THE ROLE OF A CASE MANAGER IN A MANAGED CARE ORGANISATION

by

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submitted in accordance with the requirements

for the degree of

MASTER OF PUBLIC HEALTH

at the

UNIVERSITY OF SOUTH AFRICA

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NOVEMBER 2010

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DECLARATION

I declare that **THE ROLE OF A CASE MANAGER IN A MANAGED CARE ORGANISATION** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before any other degree at any other institution.

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KATE MAMOKGATI KGASI   **DATE**

ACKNOWLEDGEMENTS

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ABSTRACT

The purpose of this study was to determine case managers' understanding of their role in a managed care organisation and to develop recommendations for the improvement of case management practice. Quantitative descriptive research was conducted to explore perceptions of case managers regarding their role. A self-administered questionnaire was used as a formal data collection instrument and 25 respondents participated in the study. The findings revealed that the majority of case managers know what is expected of them in their job but that they do experience some barriers. There appears to be uncertainty with quite a number of respondents regarding certain aspects of their role. Recommendations were made for improved case management practice.

KEY CONCEPTS: Perception; Case; Case manager; Role; Managed care; Managed care organisation; Case management; Quality healthcare; Medical scheme.

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1. INTRODUCTION

Traditionally, healthcare in South Africa has been funded by the government. The government is currently still the main role-player in providing and funding healthcare for the majority of South African citizens. The Constitution of South Africa, Act No 108 of 1996, section 27 (2) states that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights of people to have access to healthcare services (South Africa 2003). However, the South African government supports the role of the private sector in ensuring that objectives of equity, access and efficiency are achieved for the healthcare system as a whole. According to Van den Heever (1998:281), the public and private sectors are of equivalent size, but cover substantially different population sizes. Private healthcare delivery and funding in South Africa have undergone tremendous change and revolution over the years to meet the changing healthcare needs of the country's population. The health sector reform, which occurred in the South African healthcare delivery system, has influenced the way providers of healthcare are funded by managed care organisations, commonly known as medical aid companies.

The concept of managed care evolved from a system of health insurance companies, and was seen as a response to a healthcare structure of waste, expanding and expensive technology in the health insurance industry. Health insurance originated in 1929 in Baylor, Texas with the establishment of the forerunner of the Blue Cross Insurance Company (Rickel & Wise 2000:10). The insurance company initially catered for school teachers by providing a hospital insurance plan. However, Seymore (2001:6) points out that De Beers started the first medical scheme in 1889 for its employees in South Africa. Since then there has been a proliferation of medical schemes in South Africa and in 1967 the Medical Schemes Act was introduced to control the structure and functioning of medical schemes. The Act was amended in 1998. Soderlund and Hansl (2000: 378) support this view that South Africa has a history of over hundred years of private health insurance arrangements, with little public provision insurance. It was only in 1967 that the Medical Schemes Act recognised and regulated mutual health insurers.

Managed care is a general term that refers to any organisation that directs access to healthcare services to ensure that its clients receive a high quality of care in a cost-effective manner; a system of healthcare delivery that attempts to manage cost, quality and access to healthcare (Hagen 1999:1; Rickel & Wise 2000:2). Managed care is a method used to provide healthcare benefits by a medical scheme to its members.

Managed care was introduced in the United States of America in the 1970s as a means of controlling rising costs of healthcare. The introduction of managed care was influenced by the rising cost of healthcare where the therapist was "the sole clinical decision-maker regarding the type, frequency, and/or duration of the services provided" (Hagen 1999:1). In 1998 managed care was introduced in Shanghai, China. Kane and Turnbull (2003:43) state that one clinician said, "our recent efforts have focused on cost control and waste. We need better integration of social support and medical services. If managed care helped with that, it would be useful."

