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# Case management nurse in Spain: facing the challenge of chronicity through a comprehensive practice

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**Abstract** *A new type of nurse role was established in the Spanish health care system in the late 1990s, currently called case manager nurse, to ensure access to resources needed to cope with chronic conditions and comprehensive home care. This paper aims to present this figure and discuss aspects of its work. The methodology was based on the bibliographic review of papers and normative publications and interviews with primary health care nurses, nursing faculty, and case management nurses. We present a brief history of the implementation of the case manager nurse role and the conceptual and operational bases of her practice in three autonomous Spanish communities: Andalusia, Valencian Community, and Basque Country, discussing potentialities and issues concerning this practice. In the conclusions, we make some considerations on the possible implementation of the case manager nurse in the Brazilian health system.*
**Key words** *Nurses, Chronic diseases, Health care system, Professional practices*

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## Introduction

A process of reorganization of nursing work in Primary Health Care (PHC) was developed in the Spanish Autonomous Community of the Canary Islands in the late 1990s, with the definition of new protocols, management of material and human resources, and communication between levels of PHC and Hospital Care (HC). The triggering elements were ongoing, given the aging profile of the population and increased chronic conditions, as well as the high territorial dispersion in the Canary Islands. Some PHC nurses took on this mediating role as a "response to the need to enhance home care services", starting to act as care managers. This professional was first called *enfermera de enlace*, whose translation would be liaison or mediation nurse[1].

Over the next few years, besides expanding into the Spanish health system, this figure was renamed *Enfermera Gestora de Casos* (EGC, in English, Case Manager Nurse). It is worth explaining here the option of using the term *enfermera*, with a female gender: it is the form adopted in the Spanish-speaking countries and reflects the historical feminization of the profession, so we chose to keep it.

The Canary Islands are one of the 17 Spanish Autonomous Communities, consolidated after the promulgation of the Spanish Constitution of 1978. Geopolitics, history, and culture, among other aspects, define these communities. They can be compared to states or federative units, as in Brazil and other republican countries, albeit with considerable differences in their relationship with the Federal Executive. The health systems of these communities, despite the general guidelines dictated by the 1986 Spanish General Health Law, have a high degree of independence of action and proposition, which may also result in different organizational models of work for health professionals[2].

From the Canary experience, other Communities quickly adopted the EGC model. Catalonia was the autonomous community that later included the nurse in its staff, followed by Andalusia and the Valencian Community and others, some of which were more recently established, such as the Basque Country[3].

EGC is not a type of specialty in vocational training, nor is it a specific position in the organization charts. In some places, there is a mention of EGC as an advanced nursing practice or competence[3], but it cannot be considered as an expert in this modality of practice and training. So far, there does not seem to be a consensual understanding of the term "advanced practice" in Spain to allow us to enter this debate. Even without a national training or insertion standard for EGC, she can work in Hospital Care or PHC, within the same autonomous community.

Evaluations of the role of the EGC show that it is a type of action with resoluteness and positive influence on health systems and for people with complex chronic conditions. It is a practice of multidisciplinary team support characteristics, acting across the levels of care, mobilizing the various health resources in a given territory[1,3].

This paper aims to present and discuss the central aspects of the EGC work process of three Spanish autonomous communities – Andalusia, Valencian Community, and Basque Country, summarizing the main historical aspects, the professional attributions, and the results of this work.

After describing the methodology, the text is structured in two axes: in the first, we briefly address the establishment of Spanish nursing as a profession, show the main conceptual elements of the EGC proposal, and describe its path in the selected communities. In the second, we articulate some results of evaluations and research to reports obtained from nurses, managers, and researchers interviewed.

In the conclusions, we reflect on what we can draw from this experience, risking brief considerations about the eventual incorporation of EGC into the Brazilian reality.

## Methods

The study is part of the research project "Primary Health Care Nursing in a comparative perspective between Brazil and Spain: Situations of crisis and health impacts". It includes two methodological approaches: literature review and qualitative analysis of interviews.

