（１１）１ヶ月間の訪問の費用負担状況

ア　平日昼間８：00～18：00の訪問

医療保険・介護保険でカバーされている訪問は、「5～10回」（25.8%）が最も多く、次いで「21回以上」（19.4%）、「1～4回」（14.5%）・「11～20回」（14.5%）であった。平均は39.6回であった。

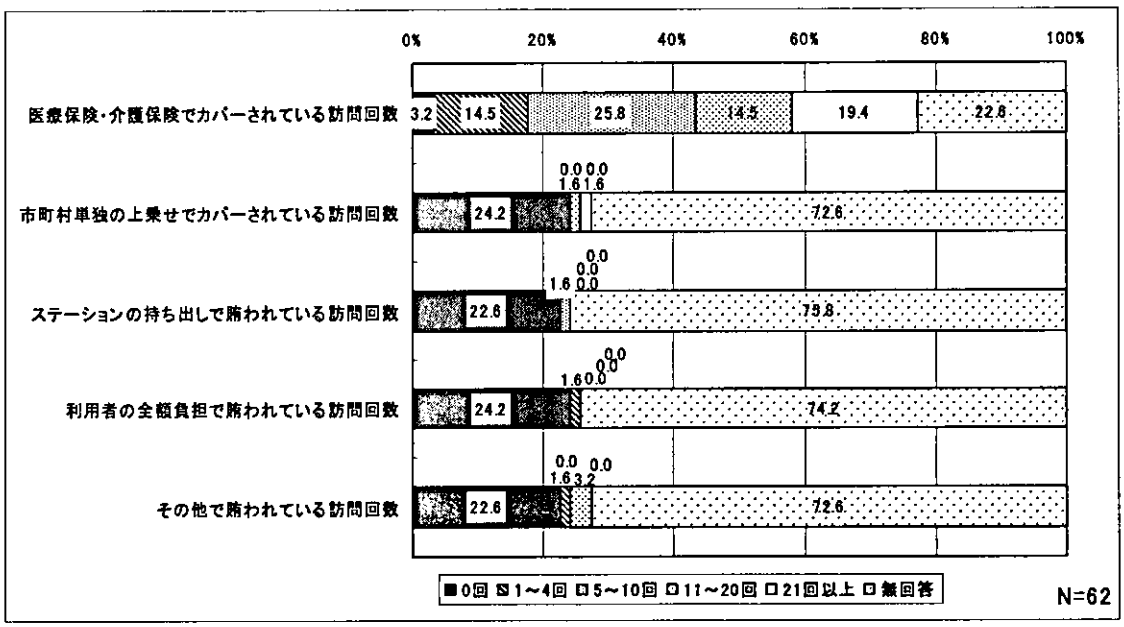
市町村独自の上乗せでカバーされている訪問は、「0回」（24.2%）が最も多く、次いで「11～20回」（1.6%）・「21回以上」（1.6%）であった。平均は2.8回であった。

ステーションの持ち出しで賄われている訪問は、「0回」（22.6%）が最も多く、次いで「5～10回以上」（1.6%）であった。平均は0.6回であった。

利用者の全額自己負担で賄われている訪問は、「0回」（24.2%）が最も多く、次いで「1～4回」（1.6%）であった。平均は0.1回であった。

その他で賄われている訪問は、「0回」（22.6%）が最も多く、次いで「11～20回」（3.2%）「1～4回」（1.6%）、であった。平均は1.7回であった。

図表 128　医療保険・介護保険でカバーされている訪問回数（平日：昼間）



イ　平日夜間・早朝 18：00～翌 6：00 の訪問

医療保険・介護保険でカバーされている訪問は、「1～4 回」（35.5%）が最も多く、次いで「11～20 回」（21.0%）、「0 回」（14.5%）であった。平均は 7.8 回であった。

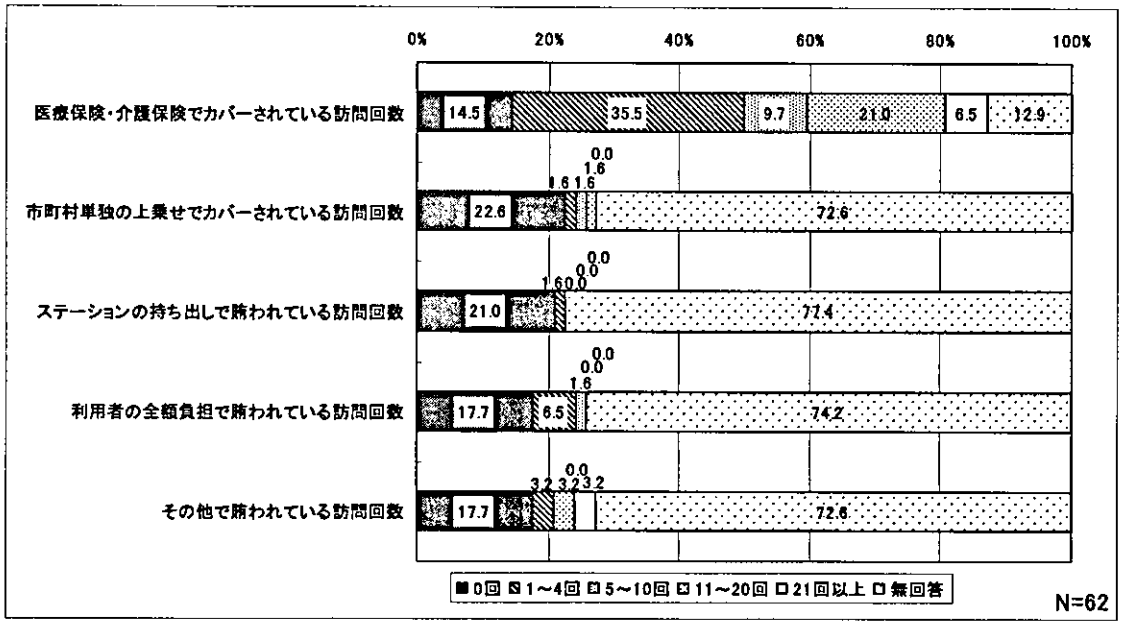
市町村独自の上乗せでカバーされている訪問は、「0 回」（22.6%）が最も多く、次いで「1～4 回」（1.6%）・「5～10 回」（1.6%）・「11～20 回」（1.6%）であった。平均は 1.4 回であった。

ステーションの持ち出しで賄われている訪問は、「0 回」（21.0%）が最も多く、次いで「1～4 回」（1.6%）であった。平均は 0.2 回であった。

利用者の全額自己負担で賄われている訪問は、「0 回」（17.7%）が最も多く、次いで「1～4 回」（6.5%）、「5～10 回」（1.6%）であった。平均は 0.9 回であった。

その他で賄われている訪問は、「0 回」（17.7%）が最も多く、次いで「「1～4 回」（3.2%）・「11～20 回」（3.2%）・「21 回以上」（3.2%）であった。平均は 7.1 回であった。

