; in addition, basic data is collected (e.g., socio-demographically information about client and ca-

re-giver, determination of the need of medicaments and resources). In the course of following visits, a comprehensive assessment is performed by all team members, with regard to professional specification: the physician examines health aspects; the nurse brings in instruments for basic needs, self-reliance, cognitive abilities and decubitus-risk; the social worker especially focuses on the socio-familial situation, the housing condition, the priority or maximum stress for the client and his family members, and the collection of statistical data.

- Due to the merely counselling function, the assessment in Hesse is performed by the Case Manager alone. The participation of relatives is of no further importance. The idea is to gain a most complex picture of the living surrounding and situation, as well as the individual need for care and assistance. During this first dialogue, it is vitally important to develop a basic confidence and – this point differs from other projects – to define the specific task of the Case Manager in accordance with the client.
- In the Netherlands likewise, a home visit is paid to the applicant of an assisted living arrangement. However, this is seen as service of the assisted living arrangement, to explain the concept of care and assistance in Nieuw Doddendaal, and to specify the request and need of assistance. Subsequent to this visit, the applicant is set on a waiting-list.
- In Luxembourg, after presenting a medical opinion attested by the family doctor, a medical evaluation is performed by a physician of the evaluation office – in absence of relatives – in order to classify the level of Care Insurance. The need for care is further evaluated through five standardised questionnaires. The first questionnaire provides the medical evaluation, the second evaluates the general living situation, the three subsequent ones assess the need of care. On separate forms, first, an assessment of the person seeking assistance (again in absence of relatives) is performed, second, an assessment of the relatives, and third, an assessment of the evaluator.

Recording the Local System of Care and Assistance

The record of access to the network of services differs in various projects due to different orientation and institutional integration.

- As a result of the preceding project “Social and Ergo-therapeutic Team”, the consultation office in Hesse has a very comprehensive data-bank including different service providers. This data-bank is updated continuously (through talks with providers and information from higher work groups).
- Concerning this, the Case Management in Austria is a step further, having a “resource record system”. This system records capacities of pro-

viders and can be called in anytime (also during an advisory dialogue) by the personal computer of a Case Manager. Data is updated by the providers themselves weekly (but since updates are not fully reliable, data has to be completed through telephone research).
- In Emilia Romagna, the co-operation on the network of a comprehensive Case Management is optional, and the capacity of the net in various regions depends on political acceptance, structure of health organisation, family doctors on duty.
- In the Netherlands, a contract with an external pool of workers who provide the necessary care, assistance and home maintenance services was set up. This contract appoints the required personnel.

Consideration of Expertise in Political Integration

Regarding the social planning, Case Management has an important side-effect which at first does not play a major role in the concept itself. When introducing a concrete service package, however, possibilities and boundaries of the system of care and assistance become more evident than from an overall view. Important information on proportion, insufficiency and quality of individual offers is added to the guidelines controlling assistance, normally given on community level, through the personal expertise of the Case Manager.

- An explicit consideration of lacks in the system of care and assistance could be established in the political planning, e.g., in Hesse. A close co-operation with the person planning the old-age assistance, as well as transfer of expertise to the political level, and work groups within the consultation and co-ordination offices of the district exist here.
- In Austria likewise, the expertise of Case Management offices is involved in planning care structures in order to avoid a too much or too little of care and assistance. Hence, the Case Manager can initiate the organisation of a special assistance structure for neglected persons.
- The report from Israel shows outcomes on the macro-level of Case Management: improvement of co-ordination and co-operation between service providers and community services were reached, as well as mediation of specialists from the health and social system, more flexibility of the services provided, improvement of quality through control, animation of volunteers, activating and supporting the informal system, internal quality control, and finally, development of further communicative networks.

For the role of Case Management within overlapping planning processes, it is important that information won through expertise in the concrete process

of Case Management is recognised by the social planning, and systematically integrated into the planning and management of service structures.

Provision of an Assistance Plan

The assistance plan can be set up in different ways regarding following questions:

1. Who plans the assistance? 2. How far is the realisation of assistance considered while planning? 3. Do consultation meetings take place during the planning?

- The person who sets up the assistance plan usually is identical with the one performing the assessment (e.g., Italy, Austria, Spain, Israel, *Land* Hesse). In the Netherlands, however, it is not determined whether the dialogue in the home of the prospective inhabitant is done by the same person as later the concrete assistance planning within the assisted living arrangement.
- Besides, special importance is paid to the distinction of planning the assistance and its realisation. In the example of Rome, a physiotherapy was considered necessary, yet its realisation delayed since a suitable therapist was not available. Even in the Netherlands, first, resources and requests are determined, then the Case Manager has to see to the corresponding of requests and service offers. In Hesse likewise, the needs and outcomes were determined on the basis of available resources; the realisation of an assistance plan is seen as a further and independent step.
- Many projects consider the requests of a person seeking assistance when setting up the individual assistance plan (e.g. Emilia Romagna, Belgium, the Netherlands, Hamburg and others). In most of the projects mentioned here, concrete assistance planning is performed during the dialogue with a client. In Luxembourg, the person in need of care is integrated into the assistance planning, inasmuch as the assistance given privately and the one carried out by specialists has to be co-ordinated with the client; although the planning itself is performed without the person in need of care.

Mediation of Services

The effort to introduce the assistance plan very much depends on the organisation of the network of service providers. In this context, the question

arises whether the assistance is granted by only one service provider, as in the Netherlands, or by various independent service providers.

- In Emilia Romagna and Luxembourg for example, networks of service providers are available to the assistance service for the elderly (SAA) or the evaluation office, respectively. In these cases, the service net is either directly activated by them, or by the person in need of care himself.
- Since no comprehensive network is available to the consultation office in Hesse, a great deal of logistic efforts is required to co-ordinate all service providers who are essential to a person seeking assistance in order to cover his needs. Therefore, various contacts have to be established to perform an individual assistance plan. Besides, the consultation office can only co-operate with service providers and financing units (Care Insurance, Health Insurance, Social Services Bureau) when the person in need of assistance agrees.

Possibilities of Co-Determination

As mentioned above, all projects consider – to a varying degree – the requests of the person seeking assistance or in need of care. A considerable degree of co-determination in planning and organising is given in the consultation office in Hamburg and Hesse because this office helps to locate the right services within a jungle of service providers and financing possibilities for the person seeking assistance. The consultation office offers assistance to the person seeking assistance, yet it is no obligatory element to receive assistance since assistance is accessible without them.

In some projects the persons seeking assistance are included in the concrete assistance planning and organisation to a less degree. Inhabitants of the assisted living arrangement in the Netherlands, e.g. decide independently – this is of great importance – which service they favour. However, the organisation by the Case Manager is done in accordance with the above mentioned workers' pool AKP. In Italy, clients' requests are integrated into the planning as well, yet planning and organisation itself is performed without the participation of the person seeking assistance.

In this context, the acceptance and co-operation of the client is essential. All participating Case Management projects point out that the clients (and their relatives) have to accept the proposals of the Case Manager throughout the whole Case Management process – from its beginning to the development of the assistance plan until the introduction of individual assistance services –, and they have to co-operate in order to obtain successful assistance.

Problems of acceptance are reported from new types of assistance (such as, e.g., day care institutions). Especially when working with migrants, the different socio-cultural background (e.g. Spain) and/ or language problems (e.g. Israel) enhance these difficulties of acceptance.

Evaluation

All projects control the actual situation, although methods differ. In some projects, discussion and control of the quality of care and assistance is performed regularly (re-assessment, control of outcomes and - based on this - modification of the assistance plan). Interim requests of alteration made by the client are assessed anytime, and if needed, the assistance plan is modified (e.g. Israel, Spain, Italy, Hesse, Netherlands). In Luxembourg, however, a re-assessment under normal circumstances is performed only after a period of half a year.

2.4 Service Profiles and Outcomes of Case Management

The Case Management projects evaluated here can be distinguished by their function as plainly supporting (e.g. Hesse), or entry to a network of service providers (Italy). Finally, other units beside Case Management exist to determine eligibility to services (Luxembourg).

The concrete process of Case Management is quite similar in all projects and includes the classical elements of assessment, planning, realisation, evaluation, as well as documentation. Differences are found within the composition and the intensity of each level, as well as the consequences for the person seeking assistance.

Some exemplary processes of Case Management – that seem particularly suitable – are illustrated in the following to point out specific differences within the system.

Spain

The process of Case Management in Spain very well demonstrates the structure of a complete Case Management process.

- *first*, establishing contact to the client,

- *second,* classification for a program of domestic care and assistance, or for other social services,
- *third,* a first visit (general assessment to classify the client, to gain information about the person in need of care, to inform the client, to assess the need for medicaments and resources),
- *fourth,* a second visit to perform a comprehensive assessment by all team members,
- *fifth,* a co-ordinated evaluation and assistance planning,
- *sixth,* a proposal of services as well as presentation of alternatives,
- *seventh*, regular home visits by various specialists to discuss with the client and his family the success of services or, if modifications are necessary, res. requested,
- *eighth, a* co-ordination meeting to discuss the case after some months, and finally
- *ninth,* the end of care by solving the problem (or removal to a home, or death).

Emilia Romagna

The case description of Emilia Romagna illustrates two important structural characteristics of the system: First, the Case Manager is a person to be permanently contacted by the person seeking assistance and his relatives; he gets involved and indicates further steps when problems occur, requests for modification are made, or the need of care is modified. Second, the Case Management in Spain does not end with the hospitalisation of the client; the process is further accompanied and, in case of an amelioration of the situation or at request, a return to the private home is sought to be organised through suitable supporting measures.

- In the examples referred to, the need of care was first mentioned by relatives or the hospital. The Case Manager performs the primary assessment of the need of care; and further applies for an assessment of the person seeking assistance by an assessment unit for complicated cases (UVG) at the assistance service (SAA).
- Next step is an assessment of the UVG and the development of an assistance program that provides accommodation in a nursing home after consultation of the family doctor and a Case Manager. The assistance service (SAA) then activates the corresponding service office (of the nursing home). The course is examined and a plan for intervention set up.
- In case of a deterioration of the health condition – presenting a new situation of need for assistance –, the Case Manager has to assess the additional needs and ask the UVG for a re-assessment; a revaluation

takes place in the nursing home, as well as setting up a new assistance program; the process of activating the necessary services is again performed by the SAA.
- In the institution, the client is further visited by the Case Manager who monitors the amelioration of his health situation. If the client requests to return to his private home, his request taken into consideration. The Case Manager re-evaluates the situation and asks the UVG for a further revaluation.

Obviously, the procedure and the moment of involvement of the various units is strictly regulated, also the institutionalisation in Emilia Romagna is no “one-way” since the person seeking assistance is accompanied even in the institution, and a return to the private home is possible, if requested and the client capable.

Israel

The division of Case Management tasks into a micro- and a macro-level (similar to the division of “internal” and “external” Case Management in Austria) as well as the complexity of tasks involving planning and realisation in the caring and nursing sector can e seen in the examples from Israel.

On micro-level, a comprehensive amelioration of the living situation of the person seeking assistance is aimed at, while the macro-level stresses the amelioration of the surrounding conditions. E.g., on the level of services improvement of co-ordination and co-operation between service providers and community services was reached, as well as mediation of specialists from the health and social system, more flexibility of the services provided, improvement of quality through control, animation of volunteers, activating and supporting the informal system, internal quality control, and finally, development of further communicative networks.

The examples (on micro-level) demonstrate that the most obvious problems, as physical infirmity, are not the major problems but the social surroundings of the person seeking assistance. Apparently, an intervention in the social environment (as, e.g., family therapy) is necessary. Interventions in cases of immigrants, however, who have difficulties with the unfamiliar surrounding, require special treatment.

Land Hesse

In Hesse, exactly one Case Management office deals with the accompanying of persons seeking assistance. In contrary to Emilia Romagna, an assessment and the assistance planning is performed by the Case Manager herself. The required assistance also includes the co-ordination of service providers as well as the securing of financing. Under certain circumstances the Health Insurance, Care Insurance and social agencies in Germany partially or fully carry the costs for assistance services, alterations in the house, etc. These services have to be applied for, and the outcome is sent to the person seeking assistance by the authorities. Assuming the granted services seem insufficient or, the services are altogether refused, opposition within a certain period is possible. The persons seeking assistance are often not familiar with the possibilities of services and simply asked too much to deal with the bureaucratic structures. The task of Case Management is to assist in filing the application and control the further proceeding. The importance of an intervention from the Case Manager can be seen in the following:

> An immigrant whose father in law lives with the couple since a short while contacted the consultation office; the father in law who has geronto-psychiatric problems had a stroke and is now fully in need of care. The consultation office was contacted for financial reasons: the social agency refused the required services he was eligible to. The Case Manager - after talking to the person seeking assistance - contacted the authority in charge. The official in charge, however, did neither know the basic legislation nor was she very helpful. Only after long-term intervention by the Case Manager and request to superior officials could a positive result be achieved. Yet the dragging fight for their right wore down the persons seeking assistance, so they decided to hospitalise the father in law.

Although the desired goal – to enable the father in law to stay in the private home – was not reached by the assistance of the Case Manager in the first place, a good contact to the responsibles was established, so a better solution for a similar situation can be found faster in future.

3 The Evaluators' Reports in Synoptic Form

3.1 Case Management in Baden-Württemberg (Germany)

Evaluator: Prof. Dr. Wolf Rainer Wendt

1. The Background of Case Management in Baden-Württemberg

Among the objectives of Case Management in Baden-Württemberg the participation of the citizens is expressly mentioned apart from co-ordination, networking and the efficiency of the work with elderly people. The citizens' participation has a priority position in the social and cultural tradition of this Land. Inter alia, this becomes clear when one looks at the national programs to support the commitment of citizens (1990 – 1993: pilot project "Co-operatives of Elderly People", 1993 – 1996: "Initiative Third Age" and "Solidarity with Relatives", 1996 – 1999: pilot project "Citizens' Commitment and Day Care").

Against this background the evaluation focuses on the issue as to how the functions of Case Management are assumed and distributed by professional social care services and the citizens' commitment. As project example serves the citizens' counselling services in the town of Kirchheim/ Teck, a municipality with 37 000 inhabitants (of which approx. 600 habitants in private households are in need of care).

Framework Conditions: National and Regional Contexts

The region is characterised by a structure of diverse social care services (stationary, ambulatory and ambulatory services and institutions. However, this structure is fragmented: The organisational division of social care structures and health services results in a lack of co-ordination

- of functions: division of medical, care and social measures
- of areas of competencies: division of stationary treatment (local and non-profit), ambulatory treatment (private sector) and rehabilitation
- of types of services: division of non-profit, private sector and local care services.

Starting from this situation elderly persons are in need of:

- information and counselling about the possibilities of support
- access and ability to reach the services
- continuity of the provision of care in case of changed need

- possibilities of rehabilitation
- specific need of assistance (e.g. geriatric and psychiatric)
- support of family members who are care persons.

The long-term care insurance which has been in force since 1995 has had different effects in this respect: On the one hand, it has led to an opening-up of the market bringing about plurality of service providers ("welfare mix"), on the other hand, it has demanded a co-ordinated action of the service providers and the individual responsibility of the persons in need of care (Section 6 of the Social Code, Book XI; this presupposes information and access to assistance). The divisions which have been noted tend to be deepened by the different competencies of the long-term care insurance funds (to be recognised as being in need of care according to medical criteria) and the municipality (care and social support before and around of the recognised need of care); general practitioners, too, remain separate of the area of long-term care in systematic terms.

Notions of Case management

In terms of Case Management there are two different notions in the separate areas:

- In social work it means assistance for the citizens by social services.
- In health care is means the management of individual cases in medical and nursing care.

Different services focus on their respective range of services and capacities in the first place and only internally consider individual Case Management as their task (e.g. planning for individual assistance, continuity of service provision). There is a lack of comprehensive management of interfaces: there is a lack of co-ordination between several service providers and service carriers and between professional and honorary assistants. The continuity of service provision for individual cases requires the comprehensive co-ordination of the service providers.

The co-ordination (with the following functions: determination of the need, support planning and provision of support) should be independent of the service provision ("purchaser-provider-split"), which in Germany as a rule is not the case.

Promotion of the Citizens' Commitment

In Baden-Württemberg the "Land Network for Citizens' Commitment" has been promoted. It has 28 pilot locations and 133 local initiatives for the promotion of the public spirit. The local location is the "Citizens' Office" ("Bürgerbüro") in Kirchheim/ Teck (in addition to this there are the initiatives of BETA, Wegzeiger-Vademecum and RANKE). The contact person at the local level for the citizens' commitment is a social worker in a special office ("Fachstelle Bürgerengagement"). Persons doing honorary work in the field of elderly persons' care can contact a social worker who is based in an old people's home and who organises this kind of assistance.

Person-related Co-ordination

The "Citizens' Office" ("Bürgerbüro") in Kirchheim assumes the functions of the "information, collection and linking offices" which have formerly been planned to cover the whole region, but are now no longer funded; their functions include the information about assistance offers, the collection of requests for assistance and the determination of the need for assistance (on request also the arrangement of the necessary assistance). In staff terms the Citizens' Office is equipped with one social worker. Until 1998 the financing was secured by funds made available by the Land to the amount of one third of the cost for specialised staff. It is planned to have a participation of the long-term care insurance funds taken into consideration their obligation to provide advice (in the view of the linking of the long-term care insurance funds to the health insurance funds it can be expected that the transition between acute treatment and long-term care will be optimised). Since 1998 the "Citizens' Office" is funded by the municipalities and the charity institutions alike.

2. Structures and Resources in Kirchheim

The Structure of Provision

The (professional and non-professional) structure is well developed, it had been intended to establish a network of the services under local management, but this did not materialise. The "Working Group of Ambulatory Services" ("Arbeitsgemeinschaft ambulanter Dienste") as an informal structure is not able to provide this, neither are the local social services up to the comprehensive co-ordination, for this reason there is no Case Management that is run comprehensively across all funds or all services.

The structure of provision (ambulatory) includes the social services of the charity institutions, support services for the household, private nursing services, a local psychiatric centre and five (in-patient) old people's homes and nursing homes. Counselling is provided by the local authorities and the long-term care insurance funds as well as by the Citizens' Office and the Wegzeiger-Vademecum (especially for those suffering from dementia).

