



Caseload management

The need for robust referral criteria and a supportive caseload management system is critical for the PHN

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This article is the second in a series of three articles. In last month's edition the author outlined the context of public health nursing in the Republic of Ireland (ROI). The article also outlined some recommendations in relation to the development of public health nursing. One of these recommendations related to the need for the development of standardised caseload management systems within public health nursing. This article now explores the development of a caseload management system within one public health nursing area in Longford and Westmeath in the Republic of Ireland (ROI). The final article, to be published in the winter issue, will examine the use of a dependency framework in adult caseloads held by PHNs.

It is generally agreed that community nursing services require an operational framework that allows for the effective management of admissions and discharges, as well as some prioritisation of service delivery. A caseload system also provides for cost effective and equitable care to meet the continuum of patient needs.¹ The emergence of primary care teams and the commencement of

multidisciplinary primary care clinical meetings have led to an increased focus on the role and contributions of the core members of the primary care team. The PHN is seen as a key member of this team.

System for caseload management

As far back as 1986 a survey of the workload of PHNs revealed the diverse and complex nature of the PHN role.² The report noted that, due to their heavy workload, it was a challenge for PHNs to implement the preventative element of the role. A further review of the PHN service in 1997, carried out by the Department of Health, recommended the development of a management system for both area and caseload analysis.³

A study carried out by the INMO in 2004 revealed that 39% of PHNs considered that their caseload size was not viable. PHNs also reported that, while the service was meant to be delivered on a priority basis, there was no guidance or criteria to support this. According to the study, this raised concerns regarding the equity of service delivery.⁴

A study by Begley et al on the role and workload of PHNs in Galway made explicit recommendations in relation to

case management.⁵ A report in 2005 by the National Council for Nursing commented on the open referral system and recommended an audit of referrals at local and regional level. This report also highlighted the impact of caseload size on the PHN role and noted that PHNs were frustrated by their inability to fulfil their primary preventive and educational roles effectively.⁶ Similar recommendations were made in a subsequent report – *Changing Models of Health Service Delivery* – which advocated a maximum caseload, a priority system and an annual review of caseloads.⁷

Developments

The Audit Commission published a key report in 1999, *A Review of District Nursing*, which provided a benchmark for district nursing services in the UK. It noted the impact of effective caseload management on the roles and responsibilities of the district nurse and made several recommendations to address this. The Commission reported that, at the time of publication, the majority of trusts in the UK had no admission or discharge criteria.⁸ On foot of this report many trusts drew up their own guidelines and implemented a programme of regular systemic

audits of their district nursing service.⁹

There have also been some reports on caseload systems and workload measurement in the ROI. A research study by Begley et al in 2004 developed and piloted a tool known as the 'Community Client Need Classification System'. The purpose of this tool was to measure the client's total need for nursing and psychological care, including education and rehabilitation. Nurses who participated in the study reported that the tool was useful in predicting the needs of new and existing clients and in measuring the PHN workload. The study recommended the development of a caseload management system with a clear referral mechanism, defined admission and discharge criteria, and the ongoing monitoring of a defined active caseload.⁵

The population health information tool piloted, and later introduced into, the Dublin North Central PHN service has proven to be a very functional and practical tool for assisting community nurses with caseload analysis and client dependency. Most importantly, it allows for the development of population-based information which can be integrated with local population and health deprivation statistics.¹⁰ At the time of admission, patients are registered in the caseload system and undergo a dependency assessment. While the dependency information does allow for the possibility of caseload prioritisation, the system does not contain guidance on either admission or discharge criteria.

Transformation Programme/HealthStats

The HSE Transformation Programme that commenced in 2006 introduced a suite of performance indicators known as HealthStats in both acute hospitals and health and social services in the community. These are intended to constitute a standardised performance, information and improvement system.¹¹

Under the HealthStats system, community nursing managers (directors of public health nursing) are required to return monthly information on referrals, active caseload sizes and discharges for all adult client groups (older person, people with disability, and under 65-year-olds in receipt of clinical nursing). Until the introduction of HealthStats there had been no formal system for the routine collection and analysis of national data on public health nursing caseloads.