First, a literature review was conducted, including papers, technical reports, and normative documents from three Autonomous Communities – Andalusia, Valencian Community, and Basque Country. We made a simple search in the SciELO, Cuiden, and CINAHL databases and the official health systems' pages. The descriptors used were, in Spanish, "*enfermera gestora de casos*", "*gestora de casos en España*", "*enfermera de enlace*", and we considered as selection criteria texts that i) described experiences with *enfermeras gestoras de caso* or *enfermeras de enlace*;

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ii) showed results of EGC performance evaluations; and iii) described the attributions of EGC. We selected ten scientific papers and six official or manual technical texts, with a description of assignments, training, and bringing evaluation indicators on the performance of the case manager nurse of the health systems of the Andalusian, Valencian and Basque Country Communities.

The qualitative approach was based on the production and analysis of individual interviews conducted with 7 primary care nurses (2), researchers and nursing teachers (2), case management nurses (2), and PHC coordinating nurse (1). Participants were selected by the snowballing method, after initial contact with the teaching nurse and nurses who had already been interviewed in other stages of the project. Inclusion criteria were knowing the work of the EGC and accepting to participate in the study, and the sample was defined by saturation, by recurrent information.

The interviews were conducted face-to-face, in health centers, hospitals, and universities. There was an email interview, in this case, requesting the sending of an audio file to answer the questions. All participants signed the Informed Consent Form, after researchers' explanations about the study, recorded and later transcribed. All transcribed material was sent to respondents for content validation. The study was submitted and approved by the Research Ethics Committees of the State University of Rio de Janeiro and the University of Alicante, Spain.

Both bibliographic data collection and interviews were held in January and February 2019, in Spanish territory, in the Andalusian, Valencian and Basque Country Communities.

## Case manager nurse – ensuring continuity of care

Spain's social and economic development is remarkable after the difficult years of Francoism. Life expectancy at 82.83 years in 2018, according to World Bank data, is one of the highest in Europe and surpasses the world mean of 72.04 years. Sociodemographic, cultural, and lifestyle changes are expressed in a high prevalence of chronic health problems, with the operational and financial impact on the health system, representing the most significant volume of health demands[4].

After the 1986 Health Reform, the health system was structured into two levels: Primary Health Care, with universal access, and Hospital or Specialized Care[5]. Nursing was fragmented into various professions, and its profile was consolidated in 1976. It was a period marked by mobilizations known as the *revolución de las batas blancas* (the white-coat revolution), requiring higher education within universities[6]. Nurses were already strengthened and organized, and actively participated in the subsequent health reform process, which gave rise to the 1986 General Health Act.

It is the theme of continuity of care that leads to the first propositions around the figure of the liaison nurse in the Canary Islands. Ensuring continuity of care for people who have been interned or require specialized care at home is problematic in an overseas territory with a broad geographical and population dispersion. In the implementation of the Home Care Program (developed by APS), discussions on how to expand the performance and resoluteness of the primary level resulted in the first experiences with the liaison nurse. It is noteworthy that Family and Community Nursing is an essential area of activity in Spanish nursing, and is characterized by addressing care for the health needs of individuals, households and communities (and not just attending to sick people), through an integrated (to the health system), integrative (of resources and people) and comprehensive (concerning care levels and health needs)[7] practice.

In the first program developed in the Canary Islands, coordinating care included: registering and evaluating all the people over 65 years of age; favoring home care for any disabled or at-risk person; maintaining and improving the quality of life of the primary caregiver of the disabled person; facilitating the provision of home care for the Primary Care team; creating or keeping relationship mechanisms between the Primary Care team and the social service network; knowing and coordinating relationship mechanisms with other levels of care; enhancing and facilitating the collection and reuse of equipment used in home care, and evaluating the economic impacts of the proposal[8].