In addition, the RANKE initiative (since 1999), in one of the town districts of Kirchheim, provides counselling and assistance for elderly persons who are in need of care and their relatives. In terms of staff specialised staff and citizens who are committed in an honorary capacity (in most cases older women who have had care experience) take part in the initiative. This initiative is funded by several institutions: the old people's home, the Citizens' Office, the Meeting Place for Elderly Persons, the municipality and the construction co-operative of the district.

Within the framework of this initiative the following services are provided on an honorary basis:

- encounters
- counselling on housing
- counselling of the relatives of persons suffering from dementia
- counselling on patients' instructions
- relief for caring relatives.

Within the framework of this initiative the following professional services are provided

- counselling on care by specialists
- placement of services for nursing and household purposes.

3. Methods in the Management of Social Care Support

In Kirchheim integrated Case Management does not exist as an independent structure, however, individual Case Management functions are divided upon the numerous services. For this reason the result of the evaluation is that there is only little need for co-ordination and counselling on care. In most cases arrangements for assistance (including the co-ordination of formal and informal assistance) are co-ordinated by the services themselves. This, however, results in the fact that in cases of acute and complex need of assistance the person is admitted to hospital or to a nursing home. In this context it can be noted that hardly any deficits can be found in a well-developed system of provision.

Components of Case Management: the Contribution of Citizens' Commitment

Those who are working in a honourable capacity offer talks at a low level "in the event of individual encounters, in discussion circles, in afternoon events for the elderly and in events in general". In this context confidential talks are possible about the burden of the care situation, as well as criticism of professional care. Moreover, they contribute to the information and the counselling for taking advantage of offers as well as legal advice.

Components of Case Management: the Contribution of Professional Staff

- *Admission:* The offers of the local system of provision are regularly recorded. From here information can be given regarding the deficits and this information can be forwarded to social planning. It is regarded as a problem that information about assistance programs are sufficiently available but not individually co-ordinated – for this reason it is unclear whether the information has arrived.
- *Assessment of the Situation and Clarification of the Needs:* Medical assessment is carried out by the medical services while care assessment is carried out by the service provider/ care services and social assessment by the local social services. However, these steps are carried out independently of each other, not integrated as was intended by the IAV office (IAV-Stelle). In addition the professional staff give informal descriptions of the situation vis-à-vis those who are participating as committed citizens.
- *The Planning of Assistance* is demanded by the legislation of benefits; however it is not carried out under the holistic consideration of health, social, care and rehabilitation aspects; the organisation of the assistance is left to the persons concerned – this could be done by a neutral Case Management office that does not exist in Kirchheim.
- *Quality Assurance and Evaluation:* It is expected that the service providers themselves carry out the quality assurance and give proof of it. There is no direct supervision for ambulatory services – in the case of deficits in the services the users themselves have to make themselves known. It is not planned to have an office for formal complaints, "occasionally" persons working in an honorary capacity take on complaints and forward them. However, it can be doubted that the monitoring of professional services by such persons will work.

4. Outcomes

The different projects in Kirchheim rather came into being by accident; and they are structures with different concepts. Linkage with the professional system of provision and the municipality is still lacking; possibilities for co-operation are therefore not yet taken fully advantage of.

Case management in the sense of continuously accompanying a process across services does not take place; to start with, this is on the basis of a citizens' structure possible (understanding talks, informal support), but not as a uniform, independent and monitoring body.

3.2 Case Management in Belgium

Evaluators: Dr. Christiane Gosset, Dr. Cécile de Froidmont

1. National Context

The ageing of the population and the growing increase of the need of care were the reasons for searching alternatives for institutionalisation and hospitalisation. It is strived for to improve the possibilities for living at home, in the private household, with respect to paying much attention to shaping the return after a hospital stay. The Ministry of Health and Social Affairs initiated the pilot program on Case Management in 1994; it aims at a care process that is holistic, multi-disciplinary and continuous at the same time. This became necessary because of a threefold development:

- The trend to reduce hospital beds and to shorten hospital stays increased the risk for elderly patients to be unable to return home.
- By developing ambulatory care patients should primarily stay at home instead of moving into old persons' homes or into nursing homes.
- The demographic development towards more elderly persons and more persons in need of care with informal assistance decreasing at the same time requires a political concept.

The Notion of Case Management

The following features are characteristic for Case Management in Belgium:

- Case management is developing in clearly structured phases defined by a assistance plan that is based on a profound assessment of the needs and the wishes of the clients and their relatives.

- The Case Manager plays a key role at the interface between hospital treatment and care and the assistance provided at home.
- Case management gives emotional support, information and health training; the Case Manager must have specific social skills in order to be able to build a trusting relationship with the clients and their families.
- The Case Manager must have experience with the target group.

Demography

Belgium has 10.2 million inhabitants, of which 22 per cent are older than 60 years (and 3.5 per cent older than 80 years). The proportion of the population that is over 60 years will increase to 30 per cent in the year of 2030.

The Infrastructure of Care

- Hospitals: In the hospital area there is a differentiated system of general, geriatric and psychiatric treatment. For reasons of cost containment the focus has shifted to acute treatment in the last few years, while the number of beds for the chronically ill decreased.
- Old persons' homes and nursing homes: old persons' homes offer housing together with family care and household assistance; the capacity of 96 500 places (9.5 for every 1 000 inhabitants or 4.3 for 100 elderly persons over the age of 60) is not to be further developed. Nursing homes that are oriented towards medical care for the chronically ill and persons in need of care have a capacity of 19 500 places (1.9 for every 1 000 inhabitants or 0.9 for every 100 elderly persons over the age of 60).
- Service housing: independent housing with services that can be chosen individually (stationary treatment possible; no data available).
- The network of ambulatory care and assistance consists of: nurses making home visits (self-employed or as staff members of a service), therapists and other home assistance, family assistance/ assistance for elderly persons (household assistance and accompanying person, health prevention and training, psychological and accompanying social measures and social assistance). The need for assistance is assessed by a social worker. The services are subsidised according to the hours worked; the clients pay an income-related contribution.
- "Centres for the co-ordination of care and household helps" provide for a documentation of the comprehensive need for assistance and need-oriented benefits, too.
- "Public centres for social assistance" provide for financial and social support.

- Furthermore, there are day care and short-term care institutions, institutions for rehabilitation, emergency household services and meal-on-wheel-services as well as technical support in the household, nursing care aids, limo service, etc.

The Position of Case Management in Social Policy

The political efforts to improve living in private households and to avoid re-hospitalisation and moving into a home are illustrated in a number of examinations and pilot projects:

- The first national initiative resulted in the project "Case management in home care of psycho-geriatric patients and their families" (1994 – 1996); in situations of a complex need of assistance individual need analyses and planning for assistance were carried out.
- The follow-up project "Case management in Belgian hospitals" (1996 – 1998) was started in 20 hospitals with Case Management for geriatric and psycho-geriatric patients with a high risk of re-hospitalisation; Case Management started at least 10 days before the patient left the hospital and included follow-up visits after three and six months.
- In the third phase the project "Hospital contact person for the continuity of care" was carried out (1998 – 1999), which in the report was chosen to be the project example. Here, too, the aim is the continuity co-ordinated in an interdisciplinary way in the transition from the hospital to the private household. 94 hospitals take part in this; in each of the hospitals a one half of the Case Manager's position is financed.
- A Case Management project in the household sphere has been planned as follow-up for optimum co-ordination of the provision of ambulatory care (1999 – 2000).

2. Structural Requirements

Number and Qualification of Hospital Contact Persons

In each hospital there is one part-time contact person (with someone replacing him or her). The qualification for this position is either training as a nurse (with professional experience record in care or in the social services of a hospital) or as a social worker of the social services of a hospital.

In addition, the following requirements are necessary: a minimum of three years of professional experience, motivation for multidisciplinary teamwork and ability to communicate.

The specific preparation includes a seven-day training with several aims, inter alia:

- to promote the awareness of the status of a pilot project for geriatric patients and of documentation and evaluation,
- to raise the understanding for stationary/ ambulatory co-operation (including making oneself familiar with ambulatory services), for co-operation in interdisciplinary teams and for the emerging need of co-ordination.

Division of Work and Team Discussions

Interdisciplinary working groups and the fact to avoid double work are included in the basic structure of Case Management. The tasks are distributed as follows:

- The care team documents the basic data of the clients (forwarded to the contact person).
- Contact person and care team decide which clients correspond to the selection criteria for Case Management, in these cases assessment according to the work.
- In interdisciplinary team discussions problems are being analysed, objectives fixed and plans drawn up for care (with a division of the specific tasks).
- During further team meetings is will be evaluated how the objectives have been reached and if necessary the planning will be modified.
- Prior to the patient's leaving the hospital the responsible persons in the hospital together with the ambulatory services discuss in a meeting how the continuity of care can be secured.

Great importance is attached to the clear division of the work with a clear definition of the tasks. Particularly when the Case Manager has been released from his or her work in a care team that he or she now meets in the function as Case Manager, he or she could be mistaken as a monitor; the management has to support the Case Manager by making his or her function transparent to other staff members.

Staff and Equipment

The Case Managers have at their disposal office space equipped with telephone, post-office box and all necessary other forms of equipment.

Persons working in an honorary capacity do not take part in Case Management. At the level of the assistance system, too, as a rule they do not play any role in Belgium either (the participation of non-professionals is limited to family members, friends and neighbours).

Financial Resources

Each hospital has a budget for the employment of part-time contact persons (for five working days). The following performance criteria are connected to this:

- time for at least ten current Case Management clients
- time for the evaluation of the assessments
- comprehensive activities (participation in local conferences on care and in project meetings)

One problematic issue is the relation between the hospital (that is run by the state) and ambulatory services (which fall under the competence of municipalities and regions): The contact person does not have at his or her disposal all the necessary information about availability, aptitude and cost of the ambulatory services.

The interdisciplinary co-operation has also resulted in a feedback by the ambulatory institutions and services; as a result of the local accompanying committee they have become more sensitive for the necessity and the possibilities for an improved co-operation, in order to avoid re-hospitalisation and early institutionalisation.

3. The Methods of Case Management

3.1 Evaluation of the Clients and their Relatives

The process of Case Management starts with the selection of the clients, proceeds with the evaluation and assistance planning in hospital and goes as far as the evaluation in the private household (15 or 90 days after the client left the hospital). The client's participation is at all times voluntary.

Selection of Clients

The target group of Case Management are elderly patients over the age of 60 years who are still living in a private household. Among these the risk group is determined according to

- physical and mental criteria (over the age of 80 years, dementia, depression, nursing care required at least three times a week, in considerable need of care/ Katz criteria)
- social risk factors (single, to be overburdened by living with or without partner)
- psychological, social and medical indicators (e.g. abuse of medical products or alcohol, aggression or other difficulties).

At least two of these criteria have to be fulfilled.

Inclusion into Case Management

Only those clients are included where the preparation of their leaving the hospital can be planned from the very beginning and with sufficient time; moreover the Case Managers should not overburden themselves, each Case Manager should look after approx. ten clients (these are model-type criteria that are also methodically well-founded, not only needs-related).

Data Collection

A comprehensive assessment of the physical, mental and social situation of the client (and if necessary of a partner) will be carried out at the latest three days after the patient was admitted to hospital and will be repeated three days before the patient is released. Two further dates for data collection are telephone interviews 15 and 90 days after return from hospital in which the use of ambulatory services as well as the number and the duration of further in-patient stays are recorded.

The assessment of the client's health includes subjective and objective data on health and the ability to cope with daily life (ADL, IADL) and the corresponding resources for assistance; in addition to this communicative, vision and hearing capacities as well as mental health and social health (according to several criteria).

The questioning of the partner or of the care person, in which in addition to his or her health status the burden of care will be examined (overview on page 22 of the report).

3.2 Case management and Political Planning

The first pilot phase has shown a stabilisation or improvement by the contribution of Case Management, while at the same time it also revealed the

problematic issue of a return to hospital that was insufficiently prepared. The second pilot phase came into effect here and it was possible to achieve a reduction of re-hospitalisation, in particular in those cases where hospital stays occurred very often. Further pilot phases were directed towards the improved preparation of the return.

3.3 The Planning of Care

Together with the client (and his or her family) and the multidisciplinary team the collected data are evaluated; and on this basis objectives are developed, the measures that are required to achieve these objectives are chosen and the necessary resources and services are indicated. The individual steps for the planning of assistance have to be accepted by the client. The objectives have to be formulated in a precise and realistic manner and in a way they can be monitored, so that it is possible to qualify in a later evaluation whether the objectives have been achieved or to modify them if necessary. The measures must be clearly separated from each other, so that there will be no overlapping of the competencies within the team. Insofar as they concern the ambulatory area they will also be discussed with the ambulatory services.

3.4 Practical Steps in order to Provide the Patient with the Necessary Assistance

The ambulatory services are either contacted by the Case Managers themselves (if social worker) or by the social worker of the social services in hospital (if the Case Manager is a nurse), they are informed about the client and are included in the common counselling and organisation of the assistance process.

3.5 Finding Local Possibilities for Assistance

The providers of ambulatory services inform the Case Managers regularly about their institutions, their range of benefits and their prices. In meetings of the "local multidisciplinary accompanying committee" the concrete inclusion is clarified individually.

3.6 Concurrence of the Planning of Assistance and the Client's Expectations

The planning of assistance can fail if the client or his or her family have expected something different, if they are not able or not willing to pay for the selected services or if the selected services are not available. In these cases the team and the representatives of the ambulatory care centre have to develop alternative possibilities for solution.

Further Aspects

In addition the housing conditions and the financial possibilities of the clients have to be included into the planning. Long-term care benefits depend on the degree of the care needed while household benefits depend on the income.

4. Profile of benefits and the results of Case Management

The example of a 78 year-old women who was hospitalised suffering from pneumonia, after she had suffered a stroke three month before (risk factors: in need of long-term care, care person is overburdened) illustrated the process of Case Management. In addition to the care services rendered so far, the husband in his capacity as care person receives relief by a meals on wheels service and technical aids; in addition the daughter and the neighbours are systematically included into the provision of care.

5. Advantages and Difficulties of the Project

Advantages for the Patient

A number of advantages can be mentioned for the patients, the care person and the family that are connected to the quick, comprehensive and tailormade assistance. If it should become necessary to decide that the patient should be admitted to a home, it will be easier to accept this decision as a result of multidisciplinary discussion than in a personalised form (feelings of guilt by the relatives).

Advantages for the Development of the Care System

The following advantages can be differentiated for the staff: the staff that is taking care of the patient becomes more sensitive for the social situation of

the patient, for the necessity of a well prepared return, reflection of their own acting and multidisciplinary co-operation; moreover development of quality control within the hospitals, exchange of experience with each other and with the ambulatory services: the local multidisciplinary committees come together every four months; the committees include on behalf of the hospitals the management, the management of the care services, the medical management, social services, therapists and Case Managers, on behalf of the ambulatory field representatives of the general practitioners, of the co-ordination centres, the care services, the pharmacies, the occupational therapists and the patients and their families.

Difficulties

- The integration of the contact person with the care units does not always go without problems; in particular if the contact persons comes from a different area, he or she can be mistaken as a monitor or it might be possible that he or she will misjudge the specific process relevant in care.
- The challenging program of a comprehensive and systematic evaluation of the clients' needs can be taken as a burden.
- Some patients refuse data collection.
- High costs and/ or the lacking availability of ambulatory services can hinder the implementation of the assistance plan.
- The contact with the general practitioners is not always as optimal, be it for reasons of too much work or for reasons of prejudice against the "hospital" perspective.
- Some contact persons have difficulties in motivating the care personnel or the social services in hospital to co-operate.
- To find all those who take part in the care at home can be difficult.
- The departments of surgery and psychiatrics have not yet been included into the Case Management model.

3.3 Case Management in Spain

Evaluator: Dr. Lluisa Marrugat

1. Introduction

Case Management is seen as the co-ordination of services for elderly people in need of assistance and their families, with these necessary services tailored to meet their specific needs and, including a cost-control of services. The selected model is a health care – social centre in Sabadell de-

voted to accomplishing both tasks. Yet it was established as neither primarily a Case Management centre nor one for the elderly, aiming to spare costs; it contains, however, the concept designs, typical components and methods underlying Case Management: co-ordinated medical and social assistance, orientation towards individual case needs, co-ordinated planning and implementation of formal and informal assistance, encouraged co-operation and co-ordination of services. It also includes the basic steps in employment: identifying, selecting, and including the appropriate clients, receiving case estimates, providing individual assistance plans, accompanying and evaluation.

2. Methodology

The study is carried out according to the qualitative method of the accompanying observation. The stages includes following phases:

- Initial phase/ review of information and literature
- Conception of the study, including the selection of model projects (local maintenance office “Centro de atención primaria”), an interview of employees, the concrete number of cases to be examined, and instruments of data collection. Three centres were selected. One is a long-standing centre experienced in Case Management and, as initiator of the ”outreach“ program (ATDOM), it was evaluated more intensively. As a basis for comparison, one centre was selected that focused mainly on co-ordination efforts and another centre still in its building phase. In each centre, cases of the elderly in various situations and with varying degrees of need were analysed.
- Field Studies (interviews, collecting of data and on-site observations): Seven semi-structured interviews were held with staff members of the Case Management.

3. Legal Framework and Jurisdiction

Important are the different structures underlying the social and health care agencies for one, and the different state levels on the other (the state, autonomous “Comunidad” and local level).

3.1 Social Services

On State level, the constitution guarantees a comprehensive provision for the elderly; its implementation, however, is for the most part limited to the pension policy; no single unified policy exists with respect to social services

which fall under local-level competence. Health services are generally accessible and free of charge.

With respect to the elderly, the 1992 “Plan Gerontológico” emphasises the relation between health and social aspects of services for the elderly and seeks integrated solutions.

Various laws on social services exist at the autonomous Comunidad level. Thus in Catalina they seek to

- expand the system of social services in their public responsibility role (via public and private institutions)
- guarantee the right of citizens to local social services
- achieve an optimal co-ordination of (public and private) services and efficiency in the employed instruments.

The services are provided by public and private services, with the latter being differentiated by social initiatives and commercial services. The public services differ in structure:

- primary social services (primary social services as contacting office, home care, short-term care, meal services, etc.) and
- secondary, specialised services for specific problem situations (day care centres, centres for the elderly and old people’s homes).

