How community matrons perceive their effectiveness in case management

Michele Grange explores the challenges experienced by community matrons when managing a caseload of 50 high-risk patients

Abstract

Aim The aim of this study was to explore community matrons’ experience of caseload management and identify situations that may restrict or enhance patient care and outcomes. The Department of Health advises that community matrons should have a caseload of 50, based on the Evercare model from the US. However, there is little evidence to justify this caseload target.

Method A phenomenological approach was adopted to analyse data from interviews with six community matrons based in two south west primary care trusts. Maximum variation sampling was used.

Findings There are difficulties in building and maintaining a caseload of 50 complex patients with long-term conditions. The higher the caseload the less effective the community matrons perceived themselves to be in reducing hospital admissions.

Conclusion A more integrated approach is required with the service being available 24 hours a day. Further research is required to identify the most appropriate caseload size and the effectiveness of managing such high-risk patients. Quantitative research would help to determine the effect of variables.

Keywords Case management, community matrons, complex care
The DH aimed to have 3,000 community matrons using case management for 50-80 patients each with complex and multiple needs (DH 2005a). However, 50 appears to be an arbitrary figure, based not on clinical evidence but taken from the US Evercare model which has significant differences to the UK model (Hudson and Moore 2006). There appears to be no reason why the Evercare model suggests 50 as a reasonable caseload size for a community matron.

Much of the literature focuses on the potential risks, benefits and impact of the community matron described in Liberating the Talents (DH 2001) and the competency framework (DH 2005b). However, there is only anecdotal evidence confirming the effect of the care provided by community matrons and what influences this (Hudson and Moore 2006).

**Literature review**

Case management has been studied in various practice settings to develop risk scoring, assessment tools and interventions that are specific to the care setting (Ebert 2001, Mion et al 2001). However, this literature falls short of defining and linking case management interventions, goals, outcomes and caseload size (Maravilla et al 2005).

A review of 14 case management studies reported overall that results were equivocal, with only two randomised controlled trials (RCTs) reporting significant reductions in hospital admissions (Hutt et al 2004).

Monitoring admission rates alone does not identify what interventions have been put into place to reduce admissions among older people. Furthermore, rates can fall without intervention. This demonstrates why many RCTs report contradictory evidence about outcome measures (Fitzgerald et al 1994, Kemper 1998, Laramee et al 2003).

Models of case management vary and it is difficult to identify the individual components of different models that contribute to positive outcome measures, and to draw definitive conclusions about the most effective form of case management. There is inconclusive evidence about the effectiveness of case management for reducing emergency admissions and improving quality of care (Sargent et al 2008).

Hudson and Moore (2006) compared the differences between UK and US Evercare models of case management. Policy on case management in England has evolved from Evercare models, which differ in context from the target populations of NHS policy. Evercare patients in the US are in a managed care programme, directed specifically at long-stay nursing home residents. However, the UK’s Evercare programme consists of patients living in their own homes who have more comorbidities and are frailer (Hudson and Moore 2006). A model effective in reducing admissions in one country may not prove to be successful in another. Gravelle et al (2007) collected data from ten pilot Evercare programmes and, although proven effective in the US, found that the Evercare model in the UK made no difference to hospital admissions or length of stay. The US Evercare evaluation (Boyd et al 1996) and one small RCT (Kane et al 2003) found a statistically significant reduction in the number of visits in the intervention group. However, the lack of randomisation in the Evercare evaluation and the fact that the RCT by Kane et al (2003) was small make interpretation of these findings difficult, given the number of RCTs that have failed to repeat them (Hutt et al 2004).

To date there appears to be a gap in the literature about community matrons managing a caseload, their effectiveness in reducing admissions and length of stay, caseload size and outcomes, with contradictory evidence from quantitative and qualitative data.

**Aim**

The aim of this study was to explore community matrons’ experience of caseload management and identify situations that may restrict or enhance patient care and outcomes.

**Method**

A phenomenological approach was adopted as it is used when the research question requires insight into human experience and the meanings of phenomena (Crist and Tanner 2003).

There were 29 community matrons based in two south west PCTs. Anyone who had been in post for less than one year was excluded as the community matron needed to have had experience of trying to build a caseload. All accepted the invitation to take part and consented to be interviewed.

Six community matrons were selected for interview. The small numbers involved in the study reflect the complexities of in-depth interviews. Maximum variation sampling ensured that geographical variation, differences in age and knowledge were represented and a range of experiences gained. This was a purposive sample suited to the phenomenological method. The

**A model effective in reducing admissions in one country may not prove to be successful in another**
Research

Caseload numbers were identified by participants as influencing how effective they could be in managing their caseload. Emphasis was not on objective measurement but on gaining understanding of the essential truths of the lived experience (Parahoo 1997).

