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NURSE MANAGER OF CASE IN PRIMARY HEALTH CARE IN MÚRCIA/SPAIN: TRAINING EXPERIENCE REPORT

ENFERMEIRO GESTOR DE CASO NOS CUIDADOS DE SAÚDE PRIMÁRIOS EM MÚRCIA/ESPANHA: RELATO DE EXPERIÊNCIA DE CAPACITAÇÃO

ENFERMERAS GESTORAS DE CASOS EN ATENCIÓN PRIMARIA EN MURCIA/ESPAÑA: INFORME DE LA EXPERIENCIA FORMATIVA

Maria Rosario Valverde Jiménez[1], Ángeles García Gómez[1], Eulalia Salas Peña[1], Antonio Contreras Fernández[1], Maria Ángeles Hernández Corominas[1], Sandra Maria da Solidade Gomes Simões de Oliveira Torres[2].

[1]Murcian Health Service, Area I – West Murcia, Murcia, Spain.
[2]Municipal Government of Natal, Department of Health, Natal, Brazil.

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ABSTRACT

Introduction: The ageing of the population, the increase in the prevalence of chronic degenerative diseases and changes in family support structures have led to an increase in the demand for social and health care.

Objectives: To describe the experience of the evaluation of a case management course for the treatment of complex chronic patients in primary care carried out by the coordination of the Project for the care of the complex chronic patient (PCC) in Primary Care (PC) in Area I Múrcia Oeste, Múrcia/Spain.

Methods: This is an experience report de:veloped through training during the case management course for the treatment of complex chronic patients in primary care, in Múrcia/Spain. Seven nurses took part in the interview.

Results: The participants in the training responded positively to most of the questions, indicating that the interviewees were aware of and satisfied with the aspects covered in the training and demonstrated positively their expectations and assessment of the new role of the NCM in these aspects.

Final considerations: Most of the questions addressed were answered positively by the participants; however, there was a feeling of insecurity on the part of the participants, which is perfectly understandable given the fact that they are starting in this new role of NCM and all the responsibilities relating to the new competencies and skills that they will have to perform for the program to succeed.

Keywords: Health of the Elderly; Inservice Training; Nursing Care; Nursing Research; Patient Care Team; Primary Health Care.

RESUMO

Introdução: O envelhecimento da população, o aumento da prevalência de doenças crônicas degenerativas, as mudanças nas estruturas de apoio à família, geraram um aumento da procura de cuidados sociais e de saúde.

Objetivos: Descrever o relato de experiência da avaliação de um curso de gestão de casos para o tratamento de doentes crônicos complexos nos cuidados primários realizado pela coordenação do Projeto atenção à prestação de cuidados ao doente crónico complexo na Atenção Primária da Área I Múrcia Oeste, Múrcia/Espanha.

Método: Trata-se de um relato de experiência desenvolvido por meio de ações de capacitação, durante a realização do curso de gestão de casos para o tratamento de doentes crônicos

complexos nos cuidados primários, em Múrcia/Espanha. Participaram da entrevista sete enfermeiros.

Resultados: Os participantes da capacitação responderam de forma positiva à maioria das questões, denotando que os entrevistados estavam bem conscientes e satisfeitos com os aspectos abordados na capacitação e demonstraram de forma positiva suas expectativas e avaliação em relação ao novo papel de Enfermeiro Gestor de Caso quanto a esses aspectos.

Conclusão: Os participantes expressaram, na maioria das questões abordadas, respostas positivas, todavia, ressaltamos um sentimento de insegurança dos participantes, perfeitamente compreensível pelo fato de estarem iniciando esse novo papel de Enfermeiro Gestor de Caso e de todas as responsabilidades referentes às novas competências e habilidades que terão de desempenhar para o sucesso do programa.

Palavras-chave: Atenção Primária à Saúde; Capacitação em Serviço; Cuidados de Enfermagem; Equipe de Assistência ao Paciente; Pesquisa em Enfermagem; Saúde do Idoso.