図表 129　医療保険・介護保険でカバーされている訪問回数（平日：夜間・早朝）



ウ　土・日祭日昼間 8：00～18：00 の訪問

医療保険・介護保険でカバーされている訪問は、「1～4 回」（17.7%）が最も多く、次いで「0 回」（14.5%）、「5～10 回」（11.3%）であった。平均は 4.4 回であった。

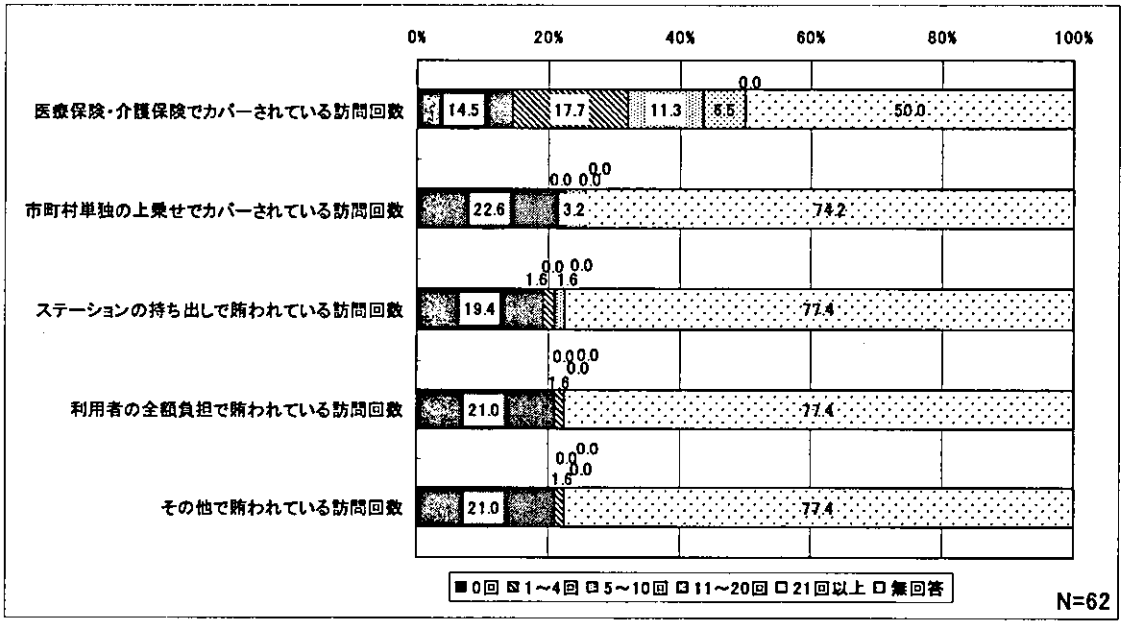
市町村独自の上乗せでカバーされている訪問は、「0 回」（22.6%）が最も多く、次いで「5～10 回」（3.2%）であった。平均は 0.9 回であった。

ステーションの持ち出しで賄われている訪問は、「0 回」（19.4%）が最も多く、次いで「1～4 回」（1.6%）、「5～10 回」（1.6%）であった。平均は 0.5 回であった。

利用者の全額自己負担で賄われている訪問は、「0 回」（21.0%）が最も多く、次いで「1～4 回」（1.6%）であった。平均は 0.1 回であった。

その他で賄われている訪問は、「0 回」（21.0%）が最も多く、次いで「「1～4 回」（1.6%）であった。平均は 0.1 回であった。

図表 130　医療保険・介護保険でカバーされている訪問回数（土・日祭日：昼間）



エ　土・日祭日：夜間・早朝 18：00～翌 6：00 の訪問

医療保険・介護保険でカバーされている訪問は、「1～4 回」（25.8%）が最も多く、次いで「0 回」（17.7%）・「5～10 回」（17.7%）であった。平均は 3.4 回であった。

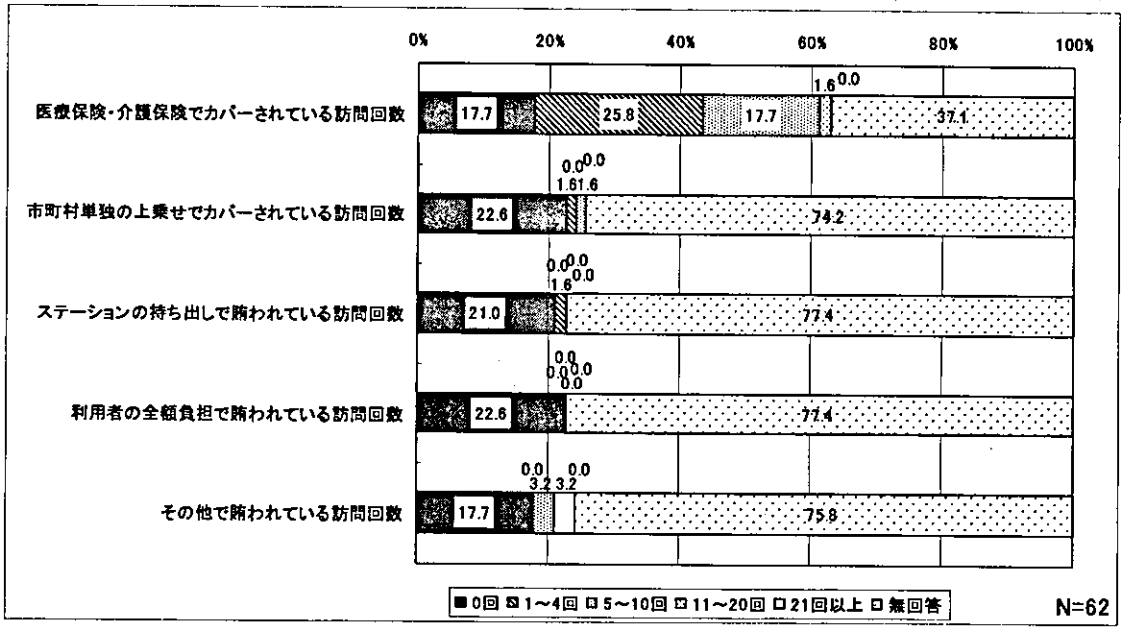
市町村独自の上乗せでカバーされている訪問は、「0 回」（22.6%）が最も多く、次いで「1～4 回」（1.6%）・「5～10 回」（1.6%）であった。平均は 0.5 回であった。

ステーションの持ち出しで賄われている訪問は、「0 回」（21.0%）が最も多く、次いで「1～4 回」（1.6%）であった。平均は 0.1 回であった。

利用者の全額自己負担で賄われている訪問は、「0 回」（22.6%）が最も多かった。平均は 0.0 回であった。

その他で賄われている訪問は、「0 回」（17.7%）が最も多く、次いで「5～10 回」（3.2%）・「21 回以上」（3.2%）であった。平均は 4.8 回であった。