The continuity of care concept is not consensual. Some authors refer to a dual dimension of the idea of continuity of care: a vertical one, concerning the relationship between levels of care, such as continuity of care between hospital and home, and another, personal-longitudinal, and over time starts from an expanded conception of care, including health promotion and prevention actions[9]. Continuity of care can be understood as:

[...] *A central concept that favors the well-being and functioning of patients depending on the level of care they require. It facilitates the effectiveness of*

*different services, is effectively coordinated between different professionals and organizations and concerning time and allows responding to the needs of people with health problems*[8].

The three Autonomous Communities studied adopted common conceptual and operational elements for the figure of EGC. Other issues were considered besides continuity of care over time and within levels of care, such as care to vulnerable population groups; the mediation between the needs of people, households and caregivers and the responsiveness of the health system; resource rationalization and streamlining, planning and anticipation of issues, complications or consequences; the expansion of decent and quality care through hospital-type care provided at home; production and maintenance of information flow about people, caregivers and households[10].

Andalusia quickly and broadly developed a case management model as early as the first half of the 2000s, which later collaborated to guide other autonomous communities. There were institutional support and the formulation of a concrete care plan for disabled and older adults, fundamental elements that helped boost the proposal[1].

The term "case management" is adopted from the experiences of countries such as the United Kingdom, the United States and Canada, and has been developed since the 1960s, initially in the area of mental health[1,9], and later in other areas, but without designating a specific professional category to assume the managerial role. Still, it is worth noting that this function has been developed by nurses in most countries that have implemented case management processes.

The year 2002 is the milestone of the implantation in the Andalusian system of the community liaison nurse, and in 2003, the hospital. In 2006, the Andalusian government published the Hospital Case Manager Nurse Manual[11], and in 2007, the PHC Case Manager Nurse Manual[12], demarcating the concomitant performance of these two figures.

What is the difference between PHC and Hospital manager nurses in the Andalusian experience? The Primary Care EGC, also known as the Community Case Manager Nurse, is aimed at people linked to a health center who require home care. This professional aims to maintain and improve the quality of life of any disabled or at risk of disability, as well as that of their caregivers; to facilitate the improvement of home care provided by the PHC team, and the coordination of this team with the social support network, and improve coordination with other levels to ensure continuity of care[13].

Hospital EGC targets hospitalized people, who, due to their complicated health situation, require the coordination of resources related to various professionals/specialties for the continuity of their care at home, also meeting the needs of their caregivers. The most common problems are musculoskeletal and fracture, disabling cardiovascular diseases, severe mental disorders, HIV-AIDS, and severe obstructive pulmonary disease.

The PHC EGC captures its patients and caregivers from data of PHC services and their teams, while Hospital EGC actively searches hospitals and receives communications from other nurses and professionals. The management of hospital resources to be used at home is also the responsibility of Hospital EGC.

The experience of the Valencian Community occurred shortly after the Andalusian in the first half of the 2000s. It became part of the Home Care Improvement Plan between 2004 and 2007, of the *Consellería de Sanitat* (Valencian Health System), primarily as an *Enfermera de Gestión Domiciliaria* (Home Management Nurse). As an ECG, it is implanted experimentally in the Valencian Departments of Castellón and Alicante, in the latter within the General Hospital, as *Enfermera de Enlace Hospitalaria* (Liaison Nurse)[14]. The positive outcome of this pilot project led the Valencian Health System to incorporate the Case Manager Nurse figure as part of the Chronic Patient Care Strategy and the Integrated Case Care Model. The family caregiver is also included as a target audience and the attributes that define the need for an intervention by the EGC: the clinical complexity, the complex household and community management, high risk of urgencies, and hospitalization[15].

The Valencian proposal is to insert the EGC within an integrated care model so that care can be exercised in any space. There is strong institutional support, evidenced by a critical level in this process, namely, the Home-based Hospital Unit (UHD), which is a hospital-based home care program, in permanent dialogue and communication with Primary Care. As in Andalusia, the PHC Community Case Manager Nurse covers homes, and the Hospital Case Manager Nurse, linked to the Hospital, covers hospital care for acute (urgencies/emergencies) and chronic cases, and the so-called home-based hospital. Both figures support the management of complex

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chronic cases at the departmental level, each encompassing several Health Centers and hospital services, depending on geographical dispersion. In numerical terms, the trend of their inclusion in the Valencian Health System was 9 Community EGCs and 4 Hospital EGCs in 2010, in two departments, reaching 53 Community EGCs and 22 Hospital EGCs in 2017. An aspect that is entirely highlighted in the technical reports is supporting the primary family caregiver through specific courses and keeping a close relationship between EGC and these people.