The nationally agreed definitions for the reporting of HealthStats are:

- Referral: a new clinical episode of care for an individual patient

- Existing patient: a patient who is currently in receipt of clinical services from a PHN/RGN, or who has been seen by a PHN/RGN within the last twelve months
- Discharged patient: any patient discharged during the reporting period.

No guidance was provided on how or who PHNs should either admit or discharge from a caseload and, significantly, no clarification was given in relation to eligibility. Eligibility for the PHN service continues to be based on the 1970 Health Act: *A health board shall, in relation to persons with full eligibility and such other categories of persons and for such purposes as may be specified by the Minister, provide without charge a nursing service to give to those persons advice and assistance on matters relating to their health and to assist them if they are sick...*

Need for local guidelines for PHNs

PHNs have reported regularly on the constant need to prioritise within their caseload, manage complex cases and implement planned health promotion activities.¹² It is a challenge for the PHN to retain this wider role while continuing to provide the hands-on care and intensive case management that are required in the current climate of earlier hospital discharges and decreasing availability of statutory and voluntary health and social supports. The 1999 Audit Commission report in the UK reported that district nurses were reluctant to discharge from caseloads, while the Begley study stated that PHNs accepted more referrals than they discharged.⁵

The counties of Longford and Westmeath, with a population of 113,000, have 39 public health nursing areas. There is a team approach to care with a full-time PHN, a part-time RGN and, in some cases, a healthcare assistant and a home help in each area. In addition each PHN is aligned to a local primary care team and a wider health and social care network.

Process mapping of PHN service

It was within this context that the Midland counties of Longford, Westmeath, Laois and Offaly set about developing a caseload management system that would include a suite of local guidelines and criteria on referral, admission and discharge, while meeting national HealthStats requirements.

Method

A group comprising representatives from nurse management, front-line PHNs and community RGNs was convened. It was chaired by the practice development

co-ordinator and supported by the Department of Quality and Risk within the HSE.

Key decisions of process mapping group

- Each referral to the service should be screened by the PHN to determine whether there is a nursing need and, if so, whether a referral meets local guidelines
- Each patient accepted onto the caseload should be registered and entered onto the caseload profile for each PHN area
- Based on information available to the PHN at the time of referral, the patient should be prioritised for a visit.

The prioritisation levels are:

Priority 1: a visit/intervention by a PHN within 48 hours

Priority 2: a visit/intervention by a PHN within seven working days

Priority 3: contact after seven working days and within three months.

Only referrals entered onto the caseload profile should be recorded for national HealthStats purposes as new referrals.

- Once the patient is entered onto the caseload profile under the appropriate client group the case should then be considered part of the active caseload
- This figure should be returned monthly for the purposes of the national HealthStats/active caseload metric
- Discharges from the caseload should be defined simply as clients no longer requiring a nursing intervention. For the purposes of the HealthStats patients admitted to acute care should be deemed discharges from the caseload
- A leaflet on the PHN service was devised to support the discharge process and advise patients on how to contact the PHN service.

Referral guidelines to PHN service

The referral guidelines stipulated that any patient admitted to the caseload must be assessed to determine if he/she has a specific nursing need that requires the expertise of a PHN. Each referral is considered individually and assessed accordingly. Unlike many of the examples of referral criteria available from the UK Trusts, our guideline did not outline a list of eligible nursing interventions.¹³ Instead a definition of nursing intervention was applied which was broad enough to allow for acceptance of patients with direct nursing care needs or who required health promotion/prevention interventions.

"Nursing is the use of clinical judgment in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to

achieve the best possible quality of life, whatever their disease or disability, until death" (RCN 2003).