RESUMEN

Introducción: El envejecimiento de la población, el aumento de la prevalencia de enfermedades crónicas degenerativas y los cambios en las estructuras de soporte familiar han provocado un aumento de la demanda de atención sanitaria y social.

Objetivos: Describir el informe de experiencia de la evaluación de un curso de gestión de casos para el tratamiento de pacientes crónicos complejos en atención primaria llevado a cabo por la coordinación del Proyecto atención a la prestación de cuidados al paciente crónico complejo en Atención Primaria en el Área I Murcia Oeste, Murcia/España.

Método: Se trata de un informe de experiencia desarrollado a través de actividades formativas durante el curso de gestión de casos para el tratamiento del paciente crónico complejo en atención primaria, en Murcia/España. Siete enfermeras participaron en la entrevista.

Resultados: Los participantes en la formación respondieron positivamente a la mayoría de las preguntas, lo que denota que los entrevistados conocían bien y estaban satisfechos con los aspectos tratados en la formación y demostraron positivamente sus expectativas y valoración en relación con el nuevo rol de Enfermero Gestor de Casos en relación a estos aspectos.

Conclusión: Los participantes dieron respuestas positivas a la mayoría de las preguntas, pero nos gustaría destacar un sentimiento de inseguridad por parte de los participantes, que es perfectamente comprensible dado el hecho de que se están iniciando en este nuevo papel de Enfermero Gestor de Casos y todas las responsabilidades relacionadas con las nuevas competencias y habilidades que tendrán que desempeñar para que el programa sea un éxito.

Decriptores: Atención de Enfermería; Atención Primaria de Salud; Capacitación en Servicio; Grupo de Atención al Paciente; Investigación en Enfermería; Salud del Anciano.

INTRODUCTION

The aging population, the increase in the prevalence of chronic degenerative diseases, and changes in family support structures have created a scenario characterized by an increased demand for social and health care. It is necessary to rationalize and adapt demand to resource utilization and promote alternatives to traditional care.

Spain is one of the countries with one of the highest aging rates in the world. According to projections by the National Institute of Statistics, in 2014, the percentage of the population aged 65 or older will reach 24.9% by 2029 and 38.7% by 2030[1]. According to the Spanish National Institute of Statistics (INE), the estimate for 2033 is that those over 65 will reach 12.3 million, corresponding to 25.2% of the total Spanish population[2].

As people age, the impact of acute processes on morbidity and mortality decreases, so chronic processes become more frequent with age. Chronic diseases and acute or intercurrent processes generate disability and dependency[3].

Given this, the costs of caring for this profile of fragile people with complex chronic diseases, multiple pathologies, advanced age, and complexity, force us to change our care model[3].

Following the recommendations of the strategy for addressing chronicity in the Spanish Health System, a project is being developed for the management of complex and advanced chronic patients, in which the Nurse Case Manager (NCM) ensures continuity of care and coordination between different care settings[3].

A proactive and coordinated care model is proposed, requiring structural changes at all levels to focus care on the person and provide training and support to caregivers in their home environment[3].

In this context, in Spain, case management is the strategy adopted by the Regional Ministry of Universal Health and Public Health to improve care for the highly complex chronic patient group or those needing palliative care.

The Spanish Health System serves the population at two levels of care: Primary Care (Health Centers) and Specialized Care (Hospitals). It boasts strengths such as high equity in access to health services, high macroeconomic efficiency, and high social legitimacy[4].

In addition to having infrastructure and care resources, it is divided into Autonomous Communities (States) that assume their own health management, following the Ministry of Health's guidelines, similar to Brazil[5]. It is important to understand that fulfilling the

needs, especially of the older population considered highly complex, vulnerable, socially isolated, and often lacking resources, requires coordinated functioning between different levels of health care.