Rothberg, Magennis and Mynhart (2000:53) indicate that, during the latter part of 1995, South Africa's healthcare providers were informed by the likes of the Medical Association of South Africa (MASA), the Representative Association of Medical Schemes (RAMS) and major business entities (Anglo American, Southern Life and Sanlam) that managed care was about to transform the private sector. Managing healthcare comprises a holistic approach to a client's health problems and case management is the system through which a client's course of treatment is co-coordinated and monitored with the assistance of a case manager to ensure quality healthcare delivered in the most cost-effective way (Kongstvedt 2007:792). The aim of the study is to explore the perceptions of case managers regarding their role in a managed care organisation.

1.2 BACKGROUND TO THE PROBLEM

The objective of managed care organisations is to be involved in clinical decisions that are also cost decisions. This objective changes the role of the therapist as the sole clinical decision-maker concerning the type, frequency, and/or duration of the services provided. The decisions involved in managed care include who receive health services, what type of services are appropriate, who should deliver the service, where can the service be rendered, when can the service be rendered, and in what quantity and for how long can the service be rendered (Hagen 1999:3). According to him, the profitability for the healthcare provider/therapist is based on cost containment, rather than generating revenue, resulting in powerful cost-cutting pressures of health funders. Managed care is therefore aimed at controlling risk, containing costs and providing financial protection to members while ensuring access to quality healthcare.

1.2.1 Healthcare funding in South Africa

Healthcare in South Africa is financed through a combination of mechanisms. In 2005 for instance, allocations from general tax accounted for about 40%, private medical schemes about 45%, and out-of-pocket payments for about 15% of total healthcare financing (Akazili & Ataguba 2010:74). According to Burger (2006), there are more than 160 medical schemes in South Africa, with a total annual

contribution of about R35 billion, servicing about seven million subscribers. Medical schemes are the single largest financing intermediary. Akazili and Ataguba (2010:75) state that in 2005, private medical schemes covered less than 16% of the population but accounted for about 45% of total healthcare financing. General tax revenue, which makes up about 40% of total healthcare finance, caters for about 68% of the population who depends entirely on the public sector for all health services.

Considering that medical aid schemes fund healthcare for less than 16% of the population, managed care is therefore vital to ensure sustainability and financial protection of members belonging to medical schemes, hence alleviating the burden of funding healthcare from the side of the government.

1.2.2 The purpose of case management in managed care organisations

Managed care is a system of cost containment programs where case management is used as one of the components of managed care strategy; managed care is therefore systems-oriented (Kongstvedt 1996:274). Powell (1996:5) states that the nature of managed care dictates that healthcare services be limited; it is economics-driven. Powell (1996:5) goes on to comment on case management that it involves "the process of getting the right service for the right client; healthcare service delivery process where goals are to provide quality healthcare, decrease fragmentation, enhance the client's quality of life, and

contain costs; a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes."

Case management involves developing systems to identify and manage high-risk and high-cost cases from day one. High-risk cases include admissions related to the following: cancer, acquired immunodeficiency syndrome (AIDS), cerebral vascular incidences, organ transplants, head injuries, severe burns, high-risk pregnancies, high-risk neonates, spinal cord injuries and neuromuscular diseases. High-risk cases have increased potential of medical complications and prolonged hospital stay (Kongstvedt 1996:274). High-cost cases are cases with potential high-cost implications to the managed care company; these are cases that cost more than R100 000 per hospital admission (criterion at the selected medical scheme). High-risk cases can also be high-cost cases.

The role of case managers go beyond containing costs to guiding and improving the morale of the patients by providing direct communication and personal attention, thus helping patients return to work quicker, and help eliminate repeated hospital admissions (Kongstvedt 1996:275). He further explains that case managers are coordinators of care, problem-solvers, facilitators, impartial advocates, and educators. They are professional collaborators with physicians

and negotiators with durable medical equipment providers, home healthcare agencies, therapists, and many other providers.

However, the case management process, which includes correct assessment, planning, implementation and evaluation of the healthcare needs of members and the making of appropriate funding decisions, should be designed to promote quality of care and should contain costs around all lines of medical approach within a managed care organisation (Cesta, Tahan & Fink 1998:37; Kongstvedt 1996:275).

