VSOP workshop. Case management for the visually impaired elderly

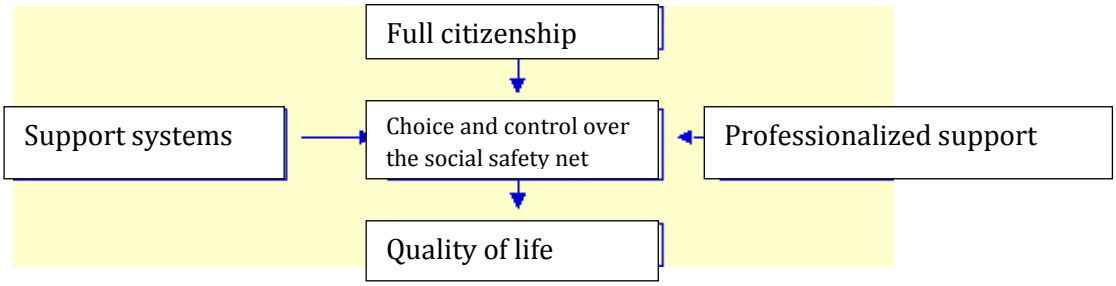
1. Social framework of the project

1.1 An altered vision regarding care policy

- VN convention of 2006 got endorsed in 2009 by the Belgian government.
- Perspectief 2020: a long term action plan and directive by the Belgium government for welfare /disability

1.2 More vocal and involved users

- In general, for the last 20 years, worldwide there has been a shift in the approach and thought pattern regarding care : citizenparadigme
- The quality of life became the focus point
- 'Integration' has been replaced by 'inclusion' (of the disabled)
- The nature of the care has altered. From charitable to self-determination
- The patient has become a citizen
- The dependent patient is once again a (stake)holder of his/her rights
- Model of citizenparadigme Van Gennep



When discussing "quality of life" in the care , the following elements should be mentioned/addressed;

The care:

- Supports the social life of the patient
- Is tailored to the patient
- Is rooted into society; in all its forms
- Is in cooperation with the mainstream
- Starts off from a holistic point of view; where the individual is responsible for the editing
- Is provided by well trained and educated employees

- Supports the social relations and network of the patient
- Is based upon cooperation
- Guarantees safety
- Leaves room for personal choice

2. Context of the project

- The government edged towards a cross-sectorial cooperation in order to create quality of life
- Care reform is the keyword of the century. From the social entrepreneurship standpoint, everyone is a participating and caring party in the realization of care reform
- Before granting approval, the government firstly works with project grants whom after being evaluated might lead to a structural foundation

3. Content and development of the project (Case management for visually impaired elderly)

In 2009 there was a an appeal made by the Federal government's health department for care reform project, focusing on those who are the most vulnerable in the healthcare system; they wanted deferment of residential care, as a direct result of the project. In other words, care reform should result in budget cuts and innovation by cooperating.

Blindenzorg Licht en Liefde(solidarity in sight) vzw has consequentially submitted a project that ran from 2010 to 2014, cooperating with a nursing home for the elderly.

Goals of the project:

To maintain the autonomy, independence and the quality of life of 120 gravely visually impaired or blind people over the age of 60, in order to extend their homestay and delay and/or avoid admission to a nursing home/residential care for as long as possible or make the switch to an autonomic life possible once more.

Project development:

A cooperation and engagement of multiple organizations through a cooperation act where each his role in the part was written up in order to achieve the goals.

The involved partners were:

- Handicap specific: Blindenzorg Licht en Liefde(Solidarity in Sight): House45 a nursing home for non-active blind and visually impaired people,St.Rafaël a redevelopment centrum for those who are blind or impaired

- Non-handicap specific: two services for homecare, a National Health Service, a nursing home and a daycare center for the elderly

Client profile /conditions in accordance with the norms of the project:

- Older than 60 years of age
- Visually impaired
- Especially socially vulnerable, by at least 4 more factors:
    - In need of aide when moving
    - Deteriorating of activities in the daily life
    - Unable to leave the premises
    - Safety
    - Behavioral issues
    - The use of a wheelchair
    - in danger of falling down
    - a short term memory issue
    - a need for personal hygiene
    - etc..