The Region of Murcia has made significant investments in Primary Health Care, being one of Spain's Autonomous Communities that invests proportionally the most in this care level: specifically, it ranks fourth with 14.9% of total health spending dedicated to Primary Care[6,7].

The Murcian Health Service (SMS) to respond to this need, implemented and continues to plan new strategies such as: including the Case Manager Nurse (NCM), Practical Experiences, Social Cohesion Initiatives, a joint approach (PHC and Hospital) of chronic diseases, atrial fibrillation detection program in Primary Care to at-risk individuals, who may be asymptomatic, among others[6].

The role of the NCM generates much interest by proposing strategies applicable to different health systems and is intended to coordinate services for patients and individuals requiring more complex community actions, promoting this coordination without requiring major structural changes in health systems[7]. This role represents an excellent model of care for people with chronic diseases, with high levels of complex care demand and resource consumption, responding to these needs[7].

Learning from other countries' experiences is essential and mandatory for all sectors, including health. International comparisons can provide a different perspective, broaden horizons, and foster learning by observing how other countries operate with different resource combinations, organizational schemes, and regulations.

The typical profile of complex cases involves a combination of the following elements: age, usually ≥ 65, patients with advanced chronic diseases or needing palliative care, multiple pathologies, polypharmacy, users of technology to compensate for vital functions, need for complex procedures, functional dependence, primarily home-based, frequent need for technical aids, cognitive impairment, dementia, fragile caregiver structure, added social problems, frequent changes in clinical and/or environmental conditions, high use of emergency services, multiple hospitalizations, and outpatient follow-up in various specialties[8].

The activities and interventions of the nurse responsible for managing complex cases involve capturing and identifying, comprehensive and personalized assessment, caregiver identification, continuity of care, information sharing, bridging care levels, phone and/or face-to-face follow-ups, consulting, partnership management and circuit improvement, departmental management, and knowledge management[8].

However, it has been observed that the care provided to dependent individuals is often characterized by a lack of coordination between social and health services, which calls for a professional capable of responding to this situation. The work performed by nurses in Primary Health Care, combined with their competencies, makes this professional group the most suited for this need.

In this sense, the NCM is not a specific specialty within professional training, nor does it appear as a specific position in organizational charts. In some areas, NCM is mentioned as an advanced nursing practice or competency[3], but it cannot be considered a specialist role within this mode of operation and training. It seems that there is no consensual understanding in Spain, so far, regarding the term "advanced practice" that would allow us to delve into this debate. Even without a national standard for training or placement of the NCM, they may operate in Hospital and/or Primary Care within the same autonomous community[3].

Evaluations of the NCM role indicate that it is a type of practice with resoluteness and positive impacts on health systems and individuals with complex chronic conditions. It is configured as a matrix-based practice, with transversal action across care levels, mobilizing the various health resources of a given territory[3,4].

The term case management is adopted from experiences in countries such as the United Kingdom, the United States, and Canada (case management) and has been developed since the 1960s, initially in mental health[4,6], and later in other areas, though without designating a specific professional category to assume the management function. The year 2002 marks the implementation in the Andalusian system of the community liaison nurse, and in 2003, the hospital one. In 2006, the Andalusian government published the Hospital Case Management Nurse Manual[8], and in 2007, the Primary Care Case Management Nurse Manual[9,10].

The Primary Care NCM targets people linked to a health center who require home care. Their goals include maintaining and improving the quality of life of all disabled or at-risk individuals and their caregivers; facilitating the improvement of home care provided by the Primary Care team, coordinating this team with the social support network, and improving coordination with other levels to ensure continuity of care[11].

The Primary Care NCM identifies their patients and caregivers based on information from Primary Care services and their teams, while the Hospital NCM conducts active searches in hospitals and receives communications from other nurses and professionals[12].