A common feature of the UK referral criteria reviewed during the process mapping was the restriction of 'district nursing service' to house-bound patients only. While this was not included in the referral guidelines for Longford/Westmeath one could argue that it is a reasonable criterion to apply in the current climate of diminishing resources. The UK national health system has universal entitlement to services, unlike that of the ROI where eligibility to GP services is dependent upon possession by the client of a General Medical Services (GMS) card. Approximately 32% of the population holds such a card. The difficulty for PHNs historically is the lack of clear guidance on the eligibility for PHN services.

The eligibility criterion documented in our guidelines is as follows: "The HSE is obliged to provide a nursing service to those aged over 65 years. Medical card holders are given priority" – Department of Health, 2007.¹⁴

Anecdotally many public health nursing service areas in the ROI are limiting their clinical nursing service to GMS card-holders only. The UK model would therefore seem to offer a more equitable service in that all house-bound patients have an entitlement and this in turn is based on need rather than means. There is the risk that the PHN, in making decisions regarding service entitlement based only on medical card status, might actually compromise the PHN's professional judgement and clinical decision-making. One of the aims of the Primary Care Strategy in 2001 was a simplification and clarification of eligibility for services. However, the latest report on primary medical care in the community sought the 'early publication of legislation clarifying eligibility for health and social services to assist in the smooth workings of primary care services to patients/clients'.¹⁵ Interestingly, the most recent guidelines published on entitlement for home care stipulated that means testing was not required and the determination for services should be based on assessed need.

Discharge guidelines to PHN service

The group decided that clear guidance on discharge was crucial in order to encourage active management of the caseload. Interestingly, in many of the Trust areas in the UK there are no formal documented discharge criteria. Instead, professional judgment is used. In her study in 2006 Thomas concluded

that robust referral and discharge criteria would contribute towards more effective time management and advocated the use of caseload profiling.¹⁶

The Longford/Westmeath discharge guideline defined a discharged patient as a client who:

- Following assessment, no longer requires any nursing intervention from the PHN service
- Is admitted to acute care
- Is admitted to long-stay care
- Is transferred to another area/new address
- Is deceased.

The leaflet on the PHN service, which was devised as part of the process mapping exercise, was welcomed by the nurses as a helpful aid to the discharge process.

Benefits

Given Hanafin's definition of a PHN as a manager, clinician and health promoter, the PHN has both management and clinical responsibility for the client groups within his/her geographical area.¹⁷ It is critical therefore for nurses to be able to articulate their own caseload composition, size and caseload dependency. Otherwise the PHN is essentially disempowered and is not in a position to readily identify service gaps and advocate for nursing or community resources. In the Longford/Westmeath PHN service, each PHN currently maintains a detailed caseload profile of all active patients. The existence and ongoing use of a caseload profile is fundamental to the success of a caseload management system.

The caseload profile contains clinical details of all adult patients that are active on the caseload. Caseload profiling allows for prioritisation and rationalisation of patient care by providing robust detailed information about caseload composition and dependency.¹⁶ The caseload profile system which has been in use since 2005, has delivered significant improvements in file management and the ongoing archiving of records.

When the caseload profiles were introduced initially in 2005 significant discrepancies were noted in caseload sizes between different PHN areas. The smallest older care caseload recorded was 83 and the largest was 326, while the mean was 171. Kane, in her study in Belfast in 2004, also noted significant variations in caseload size ranging from 48 to 350.¹⁸ However, by 2008, the mean adult caseload size in Longford/Westmeath had fallen to 135. However, it should be noted that significant differences still exist between caseload sizes. Interestingly, over the same period, new referrals of older care clients actually increased by 8%.

It can be concluded from these figures that PHNs are attempting to actively manage their caseloads. The current HealthStats information for Longford and Westmeath record an admission rate of 2% and a discharge rate of 1%. This figure is similar to the findings of Begley's study in 2004.⁵ It is evident from these statistics that there is scope for further improvement in discharge decision-making in adult caseloads held by PHNs.

Priority system

The timeframe for the priority system for new referrals that was devised for the PHN service in the Midlands reflects the structure of the PHN service delivery model. As we do not provide a seven-day/24-hour service, our response time for a patient visit/contact for a priority one patient is up to 48 hours, as against four hours in the UK.¹⁹ It could be argued that a shorter response time is required in the ROI, but the existing service delivery model does not support this level of service. A small number of community intervention teams that provide out of hours service to support public health nursing have been developed in some urban areas.