The third experience, which is also the most recent, is the implementation of the EGC figure in the Basque Country, which occurred in 2014. This autonomous community has very different social, cultural, and political characteristics compared to the rest of the country, and has been implementing programs to cope with chronic conditions, which result in comorbidities and complex cases. In the document *Estrategia para afrontar el reto de la cronicidad en Euskadi* (Strategy to face chronicity in the Basque Country), 2010, besides the survey on the epidemiological and social impact of chronic problems, there is a strong incentive for community participation in the process, as well as recognition of the leadership of people with chronic problems, expressed through the concepts of active patients, active aging and fostering autonomy[16].

The first modeling performed in 2008 for the inclusion of EGC provided for three figures, namely, two in PHC (one for chronic patients, Continuity Manager Nurse, and one for complex chronic patients), and one Hospital EGC. After evaluation, two figures remained – the Hospital Liaison EGC and the Advanced Skills Manager Nurse[17]. Between 2010 and 2012, the idea was to train 300 nurses in advanced case management skills, especially challenging case studies[18]. The term "advanced skills" is described as a process of professional qualification for the development of new competencies, through a participatory methodology, involving institutional, academic, and other actors[16,18].

There is a more explicit focus on coping with illness and complex cases, and EGC is defined as "the case management professional who responds proactively and in a coordinated fashion to identify the most vulnerable people in complicated situations and pathologies, which implies a coordinated effort and close collaboration with the person concerned and their caregivers". It is also clearly explained that it is not a matter of creating new professional categories, but establishing a differentiation in the functionality of different jobs for the development of their skills[18]. Among the three experiences, the Basque Country shows, in the documents, a more consolidated reflection on the figure of the EGC.

The Spanish nurse has been assured higher education relatively recently compared to the UK or Brazil. It is noteworthy that the category has obtained sufficient visibility and recognition to propose the insertion of a new figure, with mediating characteristics and, undoubtedly, of high decision-making capacity regarding the therapeutic projects for people with chronic problems. However, tensions are found among the fields of competence of the various professional categories.

**Case manager nurse reviews and reports**

A 2016 press release issued by the Spanish General Council of Nursing is titled with an assertion: "The management of cases in nursing: the great unknown"[19]. Taking into account the almost twenty years of implementation of the EGC in the country, it is surprising that this position is still unknown among nurses, which leads to questionings as to how it has been incorporated and its level of institutionality.

Soon after the first experiences, there seems to have been (and still is) sufficient consensus on the positivity of EGC's action, regardless of the types and names adopted - community, PHC, hospital, advanced skills, or any other. The workload required to cope with chronicity appears to be disproportionate to the speed and severity of these advancing conditions, which welcomes any proposal to improve the coordination of processes and resources. At the same time, the coverage of these services is unstable, and training varies across communities.

From an epidemiological viewpoint, various studies have been conducted to assess the impacts of EGC work, but few compare the "before" and "after". In Andalusia, there is a predominance of descriptive studies, focusing on specific cases, which show the practice of EGC in chronic situations such as hematological problems[17], diabetes[20], and HIV-AIDS[21]. All provide a general qualitative assessment concerning satisfaction, decreased caregiver workload, time/resource streamlining. More sophisticated studies have been developed, some with quasi-experimental design and statistically significant results in decreasing measurable caregiver burden. Favorable results were measured at the level of patient sa-

tisfaction and in the rationalization of resource utilization in the group submitted to EGC intervention when compared to the control group without intervention[22].