図表 131　医療保険・介護保険でカバーされている訪問回数（土・日祭日：夜間・早朝）



Ⅳ. まとめ

1．夜間・早朝訪問の実施体制

今回調査対象とした24時間訪問看護サービスを実施している訪問看護事業所においては、ほとんどの事業所で夜間専従の看護職員を雇用しておらず、看護職員を4～5人常勤で雇用しているところが約半数となっており、通常の人員配置の中で夜間・早朝対応をしている事業所が多いことが明らかになった。さらに、多くの事業所が現状のマンパワー不足を指摘しており、人員の確保や配置に苦労していることが明らかになった。

ただし、中には看護職員が1人の事業所でも夜間・早朝の対応体制を構築しているところもみられており、手薄な体制の中でも患者ニーズに応えるべく対応している事業所も存在していた。夜間・早朝の看護対応体制を充実させるための方策として、個別の困難事例をチームでケアするためのコーディネート機能の向上や地域事業所間の連携基盤整備も重要であるとの回答が多く、地域の他職種・他施設との連携が必要であると考えられていることが明らかになった。

さらに、自由回答からも、スタッフが積極的に夜間・早朝の訪問に取り組む気運が出来てきたとの記載も見られており、利用者が必要と考える時に訪問することは当然との考え方から、少ない資源を活用して訪問体制を構築している事業所が増えてきていることも明らかになった。

2．夜間・早朝と昼間との訪問看護サービス利用の相違

次に、夜間・早朝と昼間との訪問看護サービス利用の傾向について検討する。今回は、一般的に訪問看護ステーションが営業している平日昼間を除いて、休日の昼間、および夜間・早朝の傾向を把握した。土日の昼間における一事業所辺りの計画上の訪問人数の平均は11.6人であり、緊急時を含む全体の訪問人数の平均も12.0人と、ほぼ計画通りの訪問が可能であった。しかし、平日・土日を含めた夜間・早朝の訪問については、計画上の訪問人数の平均は0.7人であったのに対し、緊急時を含む全体の訪問人数の平均は3.4人であり、かなり上回っていることがわかった。さらに、個人ごとに夜間・早朝の計画的訪問回数と訪問回数全体とを比較すると、あまり差は見られないものの、計画よりも実際の訪問回数が多くなっている傾向がみられた。

これより、夜間・早朝には潜在的に訪問看護のニーズがある可能性があり、そのニーズを見越した訪問計画の策定が必要となると考えられる。現実的には緊急時対応での訪問が多いと思われるが、その予防という観点からも、24時間の訪問対応体制を構築して、夜間・早朝も計画的に訪問を実施することが重要であることが示唆された。

3．夜間・早朝の訪問看護サービスの利用者像

サービス利用者の属性としては、約4分の3が要介護認定を受けており、その中でも4割近くは要介護度5であった。また、寝たきり度もCが最も多く、約3割強を占めており、比較的重度の介護を要する人が、夜間・早朝の訪問看護サービスを利用していることが明らかとなった。

サービス利用者の夜間・早朝の訪問の利用目的として最も多かったのは、「医療処置の提供」であった。訪問看護全般についての利用目的としては「病状悪化・再発の予防」が本も多かったことに比較すると、夜間・早朝においてはその中でも特に「医療処置」に重点が置かれており、緊急時への対応についても求められていることが示唆された。

また、夜間・早朝の訪問において、介護者側からの「夜間訪問で介護負担が軽減する可能性がある」との回答が多く見られており、サービス利用者に限らず介護者にとっても、夜間・早朝訪問が望まれていることが示唆された。

4．今後の課題－夜間・早朝の訪問看護サービスの普及に向けて－

本研究の結果より、夜間・早朝のサービス提供体制を充実させるには、マンパワーの確保と共に、限られた医療・介護資源を活用すべく、地域における施設間・職種間の連絡・連携体制が重要となることが明らかとなった。事業所のスタッフの増員も必要ではあるが、現実的な対応としては、地域における夜間・早朝訪問の際のチーム体制の構築を充実させることが喫緊の課題であろう。

また、現状では介護保険で給付されるサービス回数に制限があるなど、経済的・制度的な制約もあり、夜間・早朝の訪問回数を増加しようとしても困難な場合も見受けられる。今後は、訪問看護サービスが真にニーズを持つ利用者のＱＯＬの向上に貢献するために、制度の改善も視野に入れた上で、地域連携を主眼とした夜間・早朝のサービス提供体制の強化を推進していく必要があると考えられる。

第３章
文献検索

Ⅰ．研究目的

ケースマネジメントとは、アメリカで1970年代に、要援護者(主に精神障害者)の地域生活の支援を行うことに端を発し、歴史が始まった。この手法は、一つの窓口ですべての生活ニーズを明らかにし、それらのニーズに合致するサービスと結び付けをする援助を理論として、体系化していった。そして、単に精神障害者へのアプローチだけでなく、長期にケアを必要とする高齢者・身体障害者・知的障害者、さらにはエイズ患者(HIVキャリア)に対する生活支援方法としても拡大していった。

さらに、このケースマネジメントの考え方や方法は、アメリカからイギリス、カナダ、オーストラリアといった国々、さらには日本へと導入され、世界の多くの国々で普及していった。特に、この方法は長期にケアを必要とする人である高齢者の地域生活を支援する方法として定着してきたといえる。

イギリスでは、1990年につくられたコミュニティケア法のなかでケアマネジメントという仕組みを制度化していったが、このときに初めてケースマネジメントではなく、「ケアマネジメント」という用語が使われた。これは「ケア」という言葉が温かいニュアンスをもち、またマネジメントするのはケース(事例、利用者)ではなく、ケアであるということからである。この考えは、現在、日本やアメリカでも認識され、特に日本では、「ケアマネージャー」、「ケアマネジメント」という用語が一般的に浸透している。

日本では、高齢者領域では、1989年に創設された在宅介護支援センターが、ケアマネジメントの担い手として大きな役割を果たしてきた。しかし、2000年より、介護支援専門員資格制度が開始し、対象者は介護保険での要介護者・要支援者と認定される者に限定はされているが、様々な職種がケアマネジメントに関わることが多くなった。

実務に着いている介護支援専門員の背景職種は、2000年は看護職30%、福祉職40%、その他30%であった。2003年には、看護職40%、福祉職50%、その他10%となっており、看護職も福祉職もそれぞれ10%増加している。それぞれの背景職種の専門性の違いから、介護支援専門員の質は一定ではないことが指摘されている。現在、免許更新制度や講習会の受講、キャリア体系の構築などによる質の保証が急務となっている。その中では、特に職種毎の役割の位置づけなどはないが、利用者の医療面・身体面・生活面をアセスメントすることができる看護職がどのように職種の特性を生かし、活躍していくかを模索していくことは、今後も介護支援専門員として看護職が活動していくために重要なことである。そのため、介護支援専門員としての看護職のあり方、およびケアマネジメントにおける看護(職)の役割について検討することを目的として、文献検索を行った。

(参考・引用文献；白澤政和, 橋本泰子, 竹内孝仁. ケアマネジメント概論. 中央法規. 2000.)