1.3 PROBLEM STATEMENT

Managed care organisations are experiencing legislative and financial changes on a regular basis. The success of managed care organisations thus depends on case management processes within the organisation. In South Africa managed care organisations employ nurses as case managers to meet the objectives of containing healthcare costs while ensuring that quality healthcare is provided to members of medical schemes. The researcher observed that case managers come across problems in managed care organisations due to the following reasons: lack of formal case management training from employers, nurses not having sufficient clinical experience after completing their studies, lack of specialised nursing experience or qualifications (e.g. intensive care nursing, theatre nursing technique, nephrology nursing), and work overload. These

factors may lead to poor work outputs as a case manager may not be able to make proper clinical decisions leading to incorrect approval and payment of certain health benefits. It is from this perspective that it became necessary to conduct research to explore the role of case managers in managed care organisations.

The following questions direct the study:

- What are the perceptions of case managers regarding their role in a managed care organisation?

- What barriers are currently being experienced in relation to effective case management?

1.4 PURPOSE OF THE STUDY

The purpose of the research was to determine case managers' understanding of their role within a managed care organisation and to develop recommendations for the improvement of case management practice.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- determine case managers' perceptions regarding their role in a managed care organisation; and

- identify the barriers experienced by case managers in relation to effective case management.

1.6 SIGNIFICANCE OF THE STUDY

Managed care organisations need to understand and support the role of case managers. Case managers are more likely to succeed in promoting quality healthcare and containing costs if employers understand and provide them with the necessary support.

The research findings may indicate how case managers perceive their role, whether they experience any barriers in the fulfilment of their role and whether they receive adequate support from their employer. Recommendations can be formulated which could result in improved case management practices thus benefiting the patients as well.

1.7 DEFINITION OF KEY CONCEPTS

Perception

Perception refers to the ability to understand the true nature of something; insight (Oxford English Dictionary 2003:621). In this study, perception refers to the

knowledge and understanding that case managers have regarding their role in a managed care organisation.

Role

A role is a person's function in a particular situation (Oxford English Dictionary 2003:723).

Case

A case is a person or their situation as a subject of medical or welfare attention (Oxford English Dictionary 2003:127). In this study, a case refers to patients or individuals admitted to specified settings like hospitals, sub-acute facilities (step-downs), and physical or mental rehabilitation centres.

Manager

A manager refers to a person responsible for supervising the use of an organisation's human and other resources to achieve its goals. The manager must identify the symptoms in any situation, diagnose the disease or cause of trouble, decide how it might be dealt with – in other words design a strategy for health - and start the treatment (Handy 1999:325; Jones & George 2003:3).

Case manager

A case manager is defined as an individual who coordinates and oversees other healthcare professionals in finding the most effective method of caring for specific persons (Griffith & White 2007:634)**.** The case manager in this research refers to a nurse employed by a managed care organisation, who manages or has previously managed patients admitted to a hospital, sub-acute (step- down) facility or a rehabilitation centre.

Organisation

An organisation can be described as a group of people and other resources that are structured in a way so as to work together in a coordinated fashion to achieve specific goals. Some organisations are business enterprises that ascribe to a profit motive (e.g. PEP stores and Pick n Pay), some are government organisations or parastatals (local authorities, ESKOM), and some are non-profit organisations like churches and trade unions (Swanepoel, Erasmus, Van Wyk & Schenk 2003:4). In this study, an organisation refers to a managed care organisation. Managed care organisations in South Africa are mainly privately owned. According to the Council for Medical Schemes [Sa], medical aid schemes are not-for-profit entities and belong to its members.

Managed care organisations

Managed care organisations (MCOs) are the predominant vehicles for the provision and payment of healthcare benefits (Wolper 2004:547). In this study, a managed care organisation refers to a medical aid scheme registered in terms of the South African Medical Schemes Act No 131 of 1998, as amended.

Medical scheme

According to the researcher, a medical scheme is a form of health insurance to cover healthcare costs. Members are expected to pay monthly contributions to the insurer in exchange for cover of medical expenses incurred by members of the medical scheme.