The basic unit of primary social care services is a municipality with a population over 20,000. The institutions are responsible for provision and implementation of social services by a multi-professional team, co-ordination of these services with other services provided by social initiatives or commercial services, transmission of statistical data to the Comunidad and planning of the social service system. The primary and secondary services are subject to different areas of jurisdiction: The primary services are the sole responsibility of local authorities, and the specialised “secondary" services are the responsibility of the municipality and the Comunidad.

Financing the Social Services

The structure of the social service system is financed in part by the State and the Comunidad; a smaller part, however, is contributed by clients or their family members who live in good financial standing. Municipalities with a population over 20,000 are obliged to provide primary social care services according to their budget. The services are provided by local-level financing,

in part also by refinancing from benefit reimbursements paid by clients or their relatives in good financial standing.

3.2 Health Care System

The Comunidad by means of the Catalonian Institute for Health is responsible for providing health services - beginning with the primary health services up to a net of public hospitals (development of a network of primary social service centres). The program “Vida a los Años” (fulfilled years, 1986), for the first time, aimed specifically at the elderly; up to this point, only singular assistance services was provided by hospitals, nursing homes, etc., but no integrated medical, social and family assistance for the elderly in private households. Apart from establishing a comprehensive system of assistance for those in need, it also aims at avoidance or delay of stationary care, and at the development of social health centres for those in need of assistance and care. The program is financed by both the Ministry of Health and the Social Services Ministry.

Although the social service system is financed by the Catalonian Comunidad and benefits are free of charge for the users, the long-term care in social care institutions is paid by means-tested benefits, and is mainly called upon by persons over 65 years.

4. The City of Sabadell. The Context of the Social Care Model

Demography

The industrial city of Sabadell has a population of 185,525 (a strong increase in population due to migration from Southern Spain between 1950 and 1970; a distinct working class). The age structure is rather evenly spread due to the influx, although a strong ageing process is expected for the future.

About 30,000 people are aged 65 or more (16 %, compared to 13 % in 1991), about 6,500 are aged 80 or more (3.5 %). A further increase in the ageing population is forecast by the year 2000, and after, an increase especially in the advanced aged. A tendency towards super-ageing can be expected from 2010 and especially from 2020.

The poorer social class is concentrated in some parts of the city of Sabadell, with a low level of education (no completed education or illiterate:

50 % of men and 60 % of women aged 65 or more) and a high level of unemployment.

Problem Situations of Elderly

The number of clients aged 65 or more in social centres has risen from 984 (1995) to 1,250 in 1997 and to over 1,990 in the first half of 1999. The reasons for the utilisation of services are primarily health problems, then a reduction in daily activities and social integration. The institutionalisation rate lies at 2.5 % of the population aged 60 or more (753 persons in institutions).

5. The Social Care Model in Sabadell

The establishment of social care centres was jointly agreed upon in 1984 by the Catalonian Health Care Institute and the city of Sabadell (inspired by centres in Emilia Romagna); to this day, 11 city centres offer health and social services.

The aim of these centres is to

- achieve integrated, personal, permanent and flexible services for the individual and the society.
- work towards a joint and co-ordinated effort to improve services and optimally utilise resources.
- achieve a high degree of integration and co-operation among different professions.

Organisation

The primary social service centres (CAP) were originally designed as centralised contacting offices (“a door, although sometimes with two windows“). They received adequate staffing supported by the social services of the municipality; the city also provided rooms and equipment. Qualifications of personnel include social workers, social educationalists, general practitioners, paediatricians, nurses, care staff and assistants. The centres are financed through the city budget, Comunidad subsidies, ESF funds and in part by benefit compensations.

Program for the Elderly within the Social Care Model

The elderly were the main beneficiaries of the primary social service centres, which were set up for the entire population between 1979 and 1984. Since 1985 a plan with emphasis on services for the elderly shifted this target group to the conceptional centre of attention. In 1994 the city reacted to the socio-demographic change by setting up a program for the elderly. Since then the situation of the elderly has been approached politically from all angles.

An “agency for the technical co-ordination of social care“ was developed, and sought to determine

- the need for and provision of social services
- their functional integration
- the flow of persons entering and withdrawing from the various services.

Furthermore, a “senior citizen city council“ was set up to represent their interests, a “service guide“ for the elderly created, and more.

In this context, a study was carried out on “activities to support the elderly in the social care sector“ aiming to discover more about the living conditions and needs of the elderly and their utilisation of the available assistance structures that can be the basis for enabling the elderly to remain in their own homes for as long as possible (including a good standard of living). This study serves as basis for a project aiming to

- tailor the ambulatory services to the needs of the elderly and their relatives by increasing preventative measures
- expand services offered to the elderly and their relatives when taking public, private and honorary services into account.

The study resulted in the recommendation of a new task area aiming to establish a personalised service for the elderly.

Elements of Ambulatory Services

Ambulatory service programs: household help; household emergencies; cleaning assistance; laundry services; meals on wheels; technical aids (elevating mechanisms, nursing care bed, etc.); repair services; complementary services, such as shopping, economic assistance, mobilisation of assistants in the family or neighbourhood or (alternative) voluntary assistants.

Service cheques: Assistance program in short-term emergencies; household help and telephone emergency calls (co-financed by user – administrative office – company; user pays 55 % of market price/ dependent on income); a maximum of 30 cheques for 30 hours of assistance, Monday through Friday from 8.00 a.m. to 8.00 p.m.; information is provided in an information sheet.

ATDOM (home care) program: instruments/ criteria for the care team to meet the home care quality standards and review the criteria for successful implementation;

- The program focuses on the chronically ill, the ill in their terminal stages, long-term patients, patients with dementia (also with preclusive criteria)
- Personnel capacity: care staff appointed to 3 hours per week (visits and case discussions), medical personnel 2 hours per week, social services 30 min. per unit of service
- Documentation: care documentation of clients, assessment of physical and mental capabilities, etc., patient records/ assistance plan/ documentation of treatment
- Extent: participation of 56 persons in the first year, after only upon request; planned: home visits to all elderly aged 75 or more who live alone.

Possibilities for assistance for the elderly in Sabadell can be found in health care and social-care assistance (primary social services centre, clinic with several day and short-term care stations all the way to graded areas of care, medical specialists), as well as social assistance, such as home care services, home emergency services, etc. The institutional co-ordination is carried out by the Health Office, the Social Welfare Office and the Commission for Care Assessment

6. The Co-ordination of Social Care of the Elderly

6.1 Admission Context

Structure of Population: A social care centre in a quarter with high unemployment, low education and low income levels is examined. The percentage of elderly is not higher than average, but there are many in need (some without a permanent residence, living off and on with their children).

Rooms: The social care centre is on the grand floor of a building several stories high. It includes a health services reception office (central contacting and information office), a social services reception office (differentiation between the sole need for information and further consultation/ appointment

arranged), two waiting rooms, five treatment rooms for doctors, four for nurses, one for the social worker, one for social educationalists, one consultation room, one storeroom and two toilets.

Opening Hours: The consultation office is opened from 8.00 a.m. to 8.00 p.m., after this time a home emergency service is available; home visits are made upon appointment.

Team: the social care centre has four units appointed to basic services (one doctor and one nurse each), one paediatrician, one social worker, one family care worker, one social educationalist (for children and teenagers), and administrative staff (four from the Catalonian Health Institute, one from the municipal Social Welfare Office)

6.2 Methods of Social Care Intervention (Including Case Examples)

The individual steps of assessment (Valoración) are: study of health condition and any functional limitations – family/ neighbourhood/ economic resources as well as possibilities of state-social assistance. On this basis, an assessment of the data is made and an assistance plan (Planificación) developed.

Following elements of the Case Management process have to be differentiated:

- *Admission* of client (access via direct consultation with the social care centre or via other hospitals or programs).
- *Selection*: directed to the ATDOM (home care) program or to other social services with the care personnel determining whether need-specific assistance suffice or whether a process of longer-term care is necessary.
- *Initial Visit*: general assessment including client classification, information on care personnel, comprehensive client information, determination of need for medication and auxiliary aid; finally, an appointment is set for second visit).
- *Second Visit*: comprehensive assessment by all team members: the doctor assessing the health aspects, care workers using instruments for basic needs, self-reliance, cognitive abilities, decubitus-risk; and social workers collecting data on the socio-family situation, home conditions, urgency of cases or further stress tolerance of family members.
- General Evaluation and Assistance Planning: team discussions are held (latest one month after the first visit); during these discussions, the outcomes of assistance are determined and an assistance plan is set up

(health and social needs, capabilities and readiness to co-operate on the part of the client and family).
- *Implementation*: Service suggestions, proposed alternatives.
- *Regular Home Visits:* During the regular home visits, the various professionals clarify together with the client and his family whether the assistance is effective or if any modifications are necessary or desired
- *Meeting of Co-ordinators:* the co-ordinators meet every several months to discuss cases; reassessment and modification of the evaluation and assistance plan (the measures and objectives) are discussed as well.
- *Termination:* care services are either terminated by solving the problem, removal to a home or death.

An example:

> An 80-year-old man, dement, with a 78-year-old wife, from lower class; a) First visit with assistance offers of home care, home emergency calls or day care; all refused – the wife would like cleaning assistance instead; b) 2 months later; the wife and daughter seek assistance at the consultation office, because conditions have worsened; they now apply for a place in day care; the necessary documents for the application are not complete until another 2 months pass and a social worker intervenes; problematic: especially proof of income from all family members; c) 1 month later, deteriorated health condition, nurse re-evaluates the need for care, social worker suggests the removal to short-term care or a nursing home, notice of leaving the day care, care is ensured by children and a neighbour; d) further deterioration of health condition and more care assistants organised; about one year after first contact: client passes away in his own home.

6.3 The Effectiveness of Services

The social care service model intervenes in complex cases of need of assistance and attempts to avoid or postpone admission to a home by means of assistance services meeting the client's needs (in agreement with the clients and their families). Typical situations of need are: living alone, mental illnesses (dementia, depression), exhaustion of care-giver, lack of knowledge and organisational skills of care-giver, and subsequent care for care-giver

Further examples:

- a blind woman living alone activates the emergency house call after an accident.
- a man living alone with depression is integrated in a senior citizen's club (lunch meeting) upon accompaniment of a social educationalist.

- a daughter, who provides care is exhausted but resists putting her mother into day care because of pressure from her brothers, receives home care assistance.
- an unemployed man, who takes care of his dement parents, receives home care assistance and information about nutrition, care, hygiene, further possibilities of assistance, such as short-term care.
- an overworked husband, who takes care of his leg-amputated and incontinent wife, receives care assistance, household help, relief through short-term care and day care.
- A woman falls into advancing depression as - after 9 years of requiring care - her husband passes away; motivation and accompaniment to the senior citizen's club, accompaniment from voluntary assistant.

7. Evaluation

Various stages of development and different problems become clear when compared to other model regions.

Problems of the Social Care Model

The following problems arose in less developed social care centres:

- poor co-operation between the participating institutions
- no common framework for client care/ no functioning multi-professional team work
- primary assistance is included as an exception in the health care sector
- social welfare is a secondary concern (assignment of practically hopeless cases, no integrated action plan)
- insistence on maintaining usual work processes/ scared of changes
- one-sided training of medical staff and little time willingly devoted by medical staff in the model
- various degrees of being able to adjust to process computerisation

Factors for Success

The model in Sabadell is not built on the Case Management design concept but does correspond to it with respect to problem situations and processes. The model was initiated in 1984 and is only now undergoing a consolidation phase.

The clear factors for success:

- political support
- stable/ viable organisational concept
- common action guidelines
- motivated team, experienced/ competent specialists
- good co-operation between doctors/ nurses/ social workers on account of spatial integration

According to those workers involved, the advantages of the model are integrated care initialisation, better results, better use of available resources, determination of needs not having been identified before (and development of corresponding solutions), as well as good co-operation with other agencies/ fewer misdirected cases (and thus more cost effective)

The methodical advantages seen are: situative, on-site data collection, constant communication with clients/ families about suitable forms of assistance, functional co-operation between public/ private/ honorary service providers and family/ neighbourhood assistance, institutional co-operation (less work for clients, less administrative paperwork) and that the workers involved gain comprehensive knowledge of the target group.

Demands for Improvement

One area standing improvement would be to have a single, unified reception instead of the present separation between health and social service admissions. Furthermore, short-term care and day care should be expanded, redundant care providing structures better co-ordinated, and information on service offers better available.

3.4 Case Management in Hamburg (Germany)

Evaluator: Lothar Voß

Since March 1998, the pilot project "Regional case and Care Management of elderly persons' welfare" has been developed in the Land of Hamburg; this project is funded by the Federal Ministry for Family Affairs, the Elderly, Women and Young Persons with the aim to achieve, at the personal level, optimal care and provision and at the level of the services and institutions, a co-ordination and needs-oriented matching of the benefits offered. The project duration is 30 months.

1. Framework Conditions

Demography and the System of Provision

Hamburg has 1.7 million inhabitants, 17 per cent of whom are 65 years and older. The proportion of those persons in need of long-term care (in the sense of the Act on Long-term Care Insurance) is approx. 2 per cent of the population and thus federal average; together with the persons in need who do not (yet) fulfil the criteria of the need of long-term care, approx. 74 000 persons in private households depend on assistance in their daily routine of living (4.4 per cent of the population). Further 14 000 persons are living in stationary old persons' homes or nursing institutions (0.8 per cent of the population in total or 4.9 per cent of the population over 65 years).

The structure of care provision has 420 ambulatory services and many in-patient institutions and is thus well developed.

Organisation of Old People's Welfare at the Local Level

The social services in Hamburg are organised at the level of the seven city districts. In this context counselling services for elderly persons have been developed in the districts which have the task to provide individual counselling, to co-ordinate the funds and to secure the social and cultural offers and - if required – the placement of services. The staff available for old people's welfare in the districts has been thus calculated that one social workers is responsible for about 8 000 to 10 000 elderly persons over the age of 60 years.

2. Structural Characteristics of the Case Management Project

Staffing and Qualification

The Case Management project in Hamburg was linked to social service of a district. Within the framework of this project a team was put together which includes one social worker (75 per cent part-time), a project manager (decree in social economics with 66 per cent part-time) and a project assistant (secretary 50 per cent part-time). Apart from the regular tasks in the work with the elderly persons in the district together they are responsible for the project work.

The social worker focuses on the actual Case Management-related tasks, for example by

- counselling elderly persons who have a need for assistance (both in the office and in home visits)
- placing and co-ordinating services (external services or assistance provided by persons doing community services)
- making full use of the legal possibilities in the sense of the clients.

The tasks of the project manager include the following: individual advice for individual cases, the co-ordination of the Case Management project, the drafting of the instruments, the development of the methods and support for the social worker. The project assistant, too, contributes to the support, by updating for example the data on service offers for elderly persons.

Persons working in an honorary capacity will be included into the provision of concrete assistance, if necessary, but they are not taking part within the Case Management structure.

Financial Means and Equipment

The Case Management project has sufficient financial means to the amount of approx. 16 000 DM per months for 1.9 jobs, rent and technical equipment. The office space is situated in a district office for social assistance; the technical infrastructure of this office can be used.

Availability

The team can be reached by telephone during the morning hours; dates for discussion and home visits are arranged as a rule by telephone. Apart from the home visits the social worker offers counselling four times a week in a telephone consultation and twice a week in a personal consultation.

Structure of Funding and Institutional Linking

The Case Management project is funded by the Land (by the Authority for Labour, Health and Social Affairs) and the municipality (District Office) alike; both take over one part of the costs for staff. The linking of the Case Management project to the Social Assistance Office has the advantage that it is situated at a central and generally known location. However, this has disadvantage that the image of the Social Assistance Office (little customer-friendliness) might hamper the interest for Case Management in the first place.

Linking social work to Case Management can also become a problem in terms of benefits, insofar as the social worker provides and monitors the benefits of social assistance at the same time; in her capacity as Case Manager she should represent the interests of her clients, in her capacity as representative of the Social Assistance Office she should also represent the interests of the administration. For the staff this can lead to a conflict about the targets and for the client to a loss of confidence.

3. The Objectives and Methods of Case Management

Target Group

Case management should draw up and implement individually made solutions for elderly persons in need of complex assistance. It is directed towards those inhabitants who are 60 years and over, as far as they are no longer able to sufficiently assistance themselves; Case Management does not become active in those cases where the ability of "self-management" still exists.

Method

The method applied in the Hamburg model essentially includes all the typical elements of Case Management, the implementation of which is yet to be further developed:

- In an assessment, which as a rule is carried out within the framework of a home visit, the competencies and the need for assistance of the client are identified. In this context also the resources of self-assistance and, if necessary, the social support by relatives and inhabitants are identified, too. It is planned to further differentiate the assessment.
- Furthermore, it corresponds to the conception that the objectives have to be discussed with the clients and that assistance plans are drawn up. However, these assistance plans are not yet systematically documented.
- Then the necessary steps are undertaken to implement the assistance planning by combining a suitable package of benefits against the background of the whole range of services (in agreement with the client).
- In this context the Case Manager considers the quality of the selected services and monitors the success of the measures in the further course of time. It is also planned to pay regular visits to clients who had been counselled at earlier stages, in order to be able to timely take account of a newly emerging need of assistance and to be able to deal with this in a preventive manner.

The findings of this process as to the deficits about the structure of provision are forwarded to the elderly persons' welfare in the districts, in order to be able to consider this information in the framework of further structural planning.

Case Study

The case study, about which was reported, illustrates the approaches and the methods, but also the limits of Case Management. A particular accent is placed on the acceptance and the participation of the client that is indispensable for the success of the Case Management process.

3.5 Case Management in Hesse (Germany)

Evaluator: Hermann Scheib

1. Background of Case Management in Hesse

In 1998, a network of consultation and co-ordination offices has been in the process of establishment in Hesse financed by the Land and local authorities. A project in the district of Kassel (in Northern Hesse) was selected for evaluation; here, five inter-institutional consultation and co-ordination offices were established.

This project was preceded by the pilot project called “Social and Ergotherapeutic Team (SET) in the region (1993 to 1998) with the typical CM tasks such as

- collecting of information on assistance offerings,
- advice to persons seeking assistance and their family members during home visits,
- determination of concrete need for assistance,
- development of an individual care and assistance plan in co-operation with ambulatory services,
- mediation/ organisation/ co-ordination of the required assistance,
- clarification of the financing,
- advice on housing adaptation, and
- monitoring of results and review.