A caseload management system provides transparency for service users. There is a general understanding of the terms admissions, discharge and caseloads amongst the public. The public also understand the concept of waiting lists/priority systems in the context of health services. Providing clarity and definitions for service users encourages the principle of working in partnership and also empowers the service user to take responsibility for initiating admission and discharge from the PHN caseload.

The introduction of HealthStats has been a catalyst in initiating reflection and discussion on PHN caseloads nationally. Undoubtedly the information generated by the HealthStats will highlight the workload of the PHN and, over time, allow service trends to become more explicit. Unfortunately, unless each local health office area utilises the same admission and discharge criteria and dependency guidance, discrepancies in interpretation of caseload sizes will continue to exist and valid caseload comparison will not be possible.

Clearly, if patients are being actively managed in the acute sector and discharge planning commences as recommended on the day of admission it is essential that the availability of and entitlement to community nursing services be made explicit to all health service personnel and the public.²⁰ Without a standard agreement on admission criteria/eligibility to the PHN service the validity and comparative value

of the HealthStats information is questionable. Without this agreement PHN caseloads are likely to remain inequitable in size and patient access will continue to be unclear.

Perhaps what is required is the adoption in the ROI of the so called 'Belfast Model' devised in Northern Ireland by Kane. This model provides for a rigorous assessment of factors, including patient dependency in terms of nursing time and complexity of need, caseload size, management, planned reviews and decision-making in relation to the discharge of patients.¹⁸ Based on this work, an electronic statistical tool, eCAT, (Electronic Caseload Analysis Tool) has now been developed and is to be implemented in the Belfast Trust later this year. The tool will assist caseload holders, community nurse managers and strategic planners to describe and benchmark measures of clinical need, service provision and nursing performance.

The existing Population Health Information tool has now evolved to capture HealthStat information and could be utilised for this metric return. Use of this tool nationally would ensure standardised statistical returns. If public health nursing is to develop and seamlessly integrate into the newly developing primary care teams, then it is critical that the full extent of the contribution of the PHN role and the caseload is captured and articulated. The other core members of the primary care teams, eg. therapy staff, traditionally have developed and are currently operating admission criteria, prioritisation and waiting list systems.²¹ It will not be sufficient for public health nurses to simply state the size and capacity of the nursing caseload. PHNs also need to be able to explicitly state the nursing contribution to the case management process and the implications of this for PHN caseload dependency. It could be argued that having access to explicit caseload information will empower the individual PHN and ultimately will lead to an improvement in the overall functioning and productivity for all the members of the primary care team. This point is made by Carney in her study of clinical leadership in the PHN service, where respondents spoke of not being recognised for the work that they do.²²

Defining caseloads is also likely to contribute to improved role definition for the PHN. PHNs described themselves as 'the Jack of all trades' in Nic Philbin's 2004 study. Role ambiguity was also reported in a study of PHNs by O'Neill and Cowman in 2008.²³ At the very least, caseload management systems will capture in some way the extent and volume of the PHN role. The work done to date in Longford/Westmeath meets many of the recommendations relating to caseload management made in the Begley study.⁵

The need for robust referral criteria and a supportive caseload management system is critical for the PHN when you consider that each PHN also holds a separate and distinct caseload of children and families. This caseload also requires management and prioritising on a daily basis. The priorities within this have to be weighed daily alongside the priorities of the other client group caseloads. Even with the development of supportive caseload systems the question to be asked is whether it is reasonable to expect PHNs to continue to manage this level of diverse workload and provide quality, evidence-based care with measurable outcomes? The development of robust caseload management systems should not undermine or dilute the broad health promotion/population-based approach of the PHN. Proposed systems need to be flexible enough to allow for continuation of this model of care.

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References on request from nursing@medmedia.ie (Quote NITC Pye 12:3; 10-13)



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