Given the above, during the postdoctoral internship of one of the co-authors to conduct advanced studies in the Spanish Health System's Primary Care (Murcia), the need arose to understand the experience of implementing the NCM model. Thus, based on this report, we aim to contribute to building a proposal for improving older adult care in the Primary Health Care Network in Natal, Rio Grande do Norte, Brazil.

In this regard, the opportunity to develop a training course motivated us to describe the experience report of evaluating a case management course for the treatment of complex chronic patients in primary care, conducted by the coordination of the Project for the care of complex chronic patients (PCC) in Primary Care (PC) in Area I West Murcia, Murcia, Spain.

METHOD

This is an experience report obtained through training actions developed by the Coordination of the Project for the care of Complex Chronic Patients (PCC) in Primary Care (PC) in Area I West Murcia, during the case management course for the treatment of complex chronic patients in primary care, in Murcia, Spain.

The experience report (ER) concerns the recording of lived experiences, which can originate from research, teaching, and university extension projects, among others, and is characterized by coherence, consistency, and objectivity, whose main feature is the description of the intervention[1].

The training course was part of a project to implement care for complex chronic patients in Primary Health Care, in 7 pilot health centers within a health area of 14 health centers. The project primarily involves training a nurse as a complex case manager along with training the teams in these work dynamics. The course coordinator is also the project coordinator and is responsible for leading the project and its implementation.

The complex case management training course was held over 4 afternoons and 1 morning, totaling 30 hours of basic training. The execution period was from June 26, 2023, to June 30, 2023, with the overall goal of providing fundamental skills for caring for complex chronic patients and their primary caregivers through the case management methodology.

The course content included care models, case management experiences, target population detection, referral criteria, person-centered care, instruments and tools, process mapping, practical case management of primary and hospital care, and supervision.

An interview script with 21 open-ended questions was developed to evaluate the course, covering topics: Q1 – service time as a nurse, Q2 – previous experience location, Q3 – expectations regarding the NCM role, Q4 – comparison of the NCM role with previous one, Q5 – post-training feeling, Q6 – essential skills and knowledge for NCM, Q7 – challenges and obstacles, Q8 – challenge planning and overcoming, Q9 – impact of the new NCM role, Q10 – improvement in patient care and outcomes, Q11 – keys to effective collaboration, Q12 – emotions about the new NCM challenge, Q13 – strategies used to manage stress and uncertainties, Q14 – feeling of adequate support and resources for NCM, Q15 – type of additional support expected, Q16 – collaboration of professionals with NCM (doctors, social workers, and other health professionals), Q17 – continuity planning, learning, and development of the NCM role, Q18 – appreciation of NCM development opportunity, Q19 – feedback and communication in their new NCM role, Q20 – long-term goals for this new NCM role, Q21 – reflections not previously commented, proposed by the project coordination for complex chronic patient care in Primary Health Care, applied individually and anonymously via QR code access.

The interview aimed to evaluate the course results and improve care quality through critiques, suggestions, and acquired skills.

The course was exclusively for the 7 case manager nurses and the 7 social workers from the 7 pilot centers in the project, with all 7 nurses responding to the interviews, which were organized in an Excel® spreadsheet, coded, digitized, and categorized.

Data analysis used Bardin's content analysis technique[13], following steps: pre-analysis or material organization; material exploration through classification and coding or categorization, and result interpretation.

Questions Q1 and Q2 were used for characterization, and the responses to questions 3 to 21 were categorized according to frequency, classified into positive or negative responses based on each question's content, then grouped and presented in a summary table.

The ER followed the Spanish data protection law guidelines, and the information did not require ethical review submission as it was an experience report from the co-authors themselves, with the consent of the institution where the training occurred.

RESULTS

The experience gained from the NCM training in primary health care in Murcia/Spain provided contact with nursing and social service professionals. Seven nurses with an average of 27 years of service, ranging from 18 to 36 years, participated, with 3 having experience in both PC and Hospital, 2 in PC, and 2 in Hospital, denoting excellent service time and care experience in both hospital and primary care areas.