Moreover, the development of supplementary services as well as in the co-operation and networking with services and institutions, public authorities and financing institutions, doctors and church communities etc. was

speeded up. One project leader, three social workers, two ergo-therapists, two (mobile) trained geronto-psychiatric specialists and one administrative employee were appointed to the pilot project.

On the basis of experiences won through the SET model, a reference concept was developed to establish inter-institutional consultation. In 1996, the former regional government of Hesse decided to accept and implement this reference concept as official program for the Land. In 1999, however, the new regional government decided not to continue the financing of the consultation and co-ordination offices by the *Land*.

2. Case Management by the Consultation and Co-ordination Office in Kaufungen

Approximately 245,000 people live in the district of Kassel, which has an above-average proportion of older people (22.6 % aged 60 or more). In this district of Kassel 55 ambulatory care services, 26 short-term care institutions, 10 semi-stationary care institutions, 23 stationary care institutions, 10 offers for assisted living and two geriatric clinics are available.

The consultation and co-ordination offices are financed by an institutional association of service providers, churches and local authorities with annual grants by the *Land* Hesse amounting to DM 15,000 per office, by the local authorities of DM 13,000 per office and a contribution by the institutional association itself of DM 15,000 to DM 20,000 per office.

The Case Management office in Kaufungen (since July 1998) covers an area with about 14,000 inhabitants, of whom 2,850 are aged 60 or more, respectively 2,100 aged 65 or more. There are four care services, three assistance services, one meeting centre for the elderly with various cultural offers for senior citizens (here office hours of the consultation office every 14 days).

In this case, the institutional association for the consultation and co-ordination office consists of the Red Cross clinic, the community, a social station and three providers of ambulatory care services. The co-ordination office employs one social worker on part-time (as a rule, the other four consultation offices also appoint only one social worker).

3. Evaluation of the Consultation and Co-ordination Office

Structural Conditions

The part-time employee, who has a degree as social educationalist and is a trained nurse, has completed several practical training courses and has had many years of experience in consultation offices. In future, voluntary workers are to be brought in, so far, this has not been possible due to lack of time.

The consultation office can be reached by telephone four days a week, five hours each day. The office has no fixed opening hours to the public; emphasis is set on house calls.

The consultation office has one room (18 m^2 = approx. 190 ft^2) located in the administrative building of the Red Cross clinic, which is equipped with a desk and a settee, a telephone, answering machine and a personal computer. A car is available, and conference rooms as well as other technical equipment can be used.

Contact

Contact with the consultation office is usually made by family members who, as a rule, have heard of it from the ambulatory services or through word-of-mouth. Only very few have learned about it through its public relations work. As a rule, the consultation office is sought out because of the client's need for home care and/ or home assistance and regarding questions concerning the care insurance. In the documentation, the contact person, access and reason for making contact are broken down.

Target Groups and Objectives

The services of the consultation office aim at people in need of care and their families, as well as those in need of assistance and their families. In addition, the target group includes co-operation partners, i.e. persons and institutions involved in the assistance process.

The objectives of the consultation office are a) improvement of the living situation in case of need for assistance and care as well as enabling the person in need to remain at home, b) advice and support for the family, c) public relations work/ collecting of information on care problems, and d) municipal requirement planning.

Tasks and Service Offers

The consultation office acts as mediator between the persons in need of assistance and the service providers. In addition, support in social planning is given.

On the demand side, the consultation office performs following tasks: information on assistance services, individual consultation on need-based support, alternative care, outreaching advice for those seeking assistance and their families, clarification of the assistance requirements and development of an assistance plan, implementation of the assistance plan, establishing contacts and organisation of assistance, quality control, consultation in conflict situations, psycho-social consultation, clarification of financing strategies, assistance during application, and documentation.

On the supply side, the emphasis is set on co-ordinating regional offers. This includes: establishing contact with service providers, doctors, financing agencies, voluntary workers/ co-ordination, network, quality control, initiation and ongoing support for self-assistance groups, organisation of ongoing training for voluntary workers and family members as well as public relations.

The support for social planning consists of identifying regional needs, making proposals for continued development of the local care offers, co-operation in planning bodies, co-operation in the drafting and securing of quality standards.

Methods and Forms of Work

Assistance in individual cases, which is the central task of the consultation office, meaning support and advice for the recipient throughout the process. The individual steps are described below:

- In the first step, a social assessment of health, care and socio-cultural aspects is made. This initial meeting takes place in the home in order to inquire into and/ or assess the family support network, the health situation, limitations, the social contacts, the assistance currently received, the abilities, resources and support requirements. Based on this information, the concrete need for assistance is identified, which in turn is the basis for the assistance planning.
- In the second step, the assistance is planned through evaluation of the available information and the need for additional information determined. The draft assistance plan includes priority of objectives, schedule and

steps in the implementation of the plan; it is discussed with the person seeking assistance/ the family. At the same time, they are to be motivated to try something new, alternatives or compromises worked up and the division of labour agreed.
- In the third step, the assistance plan is implemented/ assistance is arranged for. Agreements are made with providers, questions of financing clarified etc. and documented.
- In the fourth step, the assistance plan is evaluated. Here the consultation office represents the interests of the recipient vis-à-vis the contracted service providers. The assistance plan is used (as checklist) to assess whether the objectives set previously were achieved or not. Objectives are discussed with the person seeking assistance, going into the reasons, obstacles and organisational deficiencies and any necessary modifications. Everyone concerned gets feedback and, if necessary, a case conference is called in.

In addition to managing individual cases, the consultation office also serves to monitor the local care system, so that offers in the fields of care for the elderly can be updated. Thus, the consultation office possesses comprehensive documentation on all open, ambulatory, semi-stationary and stationary services offered including which services are provided, capacities, a comparison of prices, addresses, sponsors and contacts in systematic form. This information is regularly updated through personal contacts, information provided by the services, exchange of information in the working party, the "Advisory Association on Care" of the City of Kassel and press reports.

Finally, deficits in the service provision's sector are reported to the district planner for assistance to the elderly. Moreover, a rather intensive transfer of experience to the political arena by the work group of consultation and coordination offices in the district exists.

4. Case Reports

Case 1

- Transfer from hospital to home
- Preparation for a removal (welfare office is informed; timely notice of termination to the landlord; grants, where possible; one-off payments by the welfare office and the care fund etc.)
- Information on benefit claims, assistance
- Application for benefits under the care insurance, additional assistance when applying
- Monitoring of exemptions

- Monitoring of implementation

Case 2

- Information on benefit claims, assistance
- Application for social welfare assistance, additional assistance when applying or protesting against rejections
- Support for family members providing care, assessment of their stress tolerance
- Establishment of a basis of trust/ communication structure with public authorities and service providers

5. Public Relations Work

Public relations work is basically performed through three channels: firstly, though contact and build-up of communication structures with service providers, doctors, clinic social services, health insurance funds, homes, churches etc.; secondly, through press work, and thirdly, through lectures and publications.

3.6 Case Management in Israel

Evaluator: Dr. Ariela Lowenstein

Case Management is a multi-dimensional method with managerial, coordinative and clinical functions. Thus, there is no single definitive model of Case Management and its implementation is subject to a wide variety of models and factors.

1. Demographic Factors and Trends

Israel has 6.5 Mio. inhabitants with about 600,000 aged 65 or more (9 %; whereas 3 % of the population are aged 80 or more). The percentage of those aged living alone lies by 28 %. The rate of institutionalisation of persons aged 65 or more is 4.4 %. “High-risk” groups (with continuing growth) are persons aged 75 or more, aged women living alone, immigrants of Eastern Europe as well as an increasing number of persons in need of care.

2. The Welfare State in Israel

The basic principle of the welfare policy in Israel is the so-called "familial solidarity", guided by the responsibility between generations and the general openness towards immigration.

In order to maintain a maximum of self-sufficient life in the own home, as well as the participation in social life, a comprehensive system of medical care and assistance has been created:

- governmental agencies (i.e., the Ministry of Labour and Social Affairs, the Ministry of Health, and the National Insurance Institute)

The National Insurance Institute (i.e., the social security) includes old-age and survivors insurance (universal in coverage and not means-tested); the disability insurance and the long-term care insurance.

The organisational structure of the medical care and assistance is covered by local authorities (social system: local public welfare offices as major provider of services for the elderly; health system: regional health offices run by sick funds; acute health services provided by health clinics). For the first time, a co-ordination of these structures was provided by the ESHEL (Association for Planning and Development of Services for the Aged) - a co-operative in form of a partnership between the government and a public welfare organisation. Main directive of this co-ordination is the augmentation of programs for the elderly that, e.g., include day care centres and supportive neighbourhoods.

Further structures of medical care and assistance for the elderly include:

- the General Federation of Trade Unions: operating pension funds, a network of clubs for senior citizens, homes for the elderly and persons in need of care.
- voluntary organisations: operating social services and homes (mainly differentiated by immigration groups)
- private sector: institutional care and, most recently, home care services and ambulatory care services.

3. Legislation and Its Impact on the Care of Aged

During the 1980s, a conceptional shift from stationary to ambulatory treatment, i.e., residential services for the elderly, has taken place. The regulatory basis is given by the Long-Term Insurance Law enacted in 1988 and

the National Heath Insurance Law enacted in 1995, with a general entitlement to a basket of services (providing ambulatory services). However, this basket is still based on the one that was provided at the time the law was enacted. Consequences are a universal health insurance coverage, low rates of institutionalisation and a well developed ambulatory infrastructure.

Characteristics of the Long-Term Insurance Law are:

- a universal right to receive services according to needs (means-tested, but with high income levels)
- community orientated in order to avoid institutionalisation
- care services in case of high demand for care (in order to relieve family care-givers)
- priority for service provisions (according to uniform criteria); cash allowance only in case of deficient infrastructure
- use and extension of the existing infrastructure (mutual responsibility of government and sick funds)
- additional service provision by non-governmental institutions and private service providers
- development of standards in the interdisciplinary co-operation
- increased efficiency regarding the management and co-ordination of services.

System-orientated goals include expanding community-based services, improving quality and efficiency through service co-ordination, encouraging privatisation, concentrating on population 'at risk', and cost control. Person orientated goals are systematic evaluation of clients' needs, development of individualised and variable care plans to give more attention to the severely dependant elderly and their family care-givers. Limitations to this law: persons in low demand of care as well as rehabilitation services are not included; besides, the assessment tools regarding the mentally infirm are insufficient.

About 84.000 persons receive services according to the Long-Term Insurance Law (i.e., 1.3 % of the population, or 14 % of the persons aged 65 or more). The main services provided are personal care, home maintenance (on an average of 11 or 12 hours per week, 15 hours for the mentally infirm), other services include, e.g., day care centres and emergency buttons.

Procedure of the Long-Term Care Insurance

A person has to apply services of the Long-Term Care Insurance at the National Insurance Institute. They provide a comprehensive assessment which is the basis for an interdisciplinary committee (social workers, nurses, employees of the health insurance) to devise an individually tailored care plan, based on an agreed upon basket of services.

The standardised assessment-tools include physical health, ADL, IADL, communication, emotional and cognitive functioning, social participation, informal support system, physical environment, economic resources, capacity for self-care, personal history, as well as values and preferences of the client.

4. Description of the Case Management Project in Haifa

4.1 Long-Term Care Insurance and Case Management

The Long-Term Care Insurance Law provides some of the basic principles of Case Management, such as:

- central access to information and service provision
- standardisation of eligibility criteria and service restrictions
- standardisation of responsibility, evaluation, service delivery, and financing
- development of creative and flexible service packages, individually-tailored for and co-ordinated with each client
- arrangement of services and continuous control of implementation.

However, two problems remain:

- interdisciplinary teams who were supposed to perform individual Case Management, were not well enough developed due to budgetary restrictions: each social worker today has a caseload of 350 clients.
- the basket of services is not flexible enough to meet individual needs, since it is standardised because of exigency to funding, or else, due to its restricted influence caused by the purchaser-provider-split.

Accordingly, the model project “Case Management for Persons in Need of Care” was initiated in co-operation with the Social Service Bureau in Haifa (start: March 1999). Two social workers were each allocated 10 hours per week (a quarter of a full time position).

4.2 Goals and Process of the Case Management in Haifa

The basic tasks of Case Management are mediation of consultation and therapy, advocating on behalf of the clients and their care-givers as well as co-ordinating and monitoring services. The basic elements of Case Management are:

- establishing contact to the agency
- intake/ assessment of needs
- activation of a care plan, including community based services
- linking clients to various services
- activating and supporting the informal system
- monitoring the quality of services
- reassessment of needs
- evaluation of outcomes.

100 persons, who were eligible, were selected for the model project. Among those: 30 persons doing "pure" Case Management, 30 persons as 'control-comparative' group (with continued regular/ ordinary treatment) and 40 persons as a 'reserve' (in case of death or placement to residential institution). Criteria for selecting the clients were: age (above 70), gender, family status (single versus married), living arrangements (living alone or with children), physically or cognitively impaired functioning as well as financial resources.

An individual service plan was provided for 30 clients: evaluation of assessment, development of possibilities to support care-givers, family and voluntary supports (with regard to communication problems of migrants); prognosis of the further development of the person in need of care, specification of expected outcomes (including a time-plan); data on demographic information and environment; client health history (physical and cognitive); assessment of all formal and informal supports; description of all service providers and the type of service delivered, assessment of the need for co-ordination and monitoring; description of further proceeding whereby the service plan can be modified, if necessary; written information for the client about whom to contact; notation of any services identified as needed, but not yet provided, and why.

An interim evaluation was carried out three months after the start of the project. In this context the need for modification of assessment tools and care plan instruments were discussed. Further, the number of clients involved in Case Management was increased to 40 (i.e., 20 persons per Case Manager). The target group was extended to persons in need of care who were not eligible so far, to receive benefits under the Long-Term Care In-

surance Law. The Case Managers reported that they were able to answer the needs of the clients much better than previously, and that the links to the service providers were strengthened.

A meeting between the evaluator Dr. Loewenstein and the Case Managers takes place every three weeks; interim consultation, however, is possible as well

4.3 Structural Requirements

Qualification of the Personnel

The Case Managers are social workers with following qualifications: knowledge of the needs of the relevant target group, of the corresponding service providers, of the available community resources; close co-operation with the service providers, volunteer agencies and other community services, expertise in information and referral activities as well as in interviews, data collection and assessment; further, expertise in elderly assistance including its basic legislation.

Technical resources

The physical environment is partly restricted: there is only room for two Case Managers, a telephone with answering machine (since there are not enough telephone lines, Case Manager often use the services of the Volunteer Assistance Centre). The bureau is open from 8 a.m. to 3 p.m., once a week to 6 p.m.; in addition, one Case Manager is available 'on-call' in cases of emergency. Two computers are available for general administrative purposes and baseline data on clients, for Case Manager, however, no personal computers are available (so baseline data and further information on the Case Management process are divided, integrative data assessment is only possible through the National Insurance Institute).

Institutional Structure

- implementation of the project in the Social Service Bureau in Haifa Municipality
- co-operation with the interdisciplinary local committee (embedded in the Long-Term Care Insurance Law); a meeting is held every two weeks
- weekly meetings with nurses of the "community-neighbourhood clinics"; further, ongoing contact (by telephone) to three general acute hospitals and a geriatric rehabilitative clinic; meetings are arranged, if necessary

- weekly visits to day care centres
- close co-operation with the Volunteer Assistance Centre: training to voluntary staff and checking on the clients' situation.

Internal organisation: Once every two weeks, the Case Manager meet all workers with the aged of the Social Service Bureau to discuss individual clients as well as organisational issues.

Methods of Assessment

An initial assessment is performed by a nurse after the clients were found eligible. According to this assessment, the interdisciplinary committee sets up a care plan. In the further course, weekly home visits (for about two hours) are paid by the Case Manager (if needed, together with a nurse, for migrants a translator) to re-assess and modify the care plan (usually every two months; if needed, more often.)

The re-assessment includes personal data of the client, people residing with him/ her, as well as the primary care-giver; in addition, it contains an environmental assessment of building and apartment, sources of income, general background including hobbies and events, medical information, family relations and interactions, data on other support systems and services the client uses.

5. Evaluation of the Project

5.1 Methods and Instruments of Evaluation

- group therapy and individual interviews with Case Managers
- questionnaire on care time, number and type of clients, characteristics of client and care-givers, formal service use history, informal network; and evaluation of the Case Management
- clients' files: a form of the local committee for the LTC Law, a form on changes in the care plan, forms on contact with care providers, report on supervision of the nursing companies, medical report (including ADL and IADL), readiness of client to give up confidentiality, refusal of services, summary of meetings with clients and care-givers.
- care report regarding every client
- 'activities code list': short summary on problems of clients and care-givers/ degree – activities to solve these problems: regarding the assessment, the care plan, the services (supervision of the care package), the client (advocacy), the care-giver.

- evaluation of the role of the Case Manager: most frequently mentioned were the intervention in the course of care, and support of care-givers, followed by care plan development and revision, change of service provider, client assessment, and care co-ordination; least important were charting, managerial role and placement assistance.

5.2 Characteristics of Clients and Care-givers

A large number of clients are women, two thirds of them widowed. Half of the clients are holocaust survivors. About 50 % of the clients live alone, but only one third without informal supporting system (lonely and isolated). The clients age range above 85 in almost half of the cases; medical diagnosis are dementia and orthopaedic problems/ fractures (the characteristics of the comparative group were similar).

Most clients call on the services provided by the basket of services including home maintenance; of further importance are the communicative functions and the respite to care-givers. Case Manager provided considerable information on and linkage to services.

5.3 Outcomes of Case Management

Overall, Case Manager perform the typical tasks of Case Management; factors affecting the Case Management outcome include: professional background (establishing of objectives and setting of priorities), financial budget, brokerage or consolidated role of Case Manager, time budget.