Ⅱ．研究方法

日本では介護支援専門員の歴史が浅く、ケアマネジメント(ケースマネジメント)は欧米で発展してきた経緯を踏まえ、英文・和文ともに検索を行った。

英文に関しては、平成16年10～11月に、Medline(1966～2004)、CINAHL(1982～2004)で検索を行った。検索語は、「nurse」・「nursing」・「case manager」・「case management」とした。いずれも、文献が対象とする患者は45歳以上に限定した。

和文に関しては、平成16年9月に、医学中央雑誌 Web Ver.3(1982～2004)で検索を行った。検索語は、「看護師」・「看護」・「ケアマネージャー(介護支援専門員)」・「ケアマネジメント(ケースマネジメント)」とした。

なお、☆印を文献番号に付した3文献(E-①-12, E-⑨-1, E-⑨-18)は、別途文献の詳細に関するレジュメを作成し、研究チームで検討した。

Ⅲ．研究結果

(1)英文(表1～9)

英文の文献は、多数検索された。そこで、以下のように分類し、整理を行った。原著論文のみを対象とした。

①レビュー文献；31本(1991～2003)

レビュー文献では、Nursing Case Managementにおける役割・定義を述べた文献が多く見られた (E-①-2, E-①-3, E-①-4, E-①-5, E-①-8, E-①-10, E-①-11, E-①-12, E-①-20, E-①-24)。また、QOLに関する文献 (E-①-1)、地域での活動に関する文献(E-①-14, E-①-27)も見られた。諸外国でも、ケアマネジメントにおける看護(職)の役割については明確ではなく、議論が続けられている。

②モデルに関する文献；23本(1991～2004)

モデルに関する文献では、Care Delivery Model(E-②-1)、Multidisciplinary Resource Utilization Model (E-②-2)、Collaborative Practice Model(E-②-3, E-②-4)、Multisystem Model (E-②-3)、Family Caregiving Model (E-②-3)、The innovative community-focused model (E-②-5)、A Federal Health Care Model (E-②-6)、The Nursing Case Management Model (E-②-7)、The Nurse Care Management Model (E-②-8)、A 12-step Recovery Model(E-②-11)、A Nurse-Managed Model(E-②-12)、The Task-Centered model(E-②-14)、The Acute Care for Elders (ACE) Model(E-②-15)、Care Coordination Model(E-②-16)、The Nursing Home Admission Model(E-②-17)、The Vroom-Yetton-Jago Leadership Model (E-②-18)、The Threshold of change Model (TCM) (E-②-20)、The Geriatric Resource Nurse Model(E-②-21)、The Family-Centered Geriatric Resource Nurse (FCGRN) Model (E-②-22)、The individualized Care Model (E-②-23) などのモデルについて紹介・検討されていた。モデルは多岐に渡っており、様々なモデルが現在まで検討されてきたことがわかる。

③コストに関する文献；37本(1988～2004)

コストに関する文献では、レビュー文献(E-③-1, E-③-2, E-③-3, E-③-5, E-③-8, E-③-11, E-③-21, E-③-22, E-③-37)、コスト分析(調査を通したもの)(E-③-4, E-③-6, E-③-7, E-③-9, E-③-10, E-③-12, E-③-14, E-③-15, E-③-16, E-③-17, E-③-18, E-③-19, E-③-20, E-③-23, E-③-24, E-③-25, E-③-26, E-③-27, E-③-28, E-③-29, E-③-31, E-③-32, E-③-33, E-③-34, E-③-35, E-③-36)に大別できた。実際の調査を通し、コスト分析をしている文献が多数見られた。そのうち、ケースマネジメントがコストの削減に役立つと提

言している研究は、E-③-6, E-③-7, E-③-9, E-③-10, E-③-14, E-③-24, E-③-26, E-③-36, E-③-34 の 8 本であった。E-③-18, E-③-27, E-③-28, E-③-29, では、ケースマネジメントを行うことにより、従来よりもコストは増大するものの、臨床面での機能は、有意に改善するとされている。一方、E-③-20 では、ケースマネジメントと、従来のケアでは、コストに差が見られないという報告がされていた。

④疾患・対象を限定した文献；(疾患)28 本(1993～2004), (AIDS/HIV/STD)5 本(2000～2003), (小児)6 本(1998～2003), (精神)9 本(1997～2002)

ここでは、「疾患」を、AIDS/HIV/STD および精神疾患を除く、(慢性)疾患と便宜的に定義して分類した。

疾患に関する文献では、糖尿病(E-④-1, E-④-18, E-④-25, E-④-26)、心疾患(E-④-2, E-④-9, E-④-14, E-④-19)、胆石(E-④-3)、脳血管疾患(E-④-4, E-④-13)、リウマチ(E-④-5)、頚動脈狭窄症(E-④-6)、呼吸器感染(E-④-7)、アルツハイマー(E-④-8, E-④-15, E-④-24)、慢性疼痛(E-④-10)、股関節変形症(E-④-11)、疾病後のトラウマ(E-④-16)、腫瘍(E-④-17)、電熱傷害(E-④-20)、喘息(E-④-21, E-④-22)、下痢(E-④-23)、慢性腎不全(E-④-27)に関して述べられていた。

AIDS/HIV に関する文献は、E-④-28, E-④-30, E-④-31 であり、いずれも AIDS/HIV 感染患者に対するケースマネージャーの関わりについて述べている。STD に関する文献は、E-④-29, E-④-32 であり、前者はガンビア(アフリカ)、後者はコートジボアール(アフリカ)における STD の管理について述べられていた。

小児に関する文献では、小児精神保健(E-④-33)、ケアマップ(E-④-34)、マラリア(E-④-35)、病院におけるケースマネージャーの介入(E-④-36, E-④-37)、髄膜炎(E-④-38)に関して述べられていた。

精神疾患に関する文献では、危機管理ユニットでのケースマネージャーの介入(E-④-39)、重度精神疾患および物質乱用(E-④-41, E-④-42, E-④-43, E-④-45, E-④-47, E-④-48)、地域精神看護サービス(E-④-44, E-④-46)に関して述べられていた。

⑤Randomized Control Trial を用いた研究；12 本(1996～2004)

これらの研究の研究方法は、既存のサービス利用群とケースマネジメント利用群との比較(E-⑤-1, E-⑤-2, E-⑤-3, E-⑤-4, E-⑤-6, E-⑤-7, E-⑤-8, E-⑤-9, E-⑤-10, E-⑤-12)がほとんどであった。そのうち、ケースマネジメントが良い結果を導くと提言している研究は、E-⑤-1, E-⑤-2, E-⑤-3, E-⑤-6, E-⑤-8, E-⑤-9, E-⑤-10 であった。E-⑤-4 では、ケースマネジメントを行うことにより、従来よりも臨床面での機能には改善はみられないものの、QOL は有意に改善するとされている。一方、E-⑤-7 では、ケースマネジメントと、従来のケアでは、効果に差が見られないという報告がされていた。

⑥介入研究；14 本(1996～2003)

これらの研究の介入方法は、退院後のフォローアップ(E-⑥-1)、クリニカルパス(E-⑥-2, E-⑥-4)、禁煙プログラム(E-⑥-3)、アセスメントの実施(E-⑥-5, E-⑥-6, E-⑥-7, E-⑥-10, E-⑥-13)、介護者への教育(E-⑥-9)、ケースマネジメント(E-⑥-11, E-⑥-12, E-⑥-14)などであった。