Based on the responses to questions Q3 to Q21, we obtained several positive and negative responses, and we chose to present the results of each question in the order of responses, described in Chart 1↗.

Based on the results obtained from the categorizations, we can highlight those questions 3, 4, 6, 7, 8, 10, 11, 16, 17, 20, and 21 received 100% positive responses, indicating that the respondents were aware of and satisfied with the aspects covered in the training and demonstrated a positive outlook regarding the new NCM role.

For questions 5, 9, 12, 13, 14, 15, 18, and 19, there were both positive and some negative responses. In Q9, 13, 14, 15, and 18, 14% had no responses, and in Q13, it was noted that 29% did not use any strategy. In Q12, 33% reported negative feelings such as uncertainty, anxiety, and fear (11% each). In Q19, 43% indicated that there is still no feedback, and in Q5, 57% expressed negative feelings, such as insecurity, which is perfectly understandable given that they are starting this new NCM role and all the responsibilities that come with the new competencies and skills they must develop for the program's success.

DISCUSSION

In the health and illness process of the patient, effective coordination ensures continuity of care and the activation of necessary resources for each case. The Health Service implements coordination and continuity of care through the NCM[3], presenting a challenge to identify a personal profile with emotional maturity, mediation skills, and the ability to implement reorientation processes in practice. For this, it is essential to develop advanced nursing competencies for a comprehensive approach to people with complex chronic diseases[3-12].

The case manager must ensure the quality of care by coordinating all agents involved in the patient's and caregiver's health and illness process, guaranteeing continuity of care with a collaborative, comprehensive, and multi professional advanced practice model, so that the patient remains in the community for as long as possible, with the best quality of life[3].

The NCM role has been analyzed in different recent studies[3,10,12], demonstrating that their interventions can reduce hospital admissions and readmission rates, as well as facilitate the transition to the home, ensuring that their daily activities are as comfortable as possible. In this sense, the NCM must ensure the quality of care by coordinating all agents involved in the health and illness process of the patient and caregiver to guarantee continuity of care within a collaborative advanced practice model.

Several authors explain that case management is not a profession but a method[14] that requires developing skills to work with complex problems, families with multiple needs, numerous public, private, and corporate partners, and navigating the bureaucratic system.

People eligible for case management are fragile, vulnerable, or in complex situations, with functional limitations, limited social and family resources, social isolation, need for support in daily and instrumental activities, help in managing symptoms, treatment adherence, and requiring multiple care resources from the network, as well as needing multidisciplinary and continuous care[15].

Continuous education plays an essential role in training nurse leaders, fostering changes in their activities, ensuring care quality, and continuous professional development. In their role as nurse educators, we recognize the need to develop the nurse to lead their team with clarity and assertive communication, which requires refined emotional intelligence and a commitment to continuous learning[16].

Furthermore, continuing education fosters adaptation to new care models, enhancing practices through innovative approaches. Investing in continuous education allows nurses to develop more informed and proactive leadership, contributing to the improvement of processes and the quality of their work[16].

We observe that nurses require daily motivation in performing their tasks; feedback is essential for success in their work. Nurses look forward to this action during their workday, and even if resistant at first, they can demonstrate significant adherence to guidance when it is well explained and applied[16].

Training a nurse case manager is essential, as they must be able to identify patients with chronic diseases who may experience complications and coordinate all resources during the care process[17].

Nurses' concrete actions in healthcare require knowledge, skill, and attitude to empower themselves and fulfill their role within the health team, modifying existing practices, which are still heavily centered on the biomedical model[18].

Knowledge enables the nurse to minimize the issues resulting from their patients' illness, seeking strategies to help them face challenges, enabling them to assume an active role in their treatment, and fostering connections with the entire team[19].

Nurses have the capacity to bring patients closer to their social group and family through educational actions that impact treatment quality[20,21]. This approach supports the urgent need to employ educational and preventive methodologies, focusing on health education activities, planning, monitoring, and action evaluation.