Managed care

Managed care refers to a set of techniques used by or on behalf of purchasers of healthcare benefits to manage healthcare costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision. The implementation of managed care strategies follows a series of other cost control measures, including insurance benefit limitations

and exclusions, prepaid health plans, prospective payment systems, and fee schedules (Powell 1996:4).

Case management

Case management refers to a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes (Kongstvedt 2007:792).

Quality healthcare

In the context of managed care, quality healthcare refers to the best outcome for the least cost, an outcome established before treatment begins, the length of treatment established before treatment begins, timely provision of services, timely transfer of patients to the most appropriate level of care and outcomes that last over time (Hagen 1999:153).

Formal training

Formal training is based on specific standards, includes learning objectives (or an extent of knowledge, skills or abilities that will be reached by learners at the end of the training), using a variety of learning methods to reach the objectives,

and then applying some form of evaluation of activities at the end of the training (McNamara [Sa]).

Informal training

Informal training is rather casual and incidental. There are no specified training goals, or ways to evaluate if the training actually accomplished set goals (McNamara [Sa]).

1.8 RESEARCH METHODOLOGY

The research methodology refers to the process and steps in the research process (Babbie & Mouton 2001:56).

1.8.1 Research design

A quantitative, descriptive research design was used within a selected managed care organisation (medical scheme). In this study, the perception of case managers regarding their role within a managed care organisation and the barriers to effective case management were explored.

1.8.2 Population and sample

The study population consisted of case managers employed in a managed care organisation. The sample included 25 case managers employed in a managed care organisation in Pretoria, South Africa. The case managers selected for the study had to be registered professional nurses in terms of the South African Nursing Act No 50 of 1978, as amended. One of the primary reasons nurses work as case managers is that nurses are specialists in holistic bio-assessment and functional health planning, and are ideally best suited as case managers. Nursing case management balances the concept of caring and quality and therefore nurses are proving themselves to be the most effective equalisers to managed care (Powell 1996:5, 7).

Convenience sampling was used as it was ideal for the study because the phenomenon under investigation was homogeneous and therefore the risk of bias minimal.

1.8.3 Ethical considerations

The researcher obtained ethical clearance from the Ethics Committee of the University of South Africa. Approval to conduct the study at the selected medical scheme was requested from the Clinical Executive Manager of the company. Ethical considerations are discussed in detail in chapter 3.

1.8.4 Data collection

A self-administered questionnaire was used as a formal instrument to collect data based on constructs of the literature review. The researcher explained to the respondents how to complete the questionnaire, the reason for the study and the nature of questions. The case managers were given the opportunity to provide their own comments regarding their experiences as case managers in a managed care organisation. The comments allowed participants to communicate their thoughts in the study.

1.8.5 Data analysis

The quantitative data collected was captured and analysed using the Statistical Package for Social Sciences (SPSS). Quantitative descriptive data analysis involves organising and summarising representative characteristics or values. The researcher was assisted by the statistician to analyse and interpret the data.

1.8.6 Measures to ensure validity and reliability

Reliability and validity of the data collection instrument will be discussed in chapter 3.

1.9 OUTLINE OF THE STUDY

Chapter 1: Orientation to the study

Chapter 2: Literature review.

Chapter 3: Research methodology

Chapter 4: Research findings

Chapter 5: Conclusions, limitations and recommendations.

1.10 CONCLUSION

This chapter discussed the background to the research study, problem statement, purpose of the study and research questions. The key concepts were defined and the research design and methodology was indicated.

The literature review will be discussed in chapter 2.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is an organised presentation of what has been published on a topic by scholars. The purpose is to convey what is currently known regarding a chosen topic of interest (Burns & Grove 2005:93). The researcher must consider three key dimensions namely, what is known about the topic, what is not known about the topic and what needs to be known about the topic (Stommel & Wills 2004:339).

This chapter introduces aspects that were explored by the researcher regarding the role of a case manager within a managed care organisation, with case management being one component of a managed care strategy.