⑦縦断研究；9 本(1996～2004)

これらの研究の追跡期間(追跡の終了時)は、3 ヶ月(E-⑦-5)、6 ヶ月(E-⑦-8)、17 ヶ月(E-⑦-1)、24 ヶ月(E-⑦-2, E-⑦-3)、29 ヶ月(E-⑦-4)、60 ヶ月(E-⑦-6)であった。なお、E-⑦-7, E-⑦-9 は追跡期間が明記されていなかった。

⑧横断研究；19本(1994～2004)

これらの研究の研究方法は、プログラム実施の効果(E-⑧-1, E-⑧-8, E-⑧-9, E-⑧-12, E-⑧-13, E-⑧-17)、既存のサービス利用群とケースマネジメント利用群との比較(E-⑧-2, E-⑧-3)、医師の認識(E-⑧-4)、 Nursing Case Management の効果(E-⑧-5)、尺度開発(E-⑧-6, E-⑧-11)、Nurse Case Manager の役割(E-⑧-7, E-⑧-15)、利用者の意識調査(E-⑧-16)、ケースマネージャーの意識調査(E-⑧-18)、薬剤師ケースマネージャーの役割(E-⑧-19)などであった。

⑨質的研究；19本(1996～2004)

これらの文献の研究テーマは、Nurse Case Manager の役割(E-⑨-1, E-⑨-8, E-⑨-16, E-⑨-17) 、成功する Nurse Case Manager の特性(E-⑨-2, E-⑨-15)、在宅ケア利用者の意識調査(E-⑨-3, E-⑨-6, E-⑨-10 , E-⑨-14, E-⑨-18, E-⑨-19)、ケーススタディ(E-⑨-4, E-⑨-5, E-⑨-7, E-⑨-9)、GP の活動(E-⑨-11)などであった。

(2)和文(表10)

検索の結果、目的に合致するものをピックアップすると、58本が該当した。解説・特集・会議録などを除き、原著論文のみを対象とすると、26本であった。これら26本の論文が発表された年代は、2000～2004年であった。

これら26本の研究テーマは、利用者満足度(J-1)、介護支援専門員の意識調査(J-2, J-3)、在宅ケアの技術(J-4, J-7, J-22)、利用者とケア提供者の認識(J-5, J-6)、介護支援専門員の仕事上の問題点・バーンアウト(J-8, J-13, J-21, J-23, J-26)、協働のあり方(J-10, J-11)、介護保険利用状況(J-12, J-14, J-25)、病院勤務看護師の介護保険制度に関する意識調査(J-15)、介護予防(J-16)、援助困難ケース(J-20)、文献レビュー(J-24)などであった。

Ⅳ. 考察

英文の検索は、Medline(1966～2004)、CINAHL(1982～2004)で行ったが、実際に論文が発表された年代は、1988 年以降であった。これは、ケースマネジメントの歴史と一致する。レビュー論文、コストに関する論文が、初期には多く発表されている。⑤～⑨の研究に関しては、1996 年以降が主な発表時期となっており、この分野が注目され、研究されるような発展があったことが伺える。一方、和文の検索は、医学中央雑誌 Web Ver. 3(1982～2004)で行ったが、実際に論文の発表された年代は2000年以降であった。これは、介護保険制度の創設・施行に伴い、介護支援専門員の資格が新設された歴史と一致する。

諸外国でも、ケアマネジメントにおける看護(職)の役割については明確でなく、議論が続けられていることからも、日本においての役割も早急に結論が出るものではないことが予測される。十分な検討が必要である。

海外では、看護に関するケアマネジメントについての研究がすでに多数なされているが、日本ではまだ発展途上の段階といえよう。コストに関する文献は、海外では蓄積があるものの、日本の介護保険制度のコスト負担方式は独自のものであるため、日本での研究が望まれるであろう。

また、現在までに日本で行われていない Randomized Control Trial を用いた研究、介入研究、縦断・横断研究、質的研究など、参考にすべき点は多数ある。日本での状況を加味し、今後、ケアマネジメントにおける看護(職)の役割などを明らかにするための研究を進めていくことが重要である。

Ⅴ. 文献リスト(表1～10)

表 1. ①レビュー文献

No	Authors	Title	Source	Abstract
E-①-1	Sherman JJ. Johnson PK.	Nursing care management.	Quality Assurance & Utilization Review. 6(4):142-5, 1991.	Patient satisfaction, patient-perceived quality of life, and nurse satisfaction were compared before and after the implementation of nursing case management in a southeastern acute care hospital. Immune-compromised oncology patients were sampled as proxy for patients with AIDS. Clinical nurse specialists as case managers planned, coordinated, and facilitated patient care on the 36-bed study unit. Patient satisfaction showed a statistically significant increase 6 months after implementation of nursing case management.
E-①-2	Smith J.	Changing traditional nursing home roles to nursing case management.	Journal of Gerontological Nursing. 17(5):32-9, 1991 May.	1. The role of nursing case manager described here was derived from the concept of primary nursing in acute care, team nursing, and the community-based social service role. 2. Nurses in nursing homes often function within a bureaucratic, physician advocate role instead of within a professional, patient advocate role. 3. Following implementation of the nursing case manager role, nurses were able to see results of their intervention, nursing accountability was enhanced, and the number of documented positive patient outcomes increased. 4. The two primary paper tools used by nurses in this project were the care plan to direct individualized care and the progress note to report problem resolution.
E-①-3	Tahan H.	The nurse case manager in acute care settings. Job description and function.	Journal of Nursing Administration. 23(10):53-61, 1993 Oct.	Nurse administrators face many decisions about the emerging role of the nurse case manager (NCM). Who should be the NCM? What are the skills needed? How should the professional nurse function in the new role? The author reports the results of a study that helps answer these questions.
E-①-4	Goodwin DR.	Nursing case management activities. How they differ between employment setting	Journal of Nursing Administration. 24(2):29-34, 1994 Feb.	In this article, the author describes differences in case management activities in various employment settings.The diversity of case management approaches raises many questions. Are multiple case managers really required to duplicate each others' services, and if so, to what degree? How does the case manager actually "case manage" a client? How do the activities of the case manager in a direct care environment differ from case managers employed by case management companies or insurance companies?
E-①-5	Gerber L.	Ethics and caring: cornerstones of nursing geriatric case management.	Journal of Gerontological Nursing. 21(12):15-9, 1995 Dec.	1. Paternalism, the most frequent ethical concern voiced by both elders and their caregivers, is unilateral decision-making not in accord with the client's stated wishes or value system. 2. It is common that older people are intimidated by professionals and lack the sophistication and vocabulary to express their desires in a rational and assertive manner. 3. Often the family's decisions regarding client care do not correlate with the patient's choices in the sense that clients want to avoid needless pain and suffering and are more accepting than the families of the potential outcome of death. 4. Detailing the nursing care plan in writing and allowing several days for client/family review and approval lessen misunderstanding and dissatisfaction.