The reports and technical programs produced by the health systems of the communities studied provide data on the positive impacts of the intervention. In Andalusia, a positive assessment is presented: improvements in functional capacity, better medication management and lower institutionalization and use of services by the elderly population; reduced hospital readmissions and the number of days of hospitalization of people with dementia; improved treatment adherence and social integration, psychological well-being and quality of life of people with cancer; decreased hospitalization of people with severe mental disorders, among others[16].

In the Valencian Community, indicators related to urgent hospitalizations among people with chronic problems under the control of the hospital EGC stood out, with a 77% decrease compared to the 12 months before the 2007-2010 pilot project, as well as a 70% decrease in the number of hospitalizations in this group. Among the positive impacts attributed to the Community EGC's work are the increased identification of "hidden" home patients, those requiring home care but not yet identified by the PHC teams, and the provision of courses for patients and family caregivers[15]. In the Basque Country, although assessments are more recent, they also show declining hospital admissions in the covered groups in some counties, and positive satisfaction indicators among patients, relatives, and caregivers[18].

However, caution should be exercised in reading the indicators, as the assessment of this type of intervention is not simple, nor are there consolidated indicators for this. One issue concerns the "exclusivity" of nurses acting as case managers compared to other professions. Attributing the success (and also eventual failure) of this initiative to only one professional category is simplistic, since by planning, mobilizing and managing resources and processes, other professionals are allowed to expand their work at home, adding strengths and competencies for the improvement and continuity of care[22].

On the other hand, it is no coincidence that in Spain and other countries that adopt case management models, nurses are the professionals most mobilized for this intervention. The nurse's basic training is guided by ethical-political and technical principles for an integrative and educational performance, and this professional ends up developing professional skills that make her eligible for work fronts that require the ability to mediate conflicts and establish dialogic processes. It is also a category with strong adherence to the institutional culture in health systems in general[23].

The interview reports bring essential elements to consider when analyzed in conjunction with the academic and normative bibliography. From the viewpoint of the implementation process, it is interesting to observe that the reports, while not disregarding the influences of the experiences of other countries, bring as their primary motivation the confrontation of concrete conditions, which these professionals well knew in their daily lives:

*On the one hand, we have nurses who seek to provide excellent care, and on the other, we have a system whose intention is to keep the patient as little as possible in the hospital, and to be discharged as early as possible, so it implies benefits for the patient and economic benefits for the system. Because any hospitalization that increases in length would mean higher expenditure, an increase in complications, and ultimately money, right?* (PHC nurse, Basque Country).

*We study a lot, read a lot, research, and design it. But there was no way to go to other countries to watch them. And there was not a very clear model at that time* (Teacher and researcher, Canary Islands).

*Then the case manager nurse acquired another role, not only was the communication between primary care and hospitalized, but she carried those palliative complex patients who required a series of resources, and put that in communication to all the resources to provide the benefit that the patient needed. She was dedicated to those patients who require mobility of special resources* (PHC nurse, Valencian Community)

The nurse who coordinates PHC shows a desire to have as many EGCs as possible:

*It is a major figure, and that there should be at least one in each health center. This manager nurse is the one taking the initiative, and goes to the home, or homeless, because there may be complex patients, and it is the first that makes an assessment in situ of the problem and makes a clinical and community assessment of one who is living in an area.* (PHC coordinator nurse, Valencian Community).

This nurse works in a small inland province that has been suffering from a population depletion, which makes the elderly population proportionally much larger than that of young

people, and as a result, chronic problems are the ones that most impact the health system, and social resources tend to decrease with population depletion. The EGC proposal also responded to perceived needs to improve flows and records of information about people and family caregivers:

*Also, it was a fundamental issue with family caregivers, because there was no record, no census, it was not known, they were not valued; we don't know in what situation those family caregivers were in health, what their needs. Then, that on the one hand, and then on the part of the patients, because there was also a lot of registration deficit.* (EGC, Valencian Community).