The researcher conducted one semi-structured interview with each of the six participants, each lasting approximately 60 minutes. Interviews were audio-taped.

The interviews sought to:
- Determine the challenges community matrons faced in building a caseload.
- Identify the impact of case management in preventing admissions/reducing length of stay.
- Highlight how managing a caseload could be improved.

The taped interviews were transcribed by the researcher and analysed thematically. The data were organised and classified according to themes, concepts and categories. As themes were identified they were coded and sub-coded. Participants were asked to identify themes from the responses to check agreement. Once the researcher’s initial understandings were refined through interpretation of the data, further questions were raised by the researcher calling for a return to the text and revision of the interpretation.

A clear description of participants and their settings is given to enable others to see whether what has been described is similar to their setting, enabling transferability of data (Clayton and Thorne 2000).

Ethical considerations

Ethical approval was granted by the local research ethics committee. Participants were sent a letter and information sheet and asked to complete a written consent form before participation. To safeguard the confidentiality of interview participants, transcripts were coded using numbers from 1-6. On the transcripts an initial was used for each participant. Names were not tape-recorded during the interview or written on any interview material. Tapes and transcripts were kept in a locked cabinet when not in use.

Findings

All participants were female reflecting the fact that few men take on community matron roles. Sample characteristics are summarised in Table 1.

Participants highlighted a number of themes when considering their experience of caseload management. Caseload numbers were identified by participants as influencing how effective they could be in managing their caseload. Experience or age did not appear to influence how community matrons managed their caseload. However, geographical area did make a difference to caseload. This was not surprising as health visitors working for the PCT in areas of deprivation had lower caseloads due to need and higher demand on the service.

Concern was shown over the possibility that participants would have to manage up to 80 patients and whether this was realistic, with targets set by the government viewed as only including input that could be measured: ‘I do try and aim for 50 even though I only work four days a week because we’ve been told 80 is the maximum. How many visits can you feasibly do a week and actually sort people out and if you spread yourself more thinly you actually get more hospital admissions and you get burn out’ (JW).

Participants expressed that it took time to get to know such complex patients. This involved many hours of assessment and review with the patient and family, and resulted in nurses having in-depth knowledge of the person. Other services were not always privileged to this type of relationship and without fully knowing how these complex patients usually presented, resulted in other members of the team expediting an admission that could have been avoided.

Community matrons were data driven to prevent admissions, whereas other disciplines were not, which participants viewed as problematic with patients being admitted inappropriately. Participants highlighted that without working to the same agenda it could be virtually impossible to keep someone out of hospital. The community matrons were viewed as providing more acute hospital care in the community and advising when treatment was required, while other disciplines only intervened when patients decided they needed treatment. Participants viewed their role as being more active in managing these patients’ conditions rather than letting the patient have full autonomy.

A more effective way of working was seen by one participant as working with 20 patients, who they would constantly need to monitor. The remainder of the caseload would be monitored by other members of a team. This would make more time available to manage acutely unwell patients. The community matron would only participate in a patient’s care when they were unstable. This was the opposite of the proactive work they were trying to achieve: ‘We are trying to do proactive care. However, you’re so busy sometimes reacting to situations that proactive care drops further down the list’ (K).
One participant, although she recognised the advantages of working in a team, was worried that the community matron would end up managing the team. This was seen as potentially moving them away from the clinical aspect of the role for which they had been trained.

Issues such as remote access, being able to access patients’ records from one central point and an increase in resources were viewed positively. Having all community services in one base for each geographical area was also encouraged.

A 24-hour service was seen as beneficial, as some comments demonstrated that patients were being admitted when the community matron was not available such as at weekends or at night.

A broad question was asked to elicit participants’ experiences of managing a caseload. All participants focused more on the difficulties rather than the successes. The main difficulty building up a caseload was viewed as being caused by lack of understanding of the role by other members of the team: ‘I think it’s very difficult to measure something that is at the mercy of so many other people’s decisions’ (K).

Participants stressed that their ability to make a difference was influenced by others in the team, over which they had no control. Community matrons aimed to reduce inappropriate hospital admissions. However, the emergency services admitted a patient to hospital and would not have to think whether this was appropriate or not as their performance was not assessed by the amount of admissions saved.

Agendas and protocols that each discipline followed were seen as different and unless there was a consensus about managing these patients then conflict of opinion and treatment would occur.

As demand outweighed resources, participants felt they were forced into a reactive way of working. Any lower-risk patients were only visited when they became ill.

Saving an admission was viewed as subjective and difficult to measure because it was difficult to prove that the intervention prevented an admission. The larger the caseload the more admissions occurred: ‘It’s very difficult to measure the intangible. It’s a very complex thing keeping people out of hospital’ (K).