E-①-6	Becker S. Kannensohn K.	Disease management: a contracting primer.	Medical Interface. 9(8):88-90, 1996 Aug.	This article provides an understanding of the issues and steps that are required for negotiating a disease management contract. Because most of the author's experience derives from representing pharmaceutical companies and other provider driven entities, the tenor of the comments often reflects that perspective on negotiations. This article focuses on disease management contracting whereby a provider network or case manager assumes risk relating to the cost of providing care to a certain type of patient.
E-①-7	Daly GM. Mitchell RD.	Case management in the community setting.	Nursing Clinics of North America. 31(3):527-34, 1996 Sep.	This article describes a federally funded nurse managed community health organization that treats the elderly. The innovative community-focused model uses the nurse as case manager to provide health promotion, screening, and early interventions to clients enrolled in the Community Nursing Organization (CNO). It explains the advantages of integrating advanced practice nurses into the nursing staff to provide both direct care to clients and teaching/conculation to the nursing staff. The CNO demonstrates that advanced practice nurses possess autonomous practice skills and are able to integrate preventive and curative care across practice sites.
E-①-8	Glettler E. Leen MG.	The advanced practice nurse as case manager. [Review] [12 refs]	Journal of Case Management. 5(3):121-6, 1996 Fall.	The dynamic interactions of the client, service provided, and payer are complex relationships in today's health care environment. An advanced practice nurse's abilities to care physically and psychosocially for clients and their families are essential within the case management framework. With a holistic view of clients' health status, the nurse case manager develops and carries out advanced practice functions that help achieve the best outcome for the client through effective interactions with clients, payers, and providers. Those functions, illustrated by the Star Case Management Model, include interpretation, advocacy, and surveillance.
E-①-9	Malek CJ. Olivieri RJ.	Pain management documenting the decision making process. [Review] [29 refs]	Nursing Case Management. 1(2):64-74, 1996 May-Jun.	From patient admission to discharge, pain is a critical symptom of concern to the nurse case manager. This descriptive study examined nurses' decision-making regarding pain management as documented in clinical records of patients after orthopedic surgery. Using a Nurses' Pain Management Audit Tool, data analysis revealed that during the first 24 hours after emergence from the Post-Anesthesia Care Unit, these patients received less than 50% of the narcotic doses available for their pain relief. Nurses documented less than 25% of the "ideal occurrences" possible for pain assessment, as described in the Agency for Health Care Policy and Research Guidelines. Incomplete databases for guiding patient outcomes of effective pain management were perpetuated by insufficient documentation. Nurse case managers could stimulate increased commitment and quality improvement in pain management as a crucial aspect of patient care.
E-①-10	Weston MA.	Case management: integrating roles in the subacute setting. [Review]	MEDSURG Nursing. 5(1):23-8, 43, 1996 .	Nurses have great potential to advance the professional practice of nurse case management in the subacute care industry. This health care setting has created a new arena in which nursing may adapt and redefine the role of the case manager to meet the needs of an integrated system of outcomes based health care. Through cooperation and collaboration with a multidisciplinary team, the nurse case manager increases the cost effectiveness of care and enhances patient outcomes. [22 refs]

E-①-11	Browne R. Biancolillo K.	Fusing roles—the ambulatory care nurse as case manager.	Nursing Management. 28(9):30-1, 1997 Sep.	Most pathways concentrate on reducing the patient's length of stay. One multidisciplinary pathway team aims for a broader approach-promoting wellness as a means to avert hospitalization. Primary treatment teams provide and direct care for a group of patients, resulting in an outpatient system that is accessible and comprehensive.
E-①-12 ☆	Lee DT. Mackenzie AE. Dudley-Brown S. Chin TM.	Case management: a review of the definitions and practices.	Journal of Advanced Nursing. 27(5):933-9, 1998 May.	Case management has been suggested as an innovative strategy which facilitates the linking of quality and cost-effective care. However, there is little consensus about what is actually being introduced under the name of case management. It is suggested that this absence of a clear understanding of case management has been an obstacle in moving forward case management practice and research. This paper presents a critical review of the confusion surrounding case management with an attempt to unravel issues relevant to the implementation of case management into community nursing practice in Hong Kong. It is concluded that there is a need for different definitions of case management as a result of the differences in the cultural and health care context in which it is being practised. Also, if case management programmes are to be advanced, there needs to be more co-ordinated effort in researching not only the expected outcomes but also the structures and processes of these programmes so that findings of similar case management programmes can be compared for ways of future improvement.
E-①-13	MacKenzie A. Lee DT. Dudley-Brown S. Chin TM.	The processes of case management: a review of the evaluation of a pilot study for elderly people in Hong Kong.	Journal of Nursing Management. 6(5):293-301, 1998 .	This paper is based on research into case management that aimed to evaluate the processes of the introduction of case management for elderly people into the community nursing services in Hong Kong. The Hospital Authority in Hong Kong introduced a pilot Case Management scheme into the Community Nursing Services. A research project was therefore developed to evaluate this case management model. The processes were measured through information gained from group interviews, daily diaries and weekly activity sheets. The roles and work practices of the Care Coordinators and Case Managers are described and the benefits of case management to patients, carers and nurses are highlighted. Difficulties are also discussed and good practices are identified. Staff in the hospital and community need time to get used to the model of case management and to the accompanying documentation. The role of the case manager needs to be clearly dilineated.
E-①-14	Guttman R.	Case management of the frail elderly in the community. [Review]	Clinical Nurse Specialist. 13(4):174-8; quiz 179-81, 1999 Jul.	Nurse case management has become a popular strategy for coordinating healthcare services to high-risk populations. This article describes the characteristics and advantages of a unique case management approach to manage the healthcare of frail elderly living in the community. At the heart of this approach are the nurse's role in the engagement of the client and family, prevention, continuity of care, and hospital, community, and caregiver team facilitator. Specific interventions of the nurse case manager are highlighted by case studies. [12 refs]