Micro-Level Outcomes (including examples)

- *diagnosing and meeting additional needs of clients:* e.g., loneliness of an elderly client (despite living in a shared household) requires a modified care plan – family therapy to improve the couple's relation, visits of a nurse and a volunteer
- *collecting additional data:* e.g., activating other support resources
- *maintaining the clients preferred lifestyle/ delaying institutionalisation, advisory services:* list of service providers and encouragement to change services, e.g., if the client is not satisfied but afraid to express critics
- *promoting social relationship and community participation:* Day care centres were not known in one example; accompanying while visiting such an institution (or a pensioner club) can reduce inhibitions
- controlling services and ensuring more flexibility: e.g., a women with mobility problems and thus, exhausting the nurse, required provision of

an electric hydraulic level and introduction of a psychotherapy. *working with different ethnic groups (immigrants)*
- *more time for visiting clients:* weekly or twice a week, at least two hours per client
- reducing care-givers' burden
- *evaluation of clients' satisfaction:* overall clients were satisfied with the services rendered, still some concerns were raised regarding the quality of services or the specific qualification of the care-givers, lack of control over scheduling, and system level inflexibility (e.g. availability on evenings and weekends).

Outcomes on Macro-Level

On the level of services a further development of the care process, improvement of co-ordination and co-operation between service providers and community services were reached, as well as mediation of specialists from the health and social system, more flexibility of the services provided, improvement of quality through control, animation of volunteers, activating and supporting the informal system, internal quality control, and finally, development of further communicative networks.

6. Conclusions

Regarding the Case Management project in Haifa, the support of clients and care-givers had priority over supervision of services. The evaluation of Case Management showed some positive outcomes on micro-level as well as macro-level; especially the assignment of one Case Manager to a limited number of clients improved the quality of care, the service supply structure, the integration and the overcoming of barriers between different service providers or service systems.

Following questions remain:

- clients' needs: How is the client's need determined, who defines it, and how can unattended needs be met?
- choice of clients: for whom does Case Management apply? Some clients can provide the required services themselves.
- professional and voluntary staff: the professional service supply system cannot always meet all needs; thus, to supplement functions voluntary organisations should be strengthened.
- boundaries between social care and health care: How can this boundary be overcome in order to establish a comprehensive care?

3.7 Case Management in Italy

Evaluator: Dr. Aurelia Florea

1. Background of Case Management in Italy

In Italy, the legal framework for Case Management differs from region to region. Thus, Emilia Romagna is the only region in Italy to have the regional law 5/ 94, "For the Protection and Improvement of the Situation of Elderly People – Measures in Favour of Elderly People Requiring Care", containing regulations *"for the implementation of concrete measures to assist elderly people to remain in the family and in their social surroundings so that their wealth of experience, knowledge and culture will be appreciated".* The function and the professional tasks of the Case Manager are also described in this law.

Two examples from this region which differ in terms of approach will be described. Thus, in 1) Case Management in the region of Montecchio Emilia is embedded more in the social sector and has its logistical base within the local council, while in 2) Case Management in the region of Faenza is attached more to the health service with a logistical base in the local health station. In both districts, however, the system works the same way.

In the other regions, also in Rome, there is no statutory basis; in Rome, however, a one-year Case Management project was launched in June 1998.

2. Case Management through the Assistance Service for the Elderly (SAA) in Emilia Romagna

A comprehensive assistance is embodied in the Law 5/ 94, with A) an Assistance Service for the Elderly *(Servizio Assistenza Anziani, SAA)*, B) a geriatric evaluation unit *(Unità di Valutazione Geriatrica, UVG)*, C) a Case Manager *(Responsabile del caso)* and D) *a network of medical and social agencies*. These agencies are closely inter-linked so that the overall system will first be presented very briefly, even though the "actual" Case Management is handled by the Assistance Service for the Elderly (SAA), which is the central agency to which elderly people and their families turn and which initiates any further steps that may be necessary.

Here briefly the four areas with their respective tasks:

A) The Assistance Service for the Elderly *(Servizio Assistenza Anziani, SAA)* is an agency for the co-ordination and integration of social and medical functions with following tasks:

a) drafting of an initial assessment of the elderly person's situation,
b) guarantee of a co-ordinated utilisation of the entire network of medical and social agencies, and
c) appointment of a person responsible for each individual case (Case Manager).

This assistance service

- assumes the co-ordination between medical-social and purely social agencies,
- issues the approval for access to the network of medical/ social agencies as per the instructions of the geriatric evaluation unit *(Unità di Valutazione Geriatrica, UVG)*[4],
- assumes the control function for the network and the quality control for the services,
- acts as an information office for the services available and the ways of accessing them,
- organises further education and training for the personnel, and
- organises information and health campaigns for elderly people.

B) The geriatric evaluation unit *(Unità di Valutazione Geriatrica, UVG)* draws up an individual assistance plan based on a multidimensional assessment as well as in agreement with the family members, the Case Manager and the family doctor.

C) As a rule, the Case Manager is a social worker from the Assistance Service for the Elderly (SAA).

D) The network of medical-social agencies includes:

a) *Integrated Home Assistance*, guaranteeing
   - basic medical care services,
   - medical consultation in hospital,
   - home care by a nurse,
   - rehabilitation and ergo-therapy,

[4] See below, for description of this unit.

- provision with sanitary and medical assistance,
- home assistance for everyday chores, and
- reception of domestic emergency calls.

b) *Day Care Centres* are semi-stationary institutions where rehabilitation and communicative activities are carried out to reactivate or improve the remaining abilities
c) *Home for the Aged (Casa Protetta)* that ensures the basic socio-medical and health care services for persons who cannot be cared for by their families but for whom admission to a nursing home is not required according to the evaluation of the UVG.
d) *Nursing Home (Residenza Sanitaria Assistenziale, RSA)* for elderly people who cannot be cared for at home, who require constant care but no hospital treatment. The nursing home provides following services:
   - basic health care services and rehabilitation measures,
   - assistance in all everyday activities, and
   - social activities.

2.1. Case Management through the Assistance Service for the Elderly in the region of Montecchio

Framework and Structural Conditions

51,984 people live in the region of Montecchio, of whom 5,084 (9.8 %) are aged 75 or more.

Following persons are available for the general network activities to interlink the above mentioned areas in Montecchio:

- 1 responsible of the Assistance Service (SAA, part-time),
- 1 employee of the Assistance Service (SAA, 28 hours per week),
- 1 administrative employee (part-time),
- 1 social worker from the Geriatric Evaluation Unit (UVG, 10 hours per week), and
- 1 representative/ networker of the Case Manager.

The Geriatric Evaluation Unit (UVG) consists of three gerontologists (on a rotating basis), two social workers (on a rotating basis), one nurse and one administrative employee (part-time).

The network interlinks several units and services: two nursing homes (RSA), four stations for assisted living, six day care centres, eight stations for integrated home assistance, one home care service, one general practitioner, eight social workers and one assistant upon discharge from disposal.

Evaluation of the Consultation and Co-ordination Office

Concept

The network of social and medical services described above is integrated in the Case Management under the leadership of the Assistance Service for the Elderly (SAA) in different phases of the assistance process:

- In the first phase, the Case Manager assesses the need and makes initial contact with the family doctor. In cases of a complex need of assistance, the Geriatric Evaluation Unit (UVG) of the Assistance Service for the Elderly is asked for an assessment. In this case a request is sent by an employee of the SAA to the evaluation unit UVG.
- In the second phase, the UVG, the Case Manager, and the family doctor jointly evaluate the elderly person and draft an assistance plan for him/ her.
- The responsible of the Assistance Service (SAA) authorises the access to the network of services (third phase).
- In the fourth phase, the assistance plan that has been drawn up is implemented by the service network.
- The Case Manager supervises the course of the assistance plan and monitors the health and social development of the recipient in order to organise changes in the program, if necessary (fifth phase).

In cases where the elderly person lives at home, the Assistance Service is usually contacted by members of his/ her family. Where the elderly person is released from hospital, hospital staff make contact with the Assistance Service (SAA). This Assistance Service is the central office of access to the network of services, so that clients with need of various services - these can range from home assistance to complete stationary care - can contact the Assistance Service.

Accordingly, the target group of the Assistance Service (SAA) comprises the persons in need of assistance and their families. The purpose of the Service is to improve the living situation in cases of need for assistance to enable the client to remain at home for as long as possible, as well as to advise and relieve family members.

Case Reports

In one case, the need was reported by the family. After the assessment of need by the Case Manager, a request for evaluation was sent to the Geriatric Evaluation Unit (UVG) who subsequently set up an assistance program.

Due to the deterioration of the client's health condition, a renewed intervention by the Case Manager was necessary, a renewed evaluation performed by the UVG, and a new assistance program set up.

Then, the required services were activated by the SAA. In this case, a transfer to a nursing home was unavoidable. The client, however, continued to be accompanied by the Case Manager, who again submitted a needs report because the client now felt able to return home.

In these cases, renewed evaluations of the clients are always made, a new assistance program set up and the services reauthorized by the Assistance Service (SAA).

Public Relations Work

Additional public relations work is not required since the Assistance Service (SAA) is the only "gateway" to the service providers and, if the recipients are not familiar with it, the family doctors, hospitals etc. certainly are.

2.2 Case Management through the Assistance Service for the Elderly in the Region of Faenza

Framework and Structural Characteristics

The region of Faenza has 81,241 inhabitants, of whom 9,382 persons (11.4 %) are aged 65 or more.

The approach in dealing with cases is similar to that in Montecchio. Altogether, however, there are several gateways to the network since local contact offices *(Assistenti Sociali Territoriali)* are inserted and act as contact offices together with the central Case Management office.

The whole network comprises three service managers (elderly assistance, basic medical care, social worker), seven persons responsible for the implementation (one of the hospital administration, three of the municipality's administration, three co-ordinators of institutions), as well as four experts (two Case Managers, one representative of the Geriatric Evaluation Unit - UVG, one representative of general practitioners).

The Assistance Service for the Elderly (SAA) in the region of Faenza is structured as follows:

- one manager (on average 30 hours per week), employed with the basic medical assistance service in the district of Faenza,
- two employees for co-ordination and secretarial work (a total of 46 hours per week),
- a local Geriatric Evaluation Unit with its own secretary (26 hours per week)

The UVG consists of two administrative employees (30 and 16 hours per week, respectively), one medical employee (16 hours per week) for secretarial work plus one gerontologist, one nurse and the Case Managers from the local Assistance Service (partly) for the evaluation team.

Evaluation of the Consultation and Co-ordination Office

Structural Conditions

The local Assistance Service (SAA), which represents the only gateway to the network of services, employs three Case Managers (at 30 hours per week each) for the region of Faenza, and additionally four Case Managers (at 18 hours per week each) in Brisighella, Casola Valsenio, Castel Bolognese, Riolo Terme and Solarolo.

The working concept is largely comparable to that in Montecchio with two exceptions. Firstly, the gateway here is more decentralised and, secondly, the documentation and collecting of information on services is expressly computer-supported. The contact persons, access, target groups and objectives are also comparable to those in Montecchio.

Case Report

This case report shows that the recipients are monitored over a longer period, in the following case from 1996 to 1998.

The case was a 71-year-old woman for whom an individual solution was found to meet the objective need and her wishes. Despite repeated hospitalisation or, temporarily, to a nursing home, an effort was made repeatedly to comply with her wish to live at home through the provision of supplementary assistance due to the intervention of the Case Manager and based on the evaluation of the UVG. In the end, however, accommodation in an

institution was recommended and carried out regarding the increasing risks involved.

Public relations work

Additional public relations work is not necessary as this is the only gateway to services.

3. Case Management in a Model Project in Rome

3.1 Framework and Structural Characteristics in Rome

So far, no statutory regulations concerning Case Management exist in Rome, as is the case in the region of Emilia Romagna. However, women aged 56 or more and men aged 61 or more can utilise following facilities:

- seven senior citizens' clubs,
- income-related financial assistance,
- offers for free-time activities during summer months, and
- home assistance.

The home assistance is subordinated to the *Service for Autonomy and Integration of the Elderly (SIASA)*, This service provides, for example, individual assistance, assistance for hygiene, house cleaning, shopping, meal preparation, co-operation with the family doctor and local health care authorities, accompanying services, contacting closely related persons, supervising medicamentation, as well as participation in group activities.

These services are only available through the SIASA, and only after an initial contact was made during a home visit, and the actual assistance commenced and documented in a report. With this background, a Case Management pilot project started in June 1998.

Framework and Structural Characteristics in Rome, 12th District

145,169 inhabitants live in the 12th district of Rome, with 23,438 (16 %) persons aged 60 or more. The pilot project comprised 200 persons aged 65 or more. Two Case Managers (a social worker and a home nurse), so that each Case Manager looks after 100 persons. The Case Managers were given special training.

Each Case Manager has his own office (in the social service centre of the 12th district, or in the geriatric day care station of the S. Eugenio hospital respectively). They may use the available technical equipment and have a laptop including a modem, a telephone system, an answering machine and other office furnishings.

In the framework of the pilot project, evaluation teams were set up that consisted of

- the Case Manager,
- the participating family doctor,
- a manager from the 12th district,
- the doctor of the home care centre
- the UVG of the geriatric ward of the S. Eugenio hospital (consisting of gerontologists and a social worker),
- a nurse,
- a representative of the social co-operative, and
- a representative of the care co-operative.

3.2 Evaluation of the Consultation and Co-ordination Office

The working concept of the pilot project comprises the following five steps:

1st step: contact with the family doctor to identify persons in need aged 65 or more, complete the medical form and discuss existing problems.
2nd step: home visit including computer-based registration of his/ her social situation and network of relationships; the social worker processes the opening of the case solely on the scene, using a standardised instrument (VAOR-ADI).
3rd step: The pilot project team (see above) meets every fortnight to discuss the cases together with the respective family doctor, as to determine the individual assistance plan.
4th step: The assistance plan is explained to the client and possible closely related persons. Steps are taken to ensure a rapid implementation by the service providers.
5th step: Every three months, the client is visited at home in order to discuss changes that might have occurred in the interim; if changes have taken place, the case is again discussed by the team and the required steps initiated.

Unlike the project in Emilia Romagna, contact to clients in this pilot project was made through a selection of 200 patients in co-operation with various family doctors. The target group comprises elderly people with health or

emotional problems. The objective of this project is an improved support for the elderly at home and the prevention of a untimely transfer to a nursing home. Cost optimisation is a further aim.

3.3 Case Report

The client is a woman who has difficulty walking and who, moreover, is emotionally unstable. During the home visit, it turned out that the woman was already receiving two hours of home assistance four times a week. After the assessment, a home assistance was determined by the social services system in order to focus more on her social and relationship problems.

Due to staff shortages, the physiotherapy was provided after a rather long waiting period. After the physiotherapy, the health and emotional condition of the woman improved.

Shortly afterwards, hospital treatment became necessary; after her release, the woman continued to be monitored by the Case Manager, and the assistance was intensified.

3.4 Public Relations Work

Public relations work was not mentioned. Access was via the family doctor, so that publication of the pilot project in order to attract clients did not seem necessary.

3.8 Case Management in Luxembourg

Evaluator: Dr. Jacqueline Orlewski

1. National Context

In Luxembourg there are 56,600 people aged 65 or more, of whom 2,800 (5.0 %) are in need of care. Although numerous services existed in the area of home care - from household help to housing adjustments - prior to the introduction of care insurance on 1 January 1999, this multitude of various services led to such a complexity, that only those who “by accident” were well informed could arrange an optimum of care for themselves. In the stationary sector, demand (still) exceeds supply; this is due to a differing admission policy of the respective institution.

The care insurance was introduced with the general aim of improving the assistance to persons in need of care and closely related persons, whereas priority is given to home care over stationary care. The improvements relate not only to financial support but also include, primarily, a concrete consultation for those in need of care and the development and implementation of assistance plans.

To achieve these objectives, a special evaluation and orientation office *(Cellule d'Evaluation et d'Orientation - CEO)* was set up in which an interdisciplinary team (see below) co-operates. This office collects information on both the respective need situation and the various services available and performs the tasks of Case Management. It develops an individually-tailored care plan which takes the client's need into consideration.

2. Structural Requirements

Personnel Capacity

The Case Management is anchored within the evaluation and orientation office (CEO). This office initially comprised 16 full-time employees consisting of three psychologists, one physiotherapist, one work or occupational therapist, one ergo-therapist, five nurses (three of them in the field of psychiatry), two doctors, one social worker, one editor and two administrative staff members.

Due to the high demand, which may be seen as a "start up problem" in connection with the introduction of the care insurance at the beginning of 1999, the assistance of voluntary workers is required from time to time.

The staff of the CEO received theoretical training in the area of social legislation (here, in particular, the care insurance) and computer technology. In addition, practical training on the evaluation of the cases as well as on the drafting of an individual care plan was conducted.

The CEO is subordinated to the Ministry for Social Security. Its offices are located in the administration building of the Union of Health Insurances who administer the funds for the care insurance. (This shows the close link to the financing institution.) The staff of the CEO work two in one office but have a telephone with answering machine each. Laptops are available. Moreover, the CEO has a photocopier, a scanner and a fax machine. The CEO's information system is not specially designed for Case Management but covers all aspects of the care insurance. In this connection, an "info-line" was set up, and is occupied on workdays from 8.00 a.m. to 5.00 p.m. The staff of

the CEO can be reached in their offices; however, the actual access to the CEO is only possible by written application for benefits under the care insurance by the person in need of care.

3. Methods

Subsequent to the application - after the family doctor has been inquired as to the urgency of the case - an assessment is performed as an initial step. Then the applicant is assessed by the CEO doctor (medical evaluation) and by a basic evaluator from the CEO (assessment of the need for care). In case the applicant is "sufficiently mobile", the medical evaluation takes place in an office of the CEO, otherwise at home, or in a home for the aged or nursing home. The evaluation of the need of care is always performed at the respective domicile of the applicant.

Determination of the need for care is based on five standardised questionnaires[5]:

1. the medical questionnaire,
2. a questionnaire on the applicant's general living situation (in absence of family members),
3. a self-assessment by the applicant as to the degree of his/ her need for care (in absence of family members),
4. assessment of the degree of need for care by a person closely related to the applicant,
5. determination of the degree of need for care by the evaluator.

Then the assistance plan is developed on the basis of the evaluation of the received information. In the process, the necessary measures are defined, agreed with the person seeking assistance and, where appropriate, with the family and a division of labour between private and professional assistance agreed.

Implementation, which begins with the sending of the care plan to the person in need of care and to the network of service providers or stationary services, follows in a third step. The co-ordinator of the service providers therefor contacts the person in need of care and makes a first house call, during which the concrete implementation is discussed and co-ordinated.