A highly effective strategy is the use of telehealth, which can play a significant role by enabling better self-management of disease and reducing hospital readmissions. In this sense, NCMs must encourage the development and implementation of nursing intervention programs and assess their effectiveness through outcome indicators[22].

The success or failure of an experience like that of the NCM may also, in part, be attributed to greater or lesser negotiation capacity and the ability to establish trust relationships. This points to a professional profile where clinical and managerial skills must necessarily be combined with conflict mediation abilities[12].

FINAL CONSIDERATIONS

The interviewed nurses had considerable years of service and care experience in both hospital and primary care, with a suitable profile for developing the role of NCM.

Most of the training participants responded positively to the questions, indicating they were well-informed and satisfied with the training content and expressed positive expectations and evaluations regarding the new NCM role in these areas.

We highlight here some negative responses post-training that deserve attention from the Project Coordination for complex chronic patient care, such as issues related to strategies for managing stress and uncertainties (29% reported not using any strategy), emotions about the new NCM challenge (with feelings of uncertainty, anxiety, and fear at 11% each), feedback and communication in the new role (43% reported that there is still no feedback), and post-training feelings (57% expressed insecurity).

We emphasize that this sense of insecurity among the participants is entirely understandable, given that they are starting this new NCM role and facing all the responsibilities that come with the new competencies and skills they need to develop to ensure the program's success.

Given these results, we can consider the nurse training experience provided by the Project Coordination in Murcia/Spain to be positive, thus serving to support the ongoing need to create and recreate a healthcare system capable of providing effective, quality responses to the health needs of the project's target population.

Our limitations in this experience report included the training duration, and it was not possible to conduct sector follow-ups. However, we reiterate the importance of investing in enhancing continuous education and professional development.

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Authors
Maria Rosario Valverde Jiménez
https://orcid.org/0009-0006-7632-3174
Ángeles García Gómez
https://orcid.org/0009-0002-0325-1318
Eulalia Salas Peña
https://orcid.org/0009-0005-1302-6685
Antonio Contreras Fernández
https://orcid.org/0009-0007-9211-8530
Maria Ángeles Hernández Corominas
https://orcid.org/0009-0006-8646-3920
Sandra Maria Solidade Gomes Simões Oliveira Torres
https://orcid.org/0000-0003-3843-4632

Corresponding Author/Autora Correspondente
Sandra Maria Solidade Gomes Simões Oliveira Torres – Municipal Government of Natal, RN, Brazil, Department of Health.
sandrasolidade@hotmail.com

Authors' contributions/Contributos dos autores
MJ: Conceptualization, data analysis, writing the original manuscript.
AG: Supervision, Writing – review and editing.
EP: Supervision, Writing – review and editing.
AF: Supervision, Writing – review and editing.
MC: Supervision, Writing – review and editing.
ST: Conceptualization, data analysis, supervision, writing – review and editing.
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Responsabilidades Éticas
Conflitos de Interesse: Os autores declararam não possuir conflitos de interesse.
Suporte Financeiro: O presente trabalho foi realizado com apoio da Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – Brasil (CAPES) – Código de Financiamento 001.
Proveniência e Revisão por Pares: Não comissionado; revisão externa por pares.

Chart 1 – Interview questions distribution according to respondents' answers. Murcia, Spain, 2024.