E-①-15	Kaplan M.	Case management and confidentiality... including commentary by Polivka L.	Journal of Ethics, Law and Aging. 5(2):103-10, 153-6, 1999 Fall-.	In coordinating care for elderly clients throughout the long-term-care system, case managers must share client information with families, other professionals, and organizations. This often presents an ethical challenge, as the case manager attempts to balance the desire to protect the client's right of privacy and autonomy with the need to provide the necessary information to ensure that appropriate care is delivered to the older adult. This article examines the issue of confidentiality in geriatric case management and current practice guidelines that address the management of confidential information. Additional steps to promoting confidentiality in case management are discussed that address the challenges of a changing long-term-care system.(16 ref)
E-①-16	McLaughlin K. Miller JM. Wooten C.	Ethical dilemmas in critical care: nurse case managers' perspective.	Critical Care Nursing Quarterly. 22(3):51-64; quiz 98, 1999 Nov.	Nurse case managers often face ethical dilemmas as they advocate for their cri tically ill and critically injured patients.They experience the tension that exists between advocating for the critically ill, the patient's right to self-determination, and the payer source constraints. When there are no good alternatives for the patient or the list of options include none that are desirable, the nurse case manager may experience an ethical dilemma. Working with the critically ill and injured inherently presents a spectrum of biopsychosocial complexities, which present potential ethical dilemmas for the nurse case manager. The three case studies presented posed particular challenges to the nurse case managers and deal with the ethical principles of beneficence, autonomy, veracity, and justice.
E-①-17	Aronson J. Sinding C.	Home care users' experiences of fiscal constraints. Challenges and opportunities for case management.	Care Management Journals. 2(4):220-5, 2000 Winter.	With mounting fiscal constraints in home care, case managers find themselves increasingly confined in rationing roles and pressed into a narrow focus on the individual case. These pressures frustrate case management's potential to inform and contribute to more broadly-based improvements in service systems, policy formulation, and resource development. A study of home care users' perspectives in a jurisdiction where fiscal pressures have been rapidly increased reveals how rationing and service reduction affect service recipients and shape their relationships with case managers. The study sheds light on the challenges and opportunities for case managers of practicing in such straitened circumstances. Combined with their own detailed understanding of front-line service delivery, case managers can build on the knowledge of service users' perspectives to make critical contributions to both the well-being of the generally jeopardized populations who need home care and to the broadening of case management practice in keeping with its commitments to advocacy and systems level change.
E-①-18	Corazzini KN.	Case management decision making: goal transformation through discretion and client interpretation.	Home Health Care Services Quarterly. 18(3):81-96, 2000. (15 ref)	This study examines the decision-making strategies employed by case managers in a state-funded home care program for the elderly.Specifically, this study applies Lipsky's (1980) theory of street-level bureaucracy to gerontological research on case management decision making in an effort to demonstrate the presence of case management discretion, and the impact of that discretion on home care implementation. Drawing upon individual interviews and focus group interviews, results suggest the applicability of the proposed framework, and indicate the need for policy planners to identify factors for case manager discretion that result in undesirable home care goal transformation.

E-①-19	Moore-Greene G.	Standardizing social indicators to enhance medical case management.	Social Work in Health Care. 30(3):39-53, 2000.	With the advent of Medicaid Managed Care, health care professionals and administrators have sought ways to increase patient compliance and appropriate utilization of services under a capitated system. The major focus has been on medical managed care and utilization review to control cost. This paper focuses on the development and standardization of social indicators to identify the biopsychosocial problems that cause medical noncompliance and inappropriate utilization of medical services by the Medicaid patient. The development of what is called Life Indicators is discussed and serves as a basis for enhancing the medical case management model to control cost when providing services to patients with complex medical and social problems.
E-①-20	Schofield I. Ford P.	The need for specialist nurses to work with older people. [Review] [69 refs]	British Journal of Nursing. 9(20):2148-54, 2000 Nov 9-22.	This article is based on a comprehensive literature review undertaken by the Royal College of Nursing gerontological nursing programme on the development of specialist gerontological nursing practice (Schofield et al, 1998). The scope of the original review covered the development of specialist nursing, frameworks for practice, accreditation and regulation, role components and competencies, methods of evaluating the specialist role and fields of practice. The literature review's purpose was to inform work on the development of a specialist gerontological nursing BSc (Hons) degree by distance learning. This article focuses on the key findings of the literature review, setting out the potential for the introduction of specialist gerontological nurses in the UK.
E-①-21	Wild LR. Mitchell PH.	Quality pain management outcomes: the power of place.	Outcomes Management for Nursing Practice. 4(3):136-43, 2000 Jul-Sep.	This study explores how an organization, as the context of care, influences nursing practice and a nursing-sensitive, quality health outcome-pain management. The results provide important insights into organizational patterns associated with favorable pain management-related outcomes as well as the congruence between and among subunits within the organization. Outcomes were most favorable on units where nurses had attitudes supportive of aggressive pain management and higher levels of coordination and discretion.
E-①-22	Brun C. Rapp RC.	Strengths-based case management: individuals' perspectives on strengths and the case manager relationship.	Social Work. 46(3):278-88, 2001 . (31 ref)	Strengths-based practice in social work has a strong theoretical foundation as an effective helping strategy that builds on a person's successes. Although there is growing empirical evidence informing outcomes associated with strengths-based approaches, missing from the literature is an understanding of how individuals who receive these services view their experiences. The research questions that guided the study were "What are individuals' perceptions of strengths-based case management?" and "How do those perceptions compare and contrast to the key principles of strengths-based case management?" Qualitative data collection methods were used to gather individuals' experiences of participating in strengths-based case management implemented in a substance abuse aftercare program. The emerging themes centered on individuals' responses to a focus on strengths (acceptance of strengths; holding on to strengths and deficits simultaneously; and initial mistrust of the approach) and to the relationship with the case manager (acceptance of the relationship; guilt when success is not achieved; and not needing the relationship). Implications for social work practice are discussed.

E-①-23	Cisar NS. Mitchell CA.	Development of a program to manage costly outliers.[Review]	Clinical Nurse Specialist. 15(1):25-33, 2001 Jan.	Identify clinical variables of the elderly patients with multisystem failure requiring complex nursing care referred to as outlier. Identify who the outliers might be prior to becoming outliers and to manage their nursing care early in their hospital course, attempting to match resource requirements with resource availability.Patients whose hospital charges were greater than $50,000 with a length of stay greater than the primary diagnostic related group designated.Once criteria were identified, nursing strategies were developed to monitor the elderly patient, implement interventions, and evaluate patient outcomes. The goals of this program were to identify who the outliers might be prior to becoming outliers and to manage their nursing care early in their hospital course, attempting to match resource requirements with resource availability. [References: 21]
E-①-24	Fralic J. Griffin C.	Nutrition and the elderly: a case manager's guide.	Lippincott's Case Management. 6(4):177-82, 2001 .	This article reviews the physiological and nutritional changes associated with aging and provides the case manager with nutrition resources. General information on nutritional factors associated with aging, including common nutrient deficiences, is outlined. The dietitian's role in nutrition assessment, intervention, and outcomes is discussed. A list of resources for case managers interested in accessing a registered dietitian is also included.(14 ref 16 bib) Providing case management for older individuals is challenging in that this group rarely fits any DRG or managed-care mold. Because many people are living healthier and longer lives, intergenerational family dynamics such as that observed in Sophie and Leo's case may become more the norm than the exception. Well-intentioned family members, lacking the guidance of an experienced gerontologic APN case manager, may inadvertently place their aged loved ones at risk by attempting to arrive at health care, social, and housing solutions on their own. Even though 82-year-old Sophie stated subjectively that she "felt better than ever", an objective clinical assessment revealed that she still was in a convalescent period following major abdominal surgery at the same time that she was faced with providing in-home care for Leo, her 102-year old father. Sophie may have experienced response shift, or a reconceptualization of her own health state, in the aftermath of serious illness. The advanced practice knowledge and skills, systems acumen, talents, and creativity of two APN case managers in two different states contributed to successful health and social outcomes for two "master survivors," whose longevity and clinical presentations exceeded expectations. The value of APNs as case managers is clear: APNs possess the proficiency, tenacity, knowledge base, and nursing confidence needed to make a positive contribution toward individualizing care for members of the greatest generation.
E-①-25	Yamada Y.	Consumer direction in community-based long-term care: implications for different stakeholders.	Journal of Gerontological Social Work. 35(3):83-97, 2001. (26 ref)	Recently, a growing number of community-based long term care programs have been incorporating a concept of consumer direction (CD). Consumer Direction allows long-term care consumers to take more active roles in their care management, by hiring, training, supervising, and firing care providers. A limited number of existing studies show that CD consumers indeed feel they have more choice and control over their care compared to those under the traditional model. However, other studies show problematic working conditions for care providers under CD. Questions also remain unanswered regarding how CD effects different important stakeholders, including family caregivers, formal paid caregivers, and governments. More research, administrative, and practice efforts are needed to ensure CD can benefit all sectors of communities.