[5] This is basically the Canadian instrument called *Classification par type en milieu de soins et séjour prolongés (CTMSP)*, and developed by the scientific team EROS-Equipe de Recherche Opérationelle en Santé.

The care plan is obligatory for persons who live in stationary institutions since no division of benefits-in-cash or benefits-in-kind can be made.

Barring any unexpected changes, a re-evaluation can be requested after a period of six months.

4. Service Profile and Outcomes of Case Management

Case Management within the framework of the CEO assumes an important mediator function between needs and provision. This becomes especially clear in conjunction with the provision of stationary care institutions: Prior to the introduction of care insurance, the exact number of beds available was not known. Now the Union of Health Insurance has set up a contract with the respective institutions that obliges the latter to inform the CEO about vacant beds which are not occupied within 10 days of time. Various nursing homes, however, do not wait for the appointed time but immediately announce vacant beds..

In the ambulatory sector the network of services is still being set up. Since introducing the care insurance, however, an increasing number of persons in need of care fall back on services provided by the networks.

3.9 Case Management in the Netherlands

Evaluator: Dr. Clarie Ramakers

1. National Context

Of the 15.6 million inhabitants of the Netherlands (1997), two million or 13 % were 65 years of age of older, while 3 % were aged 80 or more. The elderly make strong use of the health system. In 1997, 86 % of Dutch people aged 65 or more consulted a family doctor (total population: 76 %), 60 % a specialist (37 %), while 12 % were in hospital at least once (6 %).

When a person is no longer capable of living on his/ her own, two alternatives are possible:

1. The home for the aged, which is accessible in cases of minor disability and/ or lack of social contacts. A single room, three meals a day, social assistance, an emergency call system and communicative programs are offered here.

2. The nursing home, which is available in cases of greater physical disability and a need for care. The services provided include overnight accommodation in rooms with four to six beds; during the day, residents may use common rooms; constant multidisciplinary observation and treatment (psychogeriatric nursing home for patients suffering from dementia) is guaranteed.

The decision on the assignment of a place in one of these homes is made by the Regional Examination Board (RIO). Both types of institution are financed by the social security (on the basis of the AWBZ - the law on the financing of special medical expenses) with an additional contribution being required from residents of homes for the aged.

In the Netherlands there are about 1,400 such institutions; some 3 % of those aged 65 to 84 and approximately 30 % of those aged 85 or more live in these institutions. This equates to 5.4 % of the total population aged 65 and older (113,000 in 1996), although the tendency is going down so that only an estimated 107,000 elderly people will be living in these types of institutions in the year 2001.

The trend is towards living in the community in suitably equipped dwellings combined with ambulatory care. This is provided by professional care-givers to back up informal support and comprises home care and household help. In 1995, 129 services were members of the National Association for ambulatory care and household help.

9 % of senior citizens (19 % of those 85 or more) receive regular home assistance, while 5 % of senior citizens (14 % of those 85 or more) receive home care. 85 % of the cost of these services is covered by the social security (AWBZ), while the remaining 15 % must be borne by the recipient.

In addition, welfare agencies for the aged, social welfare, family organisations etc. offer various services, so that the market was rather unclear.

Case Management as a Form of Welfare Co-ordination

The complexity as to what services were available led, in most cases, to “homes” as the standard solution. For this reason, a centralised co-ordination was established in 1974 with the aim of improving the range of welfare services through greater coherence. In the mid-80s, this centralised solution was transferred to the local/ regional level. The respective range of tasks differs, so that either a straight co-ordination of services is provided

or, in addition, individual case-related co-ordination of services (Case Management).

Case management relates to the individual (relating to a single case); care is organised and comprises the entire process, i.e. the recipient is looked after permanently from the first meeting. Furthermore, Case Management should be limited to difficult forms of co-ordination and should be independent of sponsors, i.e. it should not be provided by either the source of financing or by service providers. Moreover, the task of a Case Manager is not reserved to a particular occupational group.

The tasks to be performed can be derived directly from the above definition of Case Management. These are: definition of the target group, determination of the assistance requirements, allocation of care-givers and services, drafting of an assistance plan, implementation and supervision, evaluation.

In the Netherlands the concrete form of Case Management is not subject to any statutory regulations. For this reason, Case Management may be

- performed on a full or part-time basis,
- organised internally (by care providers or insurers) or externally (independently),
- limited in scope (e.g., only consultation and co-ordination) or comprehensive (offering all components of the full process).

Local Case Management projects

The various forms of Case Management discussed above become apparent in the following examples. A number of local and regional models, which differ in terms of sponsorship/ financing, target groups and their relationship to homes, functional designation and task profile will be described in brief.

- *Individual Welfare Grants (Rotterdam, 1988):* sponsored by the Municipality and by the Centre for Social Geriatrics and Gerontology; and is aimed at applicants for places in homes for the aged; its organisation is associated with a neutral organisation. The project performs following tasks: determination of the need for assistance from the client's point of view, co-ordination of professional and non-professional services, planning and monitoring of care. The project is financed through a so-called "experimental fund" by the Ministry of Health.
- *Integrated Care for the Aged (Aalten, 1990):* sponsored by the community and by a senior citizens' foundation. It addresses older people and is organised through co-operation with the community, and thus, indepen-

dent of sponsors. The following tasks are performed: collection of information, individual consultation and need-based co-ordination of the care structure, report of deficits to the local "steering committee".

- *Care Co-ordination (Leeuwarden, 1992):* sponsored by a home for the aged, together with the Municipality and the Province. It is aimed at applicants for places in homes for the aged and organised in the form of a co-operation between a care co-ordinator and the home for the aged. His task is to implement the individually-tailored care program including all related services.
- *Care Co-ordination (Landgraaf, 1995):* sponsored by a foundation for a home for the aged along with the Municipality and the Province. It is aimed at applicants for places in homes for the aged. The organisation comprises several sponsors. Staff members from various institutions co-operate in a care co-ordination team. Tasks are comparable to the example from Aalten mentioned above.
- *Ambulatory Care for Psychogeriatric Nursing Home Cases (Arnhem, 1995):* sponsored by a foundation for a home for the aged and a care insurer. It addresses older people still independent who require complex, particularly psychogeriatric, assistance and for whom a place in a home is "indicated". The main task is to implement a coherent care program.
- *Municipal Care Station (Kerkrade, 1997):* sponsored by a foundation for a home for the aged along with the Municipality and the Province. It is aimed at applicants for places in homes for the aged and organised via municipal care stations that include various care organisations. Its tasks are the co-ordination of care "around the clock" including day care and ensuring that meals and personal hygiene are provided for.
- *Case Management in Psychogeriatrics for Demented Elderly People (Brabant, 1998):* sponsored by an institute with national backing. It is organised through independent Case Managers and addresses elderly people with psychogeriatric illnesses (indicated or not) and their primary care-givers. Following tasks are performed: implementation of the Case Management function with care, support, consultation and mediation. Co-operation with service providers, landlords, welfare associations, senior citizens' welfare centres, etc.

2. Nieuw Doddendaal: Residence for the Elderly
(since November 1989)

The Nieuw Doddendaal residence comprises 36 one- and two-person flats plus one flat for acceptance at short notice. It has a laundry room (washing machines and dryers) as well as separate entrances and postal addresses for the individual flats; it (intentionally) does not have a central reception area or a central kitchen.

The residence and care association is the sponsor of this residence institution. The average age of the residents is 84 years, and 65 % are women. The average duration of residence in the institution is 4.3 years (in a home for the aged: 4.6 years). The average care requirement is 77.5 minutes per day (as opposed to 92.2 minutes in a home for the aged). When need for assistance and care exceeds 11 hours per week, transfer to a traditional home for the aged is recommended.

The residence is run by a small team of care-givers with two Case Managers and five staff members for residents' and administrative affairs. The two Case Managers, a general care worker and a psychiatric care worker, work part-time (20-30 hours per week). An internal team meeting takes place once a month, and a working meeting with the management is held once every two months, so that the Case Manager works a total of 24 hours per week for 40 residents. The Case Managers have their own office at the institution including a secretariat which also acts as an information and emergency centre and is occupied daily from 8.00 a.m. to 11.00 p.m. Appointments with the Case Managers are made here, there are no fixed office hours. This care structure is financed through the care budget.

Division of Labour

The Case Managers are primarily responsible for supervising the implementation of the individual care plans, while the other staff members also cover the emergency service from 8.00 a.m. to 11.00 p.m.

The residence has no service or care personnel of its own and no director with responsibility for care and residents' affairs. Thus, catering services, nursing care, household help (shopping, laundry, cleaning), accompaniment during activities and night emergency cover (11.00 p.m. to 8.00 a.m.) can be bought in as required. The cost of these services is included in a flat rate contribution to the care budget but is refunded to those who take care of such services (e.g., shopping, laundry, cleaning) themselves.

3. Case Management in Nieuw Doddendaal

In Nieuw Doddendaal the principles of choice, freedom of decision and, thus, optimisation of independence are followed rather than the standard solution of "full care", which frequently leads to a untimely loss of possible actions and of autonomy.

Definition and Tasks

The Case Manager has a function of his own but is accountable to the foundation director. The tasks of the Case Manager are to:

- evaluate the need for assistance and draw up service contracts,
- support/ organise services (discussions with service providers, agreement on details in line with the client's requests),
- evaluate and control the finances,
- provide individual consultation on changes (approx. every quarter year), and
- maintain external contacts (to the nursing home, hospital, family etc.).

Requirements for the Case Management

The qualification for the position of Case Manager include a social pedagogical qualification, social competence, knowledge of the "social landscape" in his fields of work and the ability to judge functional limitations.

Methodology

In an initial meeting/ consultation - which takes place in the new resident's present dwelling - health, care and socio-cultural aspects are discussed along with the degree of independence of the future resident. In addition, the services provided as well as the residential and care concept are explained.

When a vacancy occurs, the future resident together with his/ her family is invited to visit the institution. The residence is presented "live", details are clarified and the service and rental contracts signed. When the new resident moves in, an assistance plan is devised; this includes: a detailed plan of the care and services to be provided and a monthly evaluation of the assistance plan. If requested, interim modifications of the assistance plan can also be made.

Both the service contract and the assistance plan are deposited in the resident's flat with a copy being kept by the Case Manager. It is important to note that the right to make decisions regarding utilised services rests solely with the resident; this right is transferred to family members only when he/ she is no longer capable of making these decisions.

3.10 Case Management in Austria

Evaluator: Dr. Waltraud Saischek

The institutional organisation of the Case Management is the health care *Sprengel* ("*Gesundheitssprengel*", a territorial authority), an association which is responsible for the communal elderly assistance. An stronger orientation towards the private sector was aimed at when the *Sprengel* was excluded from the local administration. One third is financed by each the city, the *Land* and through compensation of benefits. The health care *Sprengel* supports ambulatory services and mediation offices. A "social and health care facility" can be found in each of the seven city districts of Innsbruck. The *Sprengel* employs 80 full-time employees and 21 alternative civilian service workers (for roughly 120,000 inhabitants). The Case Management was set up within the *Sprengel* as a staff position.

1. Framework Conditions

Financing Care through the Care Insurance

In Austria, nursing allowances are granted upon proof of need and classified into seven levels of dependency. In 1997, 270,000 persons received these benefits, 23 % of the recipients living in institutions and 77 % in private households (one third of these live alone). Furthermore, social assistance (land) will assume a share of the costs for those in need of care and assistance (46,500 recipients), as well as rehabilitation and health insurance for medical care. The local authority directly subsidises ambulatory and hospitalisation services if they are of public benefit; the increasing number of private services are not upheld.

A graduated social welfare rate scale applies to costs for care and home assistance. This is calculated by subtracting the difference between gross income and social assistance rate per hour

- 1 % for home assistance (recipients of nursing allowance: additional 2 €)
- 1.5 % for care (recipients of nursing allowance: additional 4 €)
- 2 % for non-medical home care/ basic care (recipients of nursing allowance: additional 6 €).

(i.e., at a difference of 200 €: between 2 € and 4 € per hour, at a difference of 500 €: between 5 € and 10 € per hour; the actual costs form the upper limit.)

In cases of social hardship, a minimum rate of 7 € per month (as a symbolic lump-sum) is paid (subsidised prices; remaining sum financed at 65 % by the land and 35 % by the city). Medical home care is considered a benefit in kind under health care insurance. Ambulatory services are granted only in that they are less or equal to the cost of stationary care; otherwise the person must move in to a home.

Demographic Development

The number of 85-year-olds will increase by over 100 % between 1992 and 2030, and the rate of 60-year-olds to the employed population will rise from about 30 % (from 1960 to 1992) to 65 % in 2030. Along with the increase in elderly population, an increase in dement people is also expected.

Legal Framework Conditions and Provision Structure

A variety of services exists; 43 % of persons in need of care require more than one service. The organisation of ambulatory services is not uniform: "social centres" have been set up in Vienna to help organise and supply assistance services. In Upper Austria the areas of care have been divided among service providers. The city of Carinthia has social *Sprengels* integrated into the administrative services; in Tyrol, separate social *Sprengels*. These offices provide basic ambulatory care and act as a "social turntable" to mediate other services. A co-ordination including a service control is aimed at.

No systematic survey of the providers exists, merely self-assessments; therefore, the financing of Case Management was determined (so far only in Tyrol).

The Targets of Case Management

Basically, Case Management should provide a "package of care" (under neutral consideration). Secondly, an effective utilisation of resources and a better survey of the service situation is aimed at; over and under-provision of services should be revealed. Instead of competing and generally orientated service providers, a development towards better co-ordinated specialisation is sought; the market survey provided by Case Management offices informs about market gaps.

- *External Case Management:* External Case Management serves to co-ordinate the market provisions as well as the information given to per-

sons seeking assistance and their relatives (who finally decide as autonomous clients)
- *Internal Case Management:* Internal Case Management is understood as the increase in efficiency of the service structure of the *Sprengel* by means of self-evaluation: internal restructuring of the association and establishment of a performance structure "based on the client's needs". The care service administration controls internal management in the form of a "package of care", thus, ensuring that needs are met fairly and, at the same, optimising service. New clients are directed from external Case Management to internal Case Management.

2. Personnel and Material Resources of the Project

Organisation of Case Management

The external Case Management exists since May 1998. At the beginning, one employee was appointed to 20 hours per week for managing the infrastructure of care provision. This was not enough and was extended to 40 hours per week. The Case Manager who is an examined nurse receives new clients, analyses their situation and organises the required and desired assistance including all available (professional and informal) resources.

The Internal Case Management is carried out by a city district team, consisting of nurses, nursing assistants, care assistants, social workers for the elderly care, social workers and social educationalists, as well as home assistants (in addition to the physiotherapist and logopedist); the co-ordinator is a certified nurse.

The Case Managers of the district hold weekly team meetings.

Division of Tasks

The external Case Management directs clients to internal Case Management or to other services. It surveys and contacts all ambulatory, semi-stationary and stationary service providers. The clients are visited once a month, in addition, the Case Manager maintains a regular telephone contact with them.

The internal Case Management is responsible for

- the first visit and determination of the client's need for care (assessment)
- co-ordination of care

- co-ordination of further care services with the external Case Manager (the future plan for the internal Case Manager is to co-ordinate the entire care services)
- regular evaluation of the care process (transfer of records from the external Case Management; documentation manuals)
- a minimum of one visit per month
- weekly meetings with Case Managers from other city districts.

Qualification of Case Managers

The Case Managers are examined care-givers/ nurses who also have a high degree of "social competence" which can be gained through an additional competence in the fields of social work (an equivalent educational concept is in progress). IN addition, 20 % of the working hours are available to the city district co-ordinators within the *Sprengel*, an amount that is used for community work otherwise.

The ambulatory services of the *Sprengel* under the responsibility of the Case Manager: appoint examined nurses (implementation of medical and non-medical care/ basic care), care assistants and care workers for the elderly (assistance in care and household help), household assistants (overall assistance), therapists (ambulatory physiotherapists and logopedist), civilian service workers (assistance with household duties, shopping, accompanying) and trainees (ambulatory assistance, home care). Furthermore, family members are included by the Case Manager (counselling, training, and supervision, to avoid overwork). Voluntary staff is momentarily not employed, since no organisational structure is available yet; but it is planned for the future.

Material Resources for Case Management

The internal Case Management is located at the multi-functional city district centres (seven city district offices plus two branch offices) since a localisation close to the citizen was the main objective, The external Case Management is located at the city centre of Innsbruck.

The technical equipment comprises telephones, answering machines, fax machines, e-mail access, mobile phones, and a company car for the Case Managers; further , a personal computer with access to a "health care information network". This network handles resources, capacity and utilisation of service providers within the ambulatory and stationary sector; the Case Manager can access this information during consultations).

External Co-operation and Difficulties

Problems of rivalry arose when the clinic's social workers placed clients: the workers felt their competence was being undermined but were not able to supply services comparable to that of a Case Manager because of a lack of clinical field service. In this case, the definition of task was necessary. The restructuring and organisation of Case Management came up against resistance from other participants as well.

Financing Institution

Case Management is financed by the *Land* and municipality. Costs were estimated to be "merely slightly higher than usual", since Case Management led to considerable savings.

3. Which Instruments does the Case Management Office Employ?

The Case Management Process

Assessment: During the initial visit, the Case Manager, together with the clinic social worker or the family doctor as well as the person concerned, their relatives and neighbours, determine the (health) condition of the client, the possible resources of assistance, the willingness to help him/ her and further need of assistance. Besides, the client's requests should be taken into consideration, if possible.

Package of care: Once the needs have been clarified, the services suitable are determined; then whether the service providers have the required capacity at the requested time.

Documentation: A transfer record is exchanged between the external and the internal Case Management, containing the required client data. The client receives a "care file" for documentation purposes. Should the client be directed to a different service, external Case Management will document this change; again the transfer record ensures a complete flow of information.

Care Conference: Regarding clients who were received by the external Case Management, a care conference is called in to discuss each individual case jointly by care services and the family doctor. As long as care and assistance are performed by services of the *Sprengel* itself, the internal Case Management will discuss the individual cases. Family doctors, too, were

taken into consideration as Case Managers, but this appeared unrealistic because of the lack of a communication structure between the system of doctors and ambulatory care; instead, they take part in the care conferences with the Case Managers.

Sprengel Conference: A conference held every quarter year to discuss professional and organisational is further held with all agents involved.