The EGC implementation process has not been free of conflicts and difficulties. The first significant conflict occurs in the context of interprofessional and interpersonal relationships: a new figure, with a different function, normatively inserted from the management:

*What dilemma is generated? Here it is: as is customary in this country, here we call it putting the cart before the horse. In other words, figures are generated, implanted, not adequately explained, and produce conflicts within the teams. With the community nurses, who say: And why is this nurse coming here if I am doing this already? And, what's more, she comes and tells me what I have to do. It is not properly explained, and so many problems are generated. But if you are sure that it is well developed to give good results. And when you get acquainted, you minimize the risk of conflict.* (University lecturer and researcher, Valencian Community).

This report draws attention to the challenge of identifying a particular personal profile, emotional maturity, and capacity to mediate that gives some, but not others, the ability to implement practice reorientation processes. The success or failure of an experience like EGC can also be partly attributed to a greater or lesser ability to negotiate and build trust. This points to a professional profile in which clinical and managerial skills must necessarily be aligned with relational and conflict mediation skills. It is also essential that the necessary resources for case management be already in place or somehow available:

*Instead of creating a service for these patients, which is the natural tendency of the health systems, what is done is putting a nurse to coordinate the services that are around them.* […] *In many cases, what is called case management is not.* (Teacher and researcher, Canary Islands).

Therefore, it is not just a matter of allocating a professional to evaluate the so-called complex chronic cases clinically. EGC's role is, above all, to ensure that services and professionals act in a coordinated and integrated manner. In the absence or shortage of these services, or in the teams in which, for some reason, the professionals are not attuned, the EGC may have to assume care tasks, which deviates from its duties:

*If, on the other hand, you find nursing teams where there is a lack, then, because it is perhaps a lack of motivation and responsibility, so then the work is more intense, that is to say, it is more intense that sometimes we have to assume part of the care work rather than case management* […] (EGC, Andalusia).

Respondents stated that the understanding and recognition of the proposal also depend on the nurses' adequate training, a need also pointed out in the documents, although there is not, so far, a consensual model of course or training for EGCs.

**What can we learn from the Spanish case management experience?**

We start from an ethical-political perspective that argues that nursing is more than a job or a profession and that it is an indispensable social practice for ensuring universal access and addressing health inequities. We must ask ourselves, as Brazilian nursing, what is there to be learned from the experience originated in Spanish nursing, given that we share, and will increasingly share, the challenges of care to chronic conditions.

A first element to highlight is the understanding of the health-illness process as a result of the complex interaction of factors at various levels of life. The process of implantation of the EGC figure in Spain comes as an emblematic panorama to think about the relevance of the nurse practice beyond individual care because the scope is broad and includes chronic patients, their main caregivers, professionals, and services. This activity risks, however, being caught by the massive red tape of the processes required to mobilize resources.

There appears to be a "desired profile" for EGC that involves the development of leadership skills and articulation and mediation skills. Also, other team and service professionals must be aware of the proposal, which is expected to be sufficiently adhered to produce capacity and resource mobilization. It is not a given condition, but must be built at each local level, based on minimum consensus between management, services, and health professionals.

The emergence of a professional function, which has been termed a "figure", such as EGC's, points to a successful option, but not entirely without a specific political and operational cost. Assuming, as an imaginative exercise, that one tries to implement such a proposal in Brazil in a local system or subsystem with minimally adequate resources and training, one still has to ask: what are the odds of EGC's work developing with the necessary autonomy and speed in the face of administrative, bureaucratic and corporatist barriers?

The issue of the existence of a minimum set of services to be managed is another factor to consider, given that, in the Brazilian model, local organizational arrangements and their resources can be very different. On the other hand, the EGC figure points to the possibility of structuring new processes, and to the discovery of unknown or underused community and institutional resources.

Therefore, the Spanish experience contributes to the ongoing need to create and recreate a health system capable of providing resolute and quality responses to health needs.

## Collaborations

HMSL David is responsible for the design and development of the study and the paper. JRM Riera, AH Mallebrera and MFL Souza participated by supporting interviews, the search for bibliographic material, and the analysis of the results.

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