E-①-26	Mick DJ. Ackerman MH.	New perspectives on advanced practice nursing case management for aging patients.	Critical Care Nursing Clinics of North America. 14(3):281-91, 2002 . (58 ref)	Providing case management for older individuals is challenging in that this group rarely fits any DRG or managed-care mold. Because many people are living healthier and longer lives, intergenerational family dynamics such as that observed in Sophie and Leo's case may become more the norm than the exception. Well-intentioned family members, lacking the guidance of an experienced gerontologic APN case manager, may inadvertently place their aged loved ones at risk by attempting to arrive at health care, social, and housing solutions on their own. Even though 82-year-old Sophie stated subjectively that she "felt better than ever", an objective clinical assessment revealed that she still was in a convalescent period following major abdominal surgery at the same time that she was faced with providing in-home care for Leo, her 102-year old father. Sophie may have experienced response shift, or a reconceptualization of her own health state, in the aftermath of serious illness. The advanced practice knowledge and skills, systems acumen, talents, and creativity of two APN case managers in two different states contributed to successful health and social outcomes for two "master survivors," whose longevity and clinical presentations exceeded expectations. The value of APNs as case managers is clear: APNs possess the proficiency, tenacity, knowledge base, and nursing confidence needed to make a positive contribution toward individualizing care for members of the greatest generation.
E-①-27	Wodarski JS. Williams-Hayes MM.	Utilizing case management to maintain the elderly in the community.	Journal of Gerontological Social Work. 39(4):19-38, 2002. (106 ref)	How will our elderly manage and who will take care of them? Implications for policy and clinical practice, with the focus of maintaining elderly in the community. Economic and demographic factors are changing our country and both have serious connotations for families and society. The baby boomers are growing old and their numbers are astounding. Our old-old (85 and older) are living longer and our family size is decreasing. Both parents are working and there is an increase in the mobility of citizens. How will our elderly manage and who will take care of them? According to research, much prejudice and potential discrimination against the aged exists. What effect does this have on society? How can a case manager insure that his or her client receives the appropriate services and in a timely manner? Intervention guidelines are provided with implications for policy and clinical practice, with the focus of maintaining elderly in the community.
E-①-28	Alkema GE. Shannon GR. Wilber KH.	Using interagency collaboration to serve older adults with chronic care needs: the Care Advocate Program.	Family & Community Health. 26(3):221-9, 2003 . (19 ref)	This article describes the Care Advocate Program, an interagency collaborative effort that involved health care organizations, social service agencies, and an academic research center to improve chronic care service delivery to older adults. The article discusses existing barriers to effective chronic care delivery as well as concepts for successful collaboration. The article describes the multiple and often competing demands of stakeholders who undertake collaborative projects. It concludes with lessons learned when partners from different settings work together to design and implement a demonstration program.

E-①-29	Lubben JE. Damron-Rodriguez J.	An international approach to community health care for older adults.	Family & Community Health. 26(4):338-49, 2003 . (45 ref)	Worldwide population ageing, concomitant increases in disability rates, and changes in family health care systems require an examination of current service delivery to optimize use of societal resources in the future. examines a community health care approach suggested by research conducted by the World Health Organization Kobe Centre for Health Development (WKC). The WKC approach, which uses a cross-national perspective, envisions a community health care system that integrates health and social services and spans health promotion, primary care, and long-term care. Prototypical approaches for organizing community health care include communal, marketplace, case management, and managed care. The ramifications of these approaches are examined from the perspectives of the older adult, the family, and formal service providers.
E-①-30	Rantz MJ. Grando V. Conn V. Zwygart-Staffacher M. Hicks L. Flesner M. Scott J. Manion P. Minner D. Porter R. Maas M.	Getting the basics right. Care delivery in nursing homes.	Journal of Gerontological Nursing. 29(11):15-25, 2003 Nov.	In this study, the key exemplar processes of care in facilities with good resident outcomes were described. It follows that with description of these processes, it is feasible to teach facilities about the basics of care and the ways to systematically approach care so they can adopt these care processes and improve resident outcomes. However, for this to happen key organizational commitments must be in place for staff to consistently provide the basics of care. Nursing leadership must have a consistent presence over time, they must be champions of using team and group processes involving staff throughout the facility, and they must actively guide quality improvement processes. Administrative leadership must be present and express the expectation that high quality care is expected for residents, and that workers are expected to contribute to the quality improvement effort. If facilities are struggling with achieving average or poor resident outcomes, they must first make an effort to find nursing and administrative leaders who are willing to stay with the organization. These leaders must be skilled with team and group processes for decision-making and how to implement and use a quality improvement program to improve care. These leaders must be skilled at building employee relations and at retention strategies so residents are cared for by consistent staff who know them. The results of this study illustrate the simplicity of the basics of care that residents in nursing facilities need. The results also illustrate the complexity of the care processes and the organizational systems that must be in place to achieve good outcomes. Achieving these outcomes is the challenge facing those currently working in and leading nursing facilities.
E-①-31	Richards S. Coast J.	Interventions to improve access to health and social care after discharge from hospital: a systematic review. [Review] [48 refs]	Journal of Health Services & Research Policy. 8(3):171-9, 2003 Jul.	To determine the effectiveness and costs of interventions intended to improve access to health and social care for older patients following discharge from acute hospitals. These services targeted patients aged 60 years and over and varied depending on whether or not they selected frail patients. Systematic literature review, following NHS Centre for Reviews and Dissemination guidelines, of randomized controlled trials evaluating needs assessment methods and patient discharge co-coordinator roles. Results were referrals to or use of health and social care (15 studies); mortality (13 studies); patients' functional health status and disability (13 studies); and patient perceptions of health (5 studies), quality of life (3 studies), cognitive functioning and psychological well-being (10 studies), social support (2 studies) and the adequacy of services (4 studies).Fifteen randomized controlled trials (23 papers), were identified. The interventions provided and patient groups targeted by these services were heterogeneous. There was, however, some evidence that services combining needs assessment, discharge planning and a method for facilitating the

				implementation of these plans were more effective than services that do not include the latter action. The assessment of need may be insufficient in itself for the adequate provision of post-discharge care. Needs assessment should be combined with a service that facilitates the implementation of care plans.