Interview questions	(%)	Responses
(Q3) Expectations for the NCM role	100	**Positive:** with equal percentages (14%) for: medium and long-term results as outcomes are not immediate, learning a lot, success, good, new projects, a great challenge, learning opportunity, professional and personal satisfaction, excellent care, and being a leader.
(Q4) Comparison of the NCM role with previous roles	100	**Positive:** viewing the patient holistically (43%), coordination and management of patient care (29%), and enriching my work, my colleagues' work, and comprehensive knowledge (29%).
(Q6) Essential skills and knowledge for NCM	100	**Positive:** 95% describing skills (communication, management, assertiveness, empathy, technical skills, leadership, willingness to work, social skills, resilience, and teamwork); only 5% expressed biopsychosocial knowledge.
(Q7) Challenges and obstacles	100	**Positive:** with equal percentages (14%) for: coordination and collaboration with colleagues; lack of knowledge about the nurse case manager role; availability of other professionals; time for new management; reluctance from some professionals to change; no obstacles.
(Q8) Challenge planning and overcoming	100	**Positive:** benefits of the new NCM role for patients, family, and caregivers (43%); through continuous communication and teamwork (14%); evaluating results (14%); with enthusiasm and perseverance (14%); and knowing how to act when needed (14%).
(Q10) Improvement in patient care and outcomes	100	**Positive:** they expressed positive responses, notably personalized care close to patient needs (57%), and equal percentages (14%) for communication, research, and information system organization; dialogue and consistency, resolving doubts, facilitating procedures, and continuous reassessments until patient independence; reducing admissions and multiple consultations.
(Q11) Keys to effective collaboration	100	**Positive:** notably communication among all professionals and team training (57%); and equal percentages (14%) for creating collaboration spaces, flexibility with other staff schedules, and providing correct operational information.
(Q16) Professional collaboration with NCM (doctors, social workers, and others)	100	**Positive:** good (57%), essential (29%), and only know upon starting (14%).
(Q17) Planning for continuity, learning, and development of the NCM role	100	**Positive:** emphasizing continuing education (56%); sharing group experiences and periodic meetings (22% each).
(Q20) Long-term goals for the new NCM role	100	**Positive:** notably improving patients' quality of life (36%); 29% to increase visibility for the NCM; 22% to reduce healthcare expenses by decreasing hospital admissions; 7% to know all patients and share knowledge among team members.
(Q21) Reflections not previously mentioned	100	**Positive:** most frequently "no" (86%), and 14% suggested training an additional team member as a backup.

Chart 1 – Interview questions distribution according to respondents' answers. Murcia, Spain, 2024.

Interview questions	(%)	Responses
(Q9) Impact of the new NCM role	86	**Positive:** 71% good and 14% excellent.
	14	**Negative:** 14% replied: "cannot visualize."
(Q14) Feeling of adequate support and necessary resources for NCM	86	**Positive:** yes (86%).
	14	**Negative:** no (14%).
(Q15) Type of additional support expected	86	**Positive:** most frequently 29% for nurse group support; equal percentages (14%) for more information, managerial support, and mobile technology; and 28% said current support is sufficient.
	14	**Negative:** no response (14%).
(Q18) Valuation of the NCM development opportunity	86	**Positive:** with equal percentages (14%) for addressing new aspects for improvements for users and professionals; learning communication, coordination, and nurse appreciation; professional development for future family residents; valuable project participation; improving communication skills and team interaction; learning something new.
	14	**Negative:** did not understand the question (14%).
(Q13) Strategies used to manage stress and uncertainties	71	**Positive:** most frequently evaluating obstacles (29%); equal percentages (14%) for communication strategies, reading and following protocols, stopping, relaxing, and meditation, as well as direction and team support.
	29	**Negative:** no strategies used (29%).
(Q12) Emotions about the new NCM challenge	67	**Positive:** positive feelings (45%); enthusiasm (11%), and respect (11%).
	33	**Negative:** uncertainty, anxiety, and fear, with 11% each.
(Q19) Feedback and communication in the new NCM role	57	**Positive:** equal percentages of 14% for good; legitimizing the case manager (NCM) role; team feedback is positive and valuable; interaction with the inter- and multidisciplinary team.
	43	**Negative:** no feedback yet (43%).
(Q5) Post-training feeling	43	**Positive:** equal percentages of 14% for "good, capable, and starting."
	57	**Negative:** insecure (57%).