- during the entire project, data was drawn and patients were followed-up, in accordance of Belrai (every 6 months). The results of the draw and caps are a major part of the multidisciplinary talks and are the founding elements that ensure the care plan's realization
- Not included as patients are people who suffer from dementia

4. Approach of the case management

- Every appeal for support made by an elderly person is touched upon during the intake, where questions are clarified, the care offer is presented and the edmontonscore is sampled
- If the client wished to be helped after the intake, his/her demand shall be discussed during the team meeting; according to content and task demand. This team is made up off social workers, ergo therapists, orthopedics,low-vision-therapists and a team coordinator
- In order to realize the project, another 1 ½ members were added to the team; who would focus on case management (team and patients):
    - She is the person that constructs the care plan in accordance with the patient, discussed the result with the team and colleagues and coordinates further care
    - She draws up the data recovered from the Belrai and discussed the caps with the colleagues, in order to customize their intervention

- She makes contact with external counselors of our partners, in accordance of their task and the agreements made with the patient
- She reaches out to other counselors (doctors, nurses, physiotherapists) as a follow up to the Belrai score/ extra demands made by the patient in accordance with the patient
- She is the patients trustee and rock during guidance
- She assists the patient with all his extra questions, needs and colleagues their interventions regarding issues beyond his/her handicap

– It is standard procedure that besides the handicap-specific-support, the case manager talks to the patient, evaluates the situation, makes adjustments and listens. This could sometimes, in some cases be done over the phone; in order to maintain the patient bond and increase trust.
– It is standard that every alteration or whenever one feels it is necessary, after an intervention in the home front, it is mentioned to the team
– The focus point of the approach is the client and his/her network; they are their own producer, they edit their support plan
    o He/she is in full control over the support regarding his questions and needs
    o The care plan is fitted to his/her (most important) goals
    o The evaluation and adjustment of the care plan is based upon his/her needs and questions
    o During the intake, one maps the network of formal and informal caretakers, chosen by the client himself and in agreement with all those involved in the support

5. Looking back at 4 years of hard work

– A multidisciplinary approach is an enrichment that demands an adjustment (the aid was carried by many players). The involvement in total care of the patient is increased.
– Case management is an essential element of a multidisciplinary way of working. Someone must maintain an overview, make tough decisions and be a rock during interventions; for the clients as well as the counselors
– Working together with external counselors demanded grave adjustments for some employees:
    - Refraining from solo-decisions
    - sharing of information/expertise
    - Make appointments with third parties regarding aide; questioning their part and information flow
    - Being a lot more flexible
    - Working in a complementary manner

– The work/support goes beyond the patients handicap. One looks at the total picture

- One must be able to let go; refrain from wanting to take on all the work itself
- Working together with third parties increased expertise/alters the task: Training packages were tailored to third parties; elaborated in function of client support and the parties their discipline . Employees become a be reference person for other counselors
- The clients and his/her choices are the focus point; for the entire task fulfilled by the counselor. Working together with multiple professionals does not make this an easy task as there is the danger the professionals will make agreements amongst themselves, in name of the patient.
- Caretakers are confronted with ‘client choice’; this sometimes does not comply with their wishes and normal way of getting involved. For instance euthanasia, the expressed desire of the client to not be helped anymore. This demands taking on another role as a caretakers and finding other ways of providing support and solving problems
- The general practitioner is still a missing link in the care plan

Conclusion:

- As a direct result of this project we have successfully succeeded in maintaining elderly at home for a longer period of time, with quality of life
- Working together with non-handicap-specific organizations and services has been an enrichment and must if one wants to work on ‘inclusion’ of the impaired in society.
- Case management is a condition sine qua when working multidisciplinary
- The clarification of questions when starting counseling, when the client his entire world is mapped, is a starting point for which one must make time and focus on during the counseling process
- Taking the time to talk and gain trust is crucial. We are still focusing too much on ‘solution-solving’ and thus forget to offer support and aid that is in sync with the patient his pace

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