Discussion

A possible limitation to the study was that as researcher, I was a community matron known to the participants with my own preconceptions about the role. I believed that 50 patients were too many for

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one person to manage effectively and as the caseload increased in size, proactive care turned to reactive care. My preconception was addressed through reflexivity, with awareness of my own contribution to the construction of meanings throughout the research process and an acknowledgement of the impossibility of remaining ‘outside of’ the subject matter while conducting the research.

Lower numbers were seen as enabling community matrons to be more effective but no agreement was made as to what this number might be. The numbers ranged from 20-40, with 100 being manageable if they worked in a team. Participants thought that any input that could not be measured was discounted by the PCT, yet they felt that it was these aspects that enhanced their job.

Furthermore, difficulty was expressed in quantifying certain tasks such as psychological support, counselling and the time spent in building up a relationship with the patient, family and carers due to the complexity of individual situations, with participants not being able to clearly identify which intervention prevented an admission.

Carrick (1998) identified similar findings advocating that in a variety of settings a caseload can be 20-45, with the complexity of cases dictating the workload volume. Furthermore, factors such as number of patients to be managed, intensity of patient population, patient need, processes and responsibilities of the case manager could serve as a framework for determining caseload numbers. Although there may be recognised tasks that determine nurse resource used, it is more difficult to account for unrecognised tasks such as psychological care (O’Brien-Pallas et al 1994). Previous information systems only recorded face-to-face visits, which was unreliable because a home visit could take anything from five minutes to several hours. This research shows remarkable links with what participants expressed as being ignored by the PCT. Despite the growing volume of research into case management there is a gap in the evidence about the effectiveness of managing different caseload size.

Concern was shown by participants that they were becoming reactive as the caseload increased to unmanageable numbers, with increased admissions. This finding is supported by Sargent et al (2008), who argue that large caseloads reduce the level of care provided, with further research recommended to identify manageable caseload size. At present there is no evidence to justify targets of 50, with case managers struggling to achieve these numbers. Furthermore, Williams (1997) emphasises that the average caseload for each case manager in secondary care is between 15-20 patients. However, community matrons are expected to manage more than 50.

Despite the growing amount of research into case management models, there is a deficit of evidence about the effectiveness of case managing different size caseloads.

Participants suggested that their ability to manage their caseload would be enhanced by working in an MDT. However, this relationship relied on an understanding of their role with each discipline working toward the same agenda. There was an opinion that there was a lack of understanding of the community matron role, causing difficulty in trying to engage with other members of the team.

There are similar findings in the plethora of research (Huber 2000, Metcalfe 2005) stating how the case manager needs to communicate and work with other agencies, yet community matrons struggled to achieve this. When communication and understanding of the role was positive participants were able to carry out their work efficiently. To carry patients across a continuum of health services, participants saw their role as being part of an integrated team.

Huber (2000) emphasises that while case management programmes manage risk and co-ordinate care as core functions, what is actually done beyond this is variable. This is complicated when multiple disciplines interacting to deliver case management is added into the actual practice environment, and the potential for communication-related problems increases.

The Evercare model that participants were trying to adhere to was seen as difficult to apply to the UK care setting because it is different to that of the US, with many patients being more difficult to manage as they were living in their own homes without 24-hour nursing availability.

Participants saw their role as being able to encompass all of the patients’ needs, which were not being met before their involvement. Although unsure whether they made a real impact in reducing admissions, participants suggested that it was more than preventing someone going into hospital. There was some disagreement over whether an admission was saved or delayed. This was identified as being subjective and difficult to measure. Participants saw patients’ issues as wider than just a pure physical element that needed to be addressed.
A disparity in case managing people in their own environment was identified as being influenced by variations among clients. Multiple simultaneous interventions caused difficulty in determining which intervention was associated with client outcome. Participants acknowledged that the effectiveness of their interventions could be influenced by nurse-patient ratio, caseload turnover, rate of change of procedures and regulations, and data collection and retrieval processes.

Conclusion
The research provides some initial exploration of community matrons managing a caseload and corroborates some of the findings of other recent studies. This study highlighted that caseload size should not be taken from other models such as Evercare in the US, because settings are likely to be different. Other factors identified, such as geographical area, non-clinical time, resources and characteristics of the target population, need to be addressed and taken into account when determining caseload size. Therefore, multiple complex factors need to be considered when setting caseload targets.

The findings indicate that community matrons are struggling to achieve and maintain caseloads as high as 50. This results in case management moving from the intended proactive to reactive care. Further research is required to identify a better method of measuring nurses’ workload to assist in acknowledging more appropriate caseload numbers.

This research suggests that for unplanned hospital admissions to be reduced, the system needs to be radically redesigned with a more integrated team approach. Out of hours also needs to be addressed. In the absence of evidence for any specific model of case management, PCTs should clarify the needs that they are trying to address and then consider how to organise services to address these needs.

References