Resource Check System (under the authority of the Institute for Biostatistics): This system checks the capacity of the service providers, which the Case Manager can access by computer. The data is updated weekly by the service providers (which must still be followed up by a telephone call since the updating process is unreliable).

Case Management as a Political Impetus

The experiences made by the Case Management office are included in the planning of care structures, so as to avoid over or under service provision. In this way, the Case Manager could initiate an assistance structure within the organisation for neglect.

4. Service Profile of Case Management

The Case Management in Innsbruck only acts in cases of complex need for assistance. Emphasis is set on following points:

- Implementation of a comprehensive assessment and analyse of the nee for assistance
- Assembling a “package of care”
- Mediation and co-ordination of suitable services
- Accompanying and evaluation in the course of the care and assistance process, modification of services due to a changed need for assistance, if necessary
- Accompanying in case of hospitalisation, a transfer to hospital, or the removal to a home
- Mediation of assisted living

The function of having an external quality control of services drifts into the background, since most services are carried out by the *Sprengel*’s own provider. However, a broad spectrum of services and institutions is available if a need for external co-operation exists.

3.11 Care Management in the United Kingdom

Evaluator: Prof. Dr. David Challis

1. National Context

In the United Kingdom the state-funded stationary provision of elderly persons strongly increased in the Eighties, without being able to have any control of the actual need. Furthermore the service offer was strongly fragmented, the result of which was that the overview was considerably confused. For this reason the Government, in 1998, changed direction that is expressed in the conception "Caring for people". This conception identifies the following six key areas:

- promotion of services with the aim that elderly persons should be able to stay and live at their homes as long as possible,
- high priority for the need of care persons,
- high-quality assessment and Case Management as corner stones of public provision,
- promotion of a well functioning independent service sector next the services of the public sector,
- definition of the responsibilities between the providers of health and social services as well as
- better use of the financial means by reducing stationary treatment.

These new tasks have been given to the departments of social welfare in the communities. They are responsible for the assessment of the need, for the drawing up of individual assistance plans and for making available Care Managers, who will be accompanying and monitoring and who will be the only access to the service provision.

This political change of direction – away from the stationary treatment and towards strengthening care at home – was initiated because of financial reasons in the first place and led, in 1993, to a legal establishment of Care Management. The aim of cost containment was achieved by the Care Management overcoming the high decree of fragmentation in respect to service providers in the social field as well as in the health area and by combining both areas. According to the conception the conditions in care should be newly structured both in terms of stationary and domestic care and in terms of formal and informal care.

The recently published paper on "Modernising Social Services" the role of Care Management once again was emphasised:

> 'In April 1993, social services' responsibilities for people needing long term care expanded significantly. Until that time, people who lived in independent residential or nursing homes were funded through DSS (Social Security) benefits. The Community Care reforms gave social services the responsibility not only to fund this type of care placement (subject, as before, to a means test) but also to carry out an assessment of care needs for the individual concerned, and ensure that the care being given was what that person needed. This focus on individual Care Management, focused towards helping more people to live in their own homes, was the key change to the system.(White Paper 'Modernising Social Services', Cm 4169, 1998, p13)

2. Organisational and Operational Features of Care Management

Care management is a task which is assumed by a total of the 150 departments for social services of the communities that differ in relation to the respective definition of Care Management: 65 per cent of the responsible authorities define Care Management as an organisational process, while 15 per cent consider it a specific job and 20 per cent define it as both.

In principle Care Managers in the United Kingdom are employed by the authorities and they work for the most part within specialist teams for elderly persons. The departments for social services that deal with Care Management employ as a rule Care Managers, social workers and therapists. In 21 per cent of the departments employees of the health sector are brought in, essentially to support the assessment. In organisational terms the majority of the authorities has placed Care Management into the area of the organisation of benefits, whereas 17 per cent of the authorities report that Care Management has been placed in the area of organisation as well as in the area of their own benefits on offer. In this respect organisational problems of a clear division between these two areas can come into existence.

The available budget for board and lodging in institutions is set at the national level, whereas the budget for domestic services is fixed by the municipalities.

3. Practices and Process of Care Management

Assessment

The following description includes 50 assessment instruments that are used in the different bodies. The quality and the content of the instruments are

very different and often no clear connection between the identified needs and the formulation of adequate solutions can be recognised. The differences are particularly great regarding the identification of the need for care, depressions, old-age dementia and behavioural disturbances. The collection of data as to how persons cope with their tasks in daily life (ADL) generally correspond in terms of the content, whereas also in this respect there are differences regarding the decree of the structural pattern.

The assessment is mainly carried out by Care Managers, social workers and occupational therapists whereby often the medical staff, too, like for example the nursery care personnel, is brought into the assessment. However, the inclusion of medical doctors into the assessment process is not stipulated.

In the assessment several levels of grading can be made according to the complications of the case and the dimension of the need of assistance. Some Care Management bodies carry out the assessment for all groups of users at a uniform level, whereas the majority differentiates between two levels in this respect: one assessment for easier cases and another assessment for more difficult cases, to which further specialists are brought in. However, there are also bodies that bring in further specialists in the overall assessment according to the seriousness of the case.

In one of the Care Management bodies, which were chosen to serve as an example, two levels are differentiated in the assessment; the more complex one is applied for cost-intensive cases, which might result in an admission to a home. In these cases qualified personnel is brought in to carry out the assessment. However, the documentation is carried out in the same way in both assessments.

Drawing up a Plan of Care Provisions

As a rule Care Manager, social worker and occupational therapist participate in drawing up a plan of care provisions. When drawing up a plan of care provisions the costs are calculated, whereby in most cases both the costs of internally provided services as well as of external service providers will be included. Almost four fifth of the responsible persons indicated that at least for one of the user groups the financial volume is limited. In many cases there are also relative limits on expenditure for the provision of elderly persons that are more often applied to elderly persons than for other user groups. This practice can be explained by a particularly high volume of expenditure for elderly persons.

The upper limit for domestic benefits is often defined via the cost of comparable benefits provided in an institution. Further criteria are the available budget and the need; thus, for example, different limits are fixed for different levels of the identified need.

In a body that has been selected to serve as an example the social workers, staff members of the municipal welfare and the occupational therapists are responsible for implementing the assistance plan. The total package of benefits is calculated and harmonised by means of the limit that is fixed for the weekly expenditure of the corresponding needs category. The Care Manager explains the established assistance plan to the user and the care persons and is responsible for its implementation.

Monitoring

As a rule the monitoring takes place in the presence of the person looking for assistance, approximately half of the bodies take into consideration regularly the information given by the care person whereas 30 per cent take into consideration this information occasionally. Other means of monitoring are telephone discussions and messages about changes provided by other bodies. In general there is only little time for this task on the grounds of the great demand for assessment. In some bodies Care Management is limited to providing assessment and to draw up the assistance planning.

Participation of the Users and their Families

In the United Kingdom the care persons have a right to the assessment of their own needs, what in practice is scarcely taken account of. The evaluator considers it as very sensible to include the users and the care persons into the implementation of the assistance plan, into monitoring and into the following assessments.

4. Implementation and Results of Care Management

Effectiveness of Care Management

Most studies deal in their evaluations of Care Management with the risk groups of elderly persons suffering from dementia who need a high degree of assistance. For this reason the focus is on the admission or new admission into hospitals or other care institutions.

Apart from the differences and the difficulties to find generally valid definitions for example for mental problems or the risk of the admission into a home, some common issue can be indicated in relation to the assessment. These are: economies made by the municipalities, the quality of life and the quality of the assistance. In addition to this in a series of studies the following factors have been identified, which can be used to monitor the results of long-term Care Management. These are the:

1. integration of the cost centre accounting into the program
2. logical linkage between assistance model, the objectives of the program and the incentives in practice
3. clear definition of the tasks
4. definition of the target groups
5. continuity of participation.

1. The inclusion of the program into the municipal authorities and the integration of cost centre accounting, which is connected to this, can result in the consequence that contra productive impulses are created, if for example for reasons of organisational constraints (too) narrow budget limits will remain. In order to avoid these contra productive impulses, cost centre accounting and the program have to be well co-ordinated.

2. In relation to the practical implementation of the program objectives a high degree of flexibility is required, otherwise the risk exists that standardised solutions which can easily be implemented would be given preference. The result would be that one turns away from individual solutions and turns to standards; and this would not be in the sense of the program.

3. The tasks can either refer to the needs of the users and the process of assistance organisation or to the result, such as the degree of hospitalisation or the quality of life.

4. With the assistance of a precise definition of the target groups those persons seeking assistance can be selected, who mostly need assistance by Care Management.

5. The continuous participation of the manager in the assessment, in drawing the assistance planning, monitoring etc., both efficient and inefficient strategies can be identified. This applies both to the individual and to the more general levels.

5. Conclusions

The spectrum regarding the assessment both in relation to the instruments used and the participating occupational categories is very broad in the United Kingdom, just as in other countries, too. In order to reach harmonisation in this respect, a regulatory framework could be developed which should then apply to the whole country.

The legally stipulated tasks of Care Management are described as "*the process of tailoring services to individual needs. Assessment is an integral part of care.*" (Department of Health, 1991, 11). This definition allows a broad spectrum of possible interpretations and does not comprehend compulsorily all tasks that should be included in Care Management, which are: assessment, establishment of a assistance plan, implementation and monitoring.

In many Care Management bodies the more complicated and more difficult cases are dealt with, where the question is to avoid the admission to a home. In this respect, however, the question arises how the easier cases should be provided for, since the political intention includes the provision of all persons seeking assistance. In the annual report on the "Social Services Inspectorate" the conclusion was made that three different types of Care Management are necessary, in order to be able to efficiently satisfy the different levels of need: first the administrative Care Management which collects information that can be retrieved if necessary. Second a body for the co-ordination of easier cases which only require few services and third an intensive type of Care Management with the corresponding staffing for those complicated case which are mainly treated at the moment

4 Conclusions for the further Conceptual Development and the Practical Implementation of Case Management

The evaluations from nine states and the structural comparison made clear that there are not only common characteristics in some respects, but also considerable differences in parts. If we are trying to identify in the following the basic structures of the application of Case Management against this background and to recommend tried and tested forms, then we have to consider that it is indispensable to adapt the models to the respective context of the situation.

4.1 International Similarities and Differences

Common Trends

The states that took part in the projects have a number of trends in common:

- The demographic trend towards a high increase of particularly very old persons that will require the development of the provision of care.
- Setting priorities for ambulatory and in-patient provision of care, which is justified on the one hand with lowering the cost and increasing efficiency, on the other hand with the interests of the persons concerned and the increase of the quality of care provision (the two arguments have different emphasis whereby in the United Kingdom the financial aspect is clearly the more significant one).
- The effort to promote the independence of the elderly persons and to support this with accompanying assistance as well as
- the approach of a comprehensively tailored and in an interdisciplinary way provided assistance in order to meet the complex situation of need.

Linking of the Social and Health Systems

It makes a fundamental difference whether the societal systems for health and social issues are linked to a uniform structure or whether they are separate from each other. In the case of a structural separation which can be found in most of the states participating in the project (however, uniform in the United Kingdom and – not in out project – in the Scandinavian coun-

tries) the question arises as to where to locate Case Management: If it is located in the health sector (e.g. in the hospital or co-operation with the general practitioners), placement problems arise in co-operation with care and social work. In the same way Case Managers who come from the context of care and social work are faced with problems when co-operating with the medical sector, such as the lack of forwarding information or lacking acceptance. In uniform health and social welfare systems communication problems at the professional level are known (there, too, are differences in the status of medical doctors and social and nursing care occupations); but by dividing the systems of social issues and health additional structural obstacles become effective, which are in a specific way tasks of co-operation and linking.

The Variety of the Participating Players

At the different societal levels of action organisations and players are participating in the provision of care. The respective division of tasks between them is a national, regional and local characteristic feature. On the one hand the responsibility for social policy and for social planning is divided in different ways between the levels of the state and the municipality and if applicable to the interim levels (*Bundesland, Reggione, Comunidad Autonoma,* etc.). Frictions can occur if political responsibility, competence and financial responsibility are distributed to the different levels. On the other hand different players co-operate with each other within regional or local systems of provision – starting from commercial organisations, non-profit organisations and national authorities to informal support systems (family, neighbours, persons working in an honorary capacity). The variety of these players has different dimensions, which has direct effects on the Case Management and difficulties in the co-operation, which have to be overcome.

Legal Basis

A decisive question in relation to the stability of the Case Management structure is its political importance, which is valued in a decisive way how far the legal stipulation has developed. Both the planning and the acceptance of Case Management on behalf of the co-operation partner and the target groups as well as the degree of professionalism and the security of employment of the advisers is influenced by the fact whether Case Management is a fixed part of the regulatory provision (as is the case in the United Kingdom, Luxembourg and in the Emilia Romagna), whether such a step is still insecure (as is the case in Belgium and – following some steps

backwards in the development – in the *Länder* of Hesse and Baden-Württemberg) or whether the structural development is still only at the level of pilot testing (as is the case for most of the cases examined in this context). In Germany the draft version of a "bill on the assistance for elderly people" provides for Case Management to be given a legal basis; the finding of a consensus between the political levels of the state, the *Länder* and the municipalities is yet to be resolved (see approach mentioned earlier).

The parallel trends and structural differences, which are mentioned here, do not result in a complete picture, but just reflect those aspects which have been examined in the course of the comparisons of the models. At least these aspects, but also further aspects which are not mentioned here, influence and vary the concrete implementation of the basis forms of Case Management which are outlined in the following.

4.2 The Forms of Case Management for the Elderly

In different perspectives the following basic structures for the implementation of Case Management can be mentioned as a result of the exchange of national experience and the comparison of concrete project examples:

(1) Types of Clients and Situations of Need

In relation to the target groups *comprehensive* Case Management and *specific* Case Management can be differentiated. Case management is characterised as "comprehensive" if it can be essentially understood as an offer for all citizens in need of assistance and if generally the target groups are defined more precisely regarding the age or the need of care. Typical situations of need are situations occurring in daily life in the private household that can no longer be coped with without assistance from another person. Target groups of comprehensive Case Management can be

- all citizens in need of care of one city district, e.g. apart from the aged persons in need of care also disabled persons of all ages
- only elderly persons in need of assistance and care
- only persons in need of care (according to legal criteria such as the criteria of long-term care insurance in Luxembourg and Germany)
- expressly also the relatives of persons in need of assistance and care.

Specific Case Management can be understood as the forms that offer the clients counselling and support in unusual situations. This can be located

with different bodies – in a hospital, a home, a surgery or another place. The linking defines at the same time the conceptual orientation of the body and the category of persons that it is directed to. In our project these have been for example

- hospital patients from private households with the risk of rehospitalisation or admission to a home (the example of Belgium)
- inhabitants of a residential community for which suitable services are to organised (the example of the Netherlands)
- applicants wanting to be housed in a home where the authorities check in the first place whether all possibilities have been made use of to remain in ambulatory care (also reported from the Netherlands).

Recommendation:

If it corresponds to the basic principle of Case Management that (elderly) persons in need of assistance can address themselves to a contact person and ask this person to inform them about all the possible provisions of assistance and to assistance them with the access, then this need requires comprehensive Case Management. However, this does not exclude that this can be supplemented by further specific forms in a sensible way; in this sense the return into the private flat after hospital treatment is a difficult step which can be essentially facilitated if one is accompanied by a Case Manager working in the hospital. In principle the establishment of a Case Management structure that is lined out comprehensively should be first priority. This structure should be easily accessible for all elderly persons in need of assistance and it should maintain a good contact with all providers.

(2) The Institutional Context and the Funding of Case Management

The institutional context of Case Management is in close connection with the chosen target groups; correspondingly one can differentiate between a location near the citizen and a location specific for the area.

- Case management near to the place of residence: municipal counselling body (part of the Social Assistance Office), in the Citizens' Centre (part of the social work in the city district), part of the ambulatory health or care system (bodies for counselling in health matters or for assessing the need of care);
- Case management in institutions: in a clinic (as part of the transmission into hospital), in a home (for the organisation of the service) or prior to a nursing home (in order to avoid the admission to a home).

Case management which is *area-specific* is mostly included in an institutional context from the very beginning (in our project examples for example into the hospital or a residential community); in this context there are just differences in detail, such as the Case Management for just one residential community or for several residential communities. The body funding the Case Management is as a rule identical with the body funding the institution.

However, there are greater differences in relation to the institutional linking of the *comprehensive Case Management*. It should be available for all (elderly) citizens with a complex need of assistance that requires a "near-the-place-of-residence" location in the municipality or in the city district. In essence the municipality would be a neutral institution for funding a Case Management body. Since it would be very costly to build such a structure from the very beginning, there are different models for linking it to already existing institutions, which are close to the citizen, such as for example citizens' centres, or counselling centres. A Case Management unit can also be located in the buildings of the authorities; it would be problematic, however, if by doing so the counselling function were mixed with the function regulating the benefits – in Germany for example by locating the Case Management unit with the social assistance offices (whereby also the stigmatising effect of the social assistance office speaks against this link).

A comprehensively outlined Case Management unit can also be funded by several institutions together. Such a construction might convey the impression of being relatively complex at first sight, but it can be connected with positive effects regarding to

- the synergy: the willingness of the participating institutions does not have to be initiated by the Case Manager, but is already given in the face of the institutional link; different competencies can be mutually supplemented, the technical infrastructure can be commonly used; respective working hours can be combined and the times where the staff can be reached personally can be thus extended;
- the neutrality: the aim to achieve neutrality across the institutions can be either achieved by dismantling the competition between the institutions or by the inclusion of the (and in this case of all the relevant) institutions;
- and the willingness to finance (see Chapter 5).

Recommendation:

Case Management which is comprehensively directed towards all elderly citizens with a complex need of assistance should be located near the place of residence, so that it can be reached by the elderly without much effort.

This can be done in the form of a link to existing citizens' centres, centres for the elderly or counselling units that are located near the place of residence (or in rural areas in the form of a central institution which is linked with decentralised units in the communities). Each institutional like must see to it that the clients and the conceptual orientation are compatible with each other (e.g. a counselling unit that offer access to benefits should not be located in the close vicinity of social assistance office that regulates benefits and is oriented towards special clients[6]).

Case management should be funded in a comprehensive and neutral way. Under these aspects it is recommended that Case Management should be funded by the state or the communities. Alternatively neutrality can be achieved by combining several funding institutions (with or without participation or moderation by the communities); this, however, requires that all providers are included.[7]

(3) Instruments, Methods and Competencies in Case Management

If one takes a look at the concrete working methods of the Case Managers, the applied instruments and methods, a fundamental difference can be recognised between the work carried out directly with the clients (micro level) and the co-operation at the level of the services and institutions of the health sector and the social welfare system as well as the contact with public offices, insurances and other institutions (in this context referred to as "macro level").

(3.1) At the Micro Level: Individual Case Management

The process of Case Management starts with a first informative talk in which the Case Manager gains a first impression of the situation of the client, in particular, his or her need for Case Management. The client obtains information about the available possibilities of counselling and assistance as well as about Case Management. If from this first contact a Case Management process develops (which is only the case for some of the clients), this process consists of the following basic elements (which in practice can have different emphasis, but should all be contained).

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6 Similar conflicts can occur if Case Management is linked to the assessment body of long-term care insurance (as is the case in Luxembourg) or with the authorisation body for places in homes (as is the case in the Netherlands).

7 The neutrality of the IAV bodies in Baden-Württemberg for example could be doubted. They were as a rule funded by a circle of free non-profit institutions, but without private-sector providers taking part.

- *Access of the Clients and Selection of the Clients:* contacting and first talks to identify the need for Case Management, guiding of the access and selection of clients, for whom Case Management could be a helpful method;
- *Assessment:* inclusion of medical, psychological, nursing care, family, social, architectural aspects and wishes/ expectations/ anxieties of clients; information and counselling about Case Management and possibilities of nursing care;
- *Planning of Assistance:* on the one hand evaluation of the assessment and on the other hand of the available offers of assistance; establishment of a service package, in which accessible offers are tailored to the need; formulation of objectives (with time schedule when the objectives will be achieved); discussion of the assistance plan with the client and his or her relatives;
- *Implementation:* Establishment of contacts to the service providers and if necessary placement of individual services with exact arrangement of the service provision; if necessary also representation of client-interests (e.g. vis-à-vis the authorities or funding institutions);
- *Monitoring of the Service Provision:* Monitoring of the targeted service provision and identification of misallocation or insufficient detailed coordination, insufficient meeting of agreements, lacking quality of benefits, dissatisfaction of the clients or their relatives, conflicts between provider and client;
- *Re-assessment:* Identification of changes in the health status or the competence to cope with daily life, documentation of the effects of the benefits received and need of assistance that continues to exists or that has been modified;
- *Modified Planning of Assistance:* monitoring whether the objectives have been reached, if necessary new formulation of the objectives or the steps and periods which are required for its implementation, adjustment of the services to a changed need;
- *Evaluation:* monitoring of the Case Management process and alternative interventions.

These steps and the order in which they are performed are not to be understood as a rigid model which has to be observed compulsorily for each individual case; however, they can serve as a means of orientation, whether within a Case Management process all relevant aspects have been considered and they can also indicate deficits (if the Case Manager, for example can only be active up to the level of assistance planning, whereas the monitoring of the implementation does not fall within his or her competence).

The individual steps of Case Management require different competencies of the Case Manager. In context with the activities required for assessment and the needs analysis medical, nursing care, psychological and sociological knowledge is necessary. In addition the implementation and the monitoring require a well-trained power of faculty, communication competence and the ability of self-assertiveness.

Recommendation:

Case management should include the elements mentioned; it should not be limited to mere counselling, but also has to include the further process of placing the assistance and the later monitoring, whether the assistance provided had the expected effect and or whether they have to be modified.

The instruments used in the assessment should contain all the necessary information– not more and not less. In order to avoid that too many data are recorded, in some projects a two-step assessment is successfully practised which as a rule is a very short one and will only be extended in particularly serious cases.

The necessary competencies of the Case Managers touch in terms of qualification medical, nursing care, social and psychological and social work skills – a complex requirement, which suggest a preference for a multidisciplinary form of organisation (see Chapter 4). By personal qualifications such as social and communicative competencies, experience and power of persuasion, the work of the Case Manager is essentially facilitated.

(3.2) At the Meso and Macro Levels: Inclusion of Case Management into the Structure of Provision

Apart from the client-oriented work, Case Managers also have comprehensive tasks to fulfil. That this also includes as for any other service industry structure, too, team discussions, contacts to the funding institutions and public relations work, is only mentioned in this context, since these tasks are not specifically related to Case Management. However, a direct part of Case Management is the knowledge of the available service offers and the related communication at the level of the services and institutions (characterised as "meso" level).

The working level is extended by the requirement to be able to deal with state institutions and legal provisions also at the "macro" level", at which the

system differentiations in social welfare and health systems, in long-term care insurance and in social assistance, etc. are included.

The following individual working steps have to be undertaken in this context:

- *Overview of the Offers:* A qualified counselling presupposes the possibly complete and current knowledge of the services available. This requires a collection, documentation and regular up dating of offers from all areas that are directly or indirectly concerned. This spectrum of offers has to be documented including the information on the concept of service provision (e.g. specialisation on particular clients or particular times of the day), the available capacities in total and the currently free capacities and the contact persons.
- *Linking of the Providers:* The knowledge about the providers is just one first step, at the basis of which a contact will be made with the aim to harmonise and co-ordinate service provision and if necessary also to conclude long-term, sensible and efficiency-increasing arrangements and agreements up to the stable linking of a need-oriented functioning system of provision.
- *Electronic Exchange of Information:* Apart from the co-ordination regarding the content increasingly the establishment of networks in technical terms gains importance; an optimal overview of offers can be achieved if the Case Manager constantly has "online" access to the current state of affairs regarding the offers and the free capacities, also during the process of counselling.
- *Placement of Services:* If the Case Management is both included via information and via good contacts in such a system of provision, the placement of service will be improved in qualitative terms in concrete cases and facilitated in technical terms. A borderline case is the form of Case Management that can exclusively place these services, so that there is no way round this exclusive "one door" access (e.g. in the United Kingdom where the financing is tied to this way of access). As a rule Case Management has the function to open up the way to services in a concentrated and bundled manner via one access only ("one stop"), which, however, does not exclude the direct contact of the client to the services.
- *Contacts:* Furthermore the establishment of regular contacts to national, municipal and local authorities, funding institutions (health insurance, long-term care insurance, social assistance, etc.), regional and national working groups, etc. constitutes a further part of the comprehensive tasks of Case Management.
- Social Planning: The Case Managers acquire during the course of their work specific knowledge about the structure of the provision of services

and its deficits from the perspective of the users; by forwarding this information to the bodies responsible for social planning, these bodies obtain a qualitative access about the practical experience which they would not be able to obtain otherwise (e.g. via significant values about planning).

Recommendations:

The Case Managers have to maintain good contacts and regular exchange of information with the services and institution in the associated area. In this respect a good quality in the relationship with willingness for mutual co-operation has to be achieved. This requires on the one hand good communication skills of the Case Manager, one the other hand also a clear profile of his or her function, in order to achieve that he or she externally conveys a clear and unambiguous picture. Without such a clear profile it will be difficult to achieve that the representatives of other organisations will meet the Case Manager with acceptance instead of fear of competition and/ or an anti-information attitude of blockage.

It should be intended to achieve an optimal linkage with the providers, in order to be able to better harmonise and co-ordinate their services, to initiate necessary specialisation's and if necessary to dismantle parallel structures.

In technical terms the establishment of a network in the sense of always having a current overview, which is available to the Case Manager via a corresponding IT program at any time, is possible and helpful. The desired current status, however, presupposes the essentially co-operative attitude of the providers.

(4) Organisational Types of Case Management

In organisational terms several variations are possible (which are also represented in the evaluated project examples):

- the model of the individual Case Manager
- a Case Management unit with several staff members
- Case Management as part of a task within the framework of an interdisciplinary team.

The model of the individual Case Manager is supported by the aspect of coherence, that the whole process of Case Management is bundled in one person, which reduces the need for placement; formally it seems to be more

feasible to create one new job (in some examples even just as part-time employment) than the creation of a new structure with several employees. The reasons that speak against a one-person structure, however, seem to be more serious:

- The multidisciplinary competencies, which are mentioned in Chapter 3, are very high requirements that the candidate has to meet. And one person can hardly fulfil these only.[8]
- Furthermore this solution does not offer the Case Managers any possibility of mutual inspiration, counselling or specialist exchange about the cases to be dealt with.
- And finally the issues of flexible timing, availability and replacement in the case of holidays or illness cannot be solved in a satisfying way if there is only one person employed.

In contrast to this Case Management that is carried out by a multidisciplinary team (either exclusively or with proportional working time) has the advantage that different professional perspectives are included. For successful integration of these perspectives it is decisive, however, that there is a high willingness for co-operation and that the internal communication is organised without any frictions. If for example the assessment is carried out by several professions in a proportional way, this results in the necessity to organise a well functioning division of the work, to discuss and agree on the criteria of assessment, to bring together the different perspectives in a common assessment and assistance planning and to discuss them in an atmosphere of mutual acceptance.

Recommendations:

Case management requires multidisciplinary competencies, in particular nursing care, social work and also basically medical and psychological competencies. Since the combination of these in one employee can mean a burden too high for one person, a team solution is preferred to be recommended – in the case of sparse resources also the combination of several part-time jobs or several employees who are participating proportionally with their working time in Case Management.

If several Case Managers or several professions work together, the uniformity of the evaluation criteria and the integration of the perspectives in a

[8] Some projects reported that a dually qualified specialist (nurse and social worker) was recruited for the Case Management position who also had long years of professional experience in different areas. This, however, is more of a lucky chance than a reliable long-term planning component.

common evaluation and assistance planning must be assured. This requires a good organisational co-ordination as well as a willingness to co-operate and mutual acceptance.

(5) Financing

The questions of financing are raised at the level of the Case Management benefits and at the level of the Case Management structure. In principle financing by the state (at the national, regional or local level), by insurance provisions and client contributions are to be considered. In most of the project examples that are considered in this context the benefits are provided for the client free of charge; state financing is predominant (in combination of the different levels). The Case Management structures (costs for staffing and equipment) that are considered in this context, too, are mostly financed by means allocated to project funding, often with the participation of the funding institution. Only in those cases where Case Management is legally enshrined (see above Chapter 4.1), its structures and benefits are funded within the framework of regulatory financing (through the state or the insurance).

A fundamental difference of the principles of financing is in regard to the budget and the need. If the task of Case Management is primarily to administer a fixed budget and to put into practice the optimum of quality within the framework of the possibilities, the aim of cost containment has priority (as is the case in the United Kingdom). However, if the task of Case Management is to primarily identify the need for assistance and to organise the necessary provision and secondarily to see to it that this is implemented at a good price, then the quality of the provision is the aim (as is the case in most of the evaluated projects). Both approaches are so different, that a comparison (here: between the experience of the United Kingdom and the experience of the other participating countries) can only be carried out within narrow limits.

However, the international co-operation project has also furnished proof for the fact that optimising the quality of provision can also have cost-reducing effects; the examinations carried out by the University of Liege prove that the further admissions of patients into hospital considerably decreased ("effect of the revolving door") if their discharge from hospital was accompanied by a Case Manager. In this context the advantages of an advanced Case Management structure can be demonstrated which tie the increase in value of the quality of provision to the increased efficiency of the service and the corresponding cost reduction.

Recommendations:

It is important for a stable and performing Case Management structure, which is recognised by its co-operation partners that it can build up on a legal basis with secured regulatory financing. In order to be able to put this through also at the political level, one can use arguments of the international project comparison as regards contents and organisation:

- In regard to the contents-related aim of Case Management it has been shown that the development of the quality of provision can have cost-reducing follow-up effects. The aims of needs-oriented assistance for elderly persons and the increase of efficiency of service provision are therefore not contrary, but they are compatible.
- In organisational respect examples can be quoted in which several service providers have joint together to form one entity and contribute respectively to the financing of Case Management. Thus, not only the burden of building a new structure is divided between several institutions, but also at the same time the aim of neutrality across the institutions has been put into practice.

In respect of the moderation of a comprehensive responsibility across the institutions, it has been recognised in most participating countries that the municipalities have a particular responsibility, either by direct participation or by an excluded organisation.

4.3 Summary and Perspectives

1. Against the background of a demographic development for the whole of Europe – if yet with certain differences – by which a strong increase of the number and the proportion of elderly and very old persons with an increased need for assistance can be expected, the social situation and the health status of elderly persons has led to numerous projects and pilot projects aiming altogether at further developing the grown support systems in a needs-oriented way. The project on "Case management in different national systems of assistance for the aged" of the Federal Ministry for Family Affairs, the Elderly, Women and Young Persons has had the task to analyse the variety of these development approaches, to compare and to make the attempt to gain results for the further perspectives of national systems of assistance for the aged, in particular also for the development of the assistance for the aged in the Federal Republic of Germany. This could also be regarded as a contribution to promoting

the development of convergence in respect to the assistance for the aged in the whole of Europe.

2. The most important result of the project is the finding that almost all projects in the participating countries, despite all the differences in the starting situation and in the framework conditions, correspond to the aim, namely to make available to elderly persons the specific assistance they need in the course of the ageing process according to their individual needs in a professional and co-ordinated way, i.e. in a coherent system. The common aim in this respect is to make sure that elderly persons are able to maintain the largest possible independence in leading their daily lives, in particular also in those times when their need for assistance increases.
3. In relation to the preparation and co-ordination of the necessary complex provision of assistance particular problems practically arise in all project locations from the fact that the individual benefits, in particular those provided by the social welfare system on the one hand and those provided by the health system on the other hand, are in many cases linked to different areas of benefits, institutions and funding agencies. The difficulties arising at the interfaces and transitions between different areas of intervention, in particular when the client is discharged from stationary treatment in hospital with the aim to return into his or her own home, can only be overcome by a targeted development of the structure and the organisation on the basis of a sound legal and financial basis. The Region of Emilia Romagna has developed in its Regional Law No. 5/94 an outstanding example for a legally sound and integrated system of assistance that includes all necessary assistance available from the social welfare and the health systems. For important elements this law could become a model for the further development of legislation in other European regions, too.
4. The establishment and the development of integrated assistance systems must come from the national, regional and local conditions and framework conditions. The complex need of assistance by elderly persons generally requires the combination of all institutions and organisations that offer appropriate assistance. In this respect it is of particular importance that the social environment of the elderly persons as well as persons working in an honorary capacity are included and activated. In project locations where Case Management is not located in certain institutions such as hospitals or attended residential communities, the co-ordination and moderation of the assistance offers have proved to be particular successful at the level of the municipal authorities. What is important in any case is easy accessibility on the spot of the assistance offers.

5. With the exception of a few examples the participating projects are aimed at: specifically identifying the need of assistance of elderly persons if they desired this, in a more or less standardised form with the participation of different occupational categories, developing in accordance with the persons concerned and their social environment on this basis a comprehensive and complex concept for assistance, at implementing this concept, at revising it if necessary and at evaluating the course of the assistance process and at documenting it. Case management understood in such a way can be regarded today as an internationally tried and tested and recognised instrument for the establishment and the practical implementation of assistance concepts for elderly persons with a complex need of assistance. It comprehends in particular the following elements:
   – case finding (access to the offer of counselling),
   – assessment (identification of the need for assistance),
   – planning (establishment of an assistance plan),
   – linking (implementation of the assistance plan and placement of the assistance),
   – monitoring (monitoring of the assistance planning),
   – evaluation (evaluation of the assistance process),
   – documentation (documentation).

   From the practical experience gained in the participating projects one can expect that Case Management can be particularly efficient if it is organised separately of the function of service provision and separately of the function of the carrier of social welfare (social assistance, social welfare), since thus possible conflicts of interests can be avoided.

   It can be recommended to base the structures, methods and instruments of Case Management that is understood in a way of further developing the assistance systems for elderly persons on a compulsory footing.
6. The inclusion of geriatric rehabilitation models into the overall framework of Case Management is of particular importance. In this respect particular difficulties can be found in the fact that geriatric rehabilitation is carried out in special institutions which are laid out mainly for these purposes (geriatric departments in general hospitals, special clinics for geriatrics, rehabilitation institutions), whereby the locations of these institutions, the time dimension of the rehabilitation treatment and their highly specific requirements make the co-ordination with further help within the framework of the assistance for the aged more difficult. It would be promising if the hospital made contact with the Case Management already during acute treatment in the general hospital, so that the inclusion of the rehabilitation phase would be an automatic result. The objectives and the course of the rehabilitation process are then to be integrated as one indispensable basic element of an efficient system of

assistance for the elderly into Case Management. This also applies to ambulatory and in particular to mobile offers of rehabilitation, which are particularly tailored to make sure that the client can remain in his or her own household. Case management projects which are located in the social services of hospitals, such as for example in Liege/ Belgium, give impressive evidence of the efficiency of accompanying geriatric patients in a qualified way before, during and after being discharged from hospital.

7. The services of Case Management related to the elderly person in need of care are supplemented and extended in many of the participating projects by adapting the gained experience at the social planning level as well as in the regional co-ordination of the service providers. In precise terms this means that from the person-related Case Management impulses come into existence for dismantling the deficits in provision or in the co-operation of the service providers and the further development of the assistance offers for elderly people. In this an important contribution can be seen for the social planning as a whole.
8. The practical experience made with Case Management show that by means of these instruments the respective specific assistance can be made available according to the needs and in time and that they can be matched with each other in terms of content and time. This increases the efficiency of the respectively applied elements of assistance, increases the efficiency of the assistance as a whole and avoids oversupply. It can be proved that, when carried out in a competent way, Case Management can essentially contribute to
   - shorten the duration of treatment in hospital or to avoid the admittance to hospital,
   - make use of the existing potentials of rehabilitation,
   - strengthen the social environment of elderly persons,
   - develop individual networks for assistance,
   - maintain the largest possible independence in leading one's life,
   - avoid or to postpone permanent stationary care.

   Thus assistance systems for the elderly that make competent use of the instrument of Case Management offer the opportunity to provide assistance for a continuously increasing number of elderly and very old persons to maintain their quality of life and at the same time to contain the high costs of permanent stationary care.

   The development of such instruments as a regulatory basic element of a contemporary system for the assistance for elderly persons is to be recommended in terms of departmental politics, social policy and financial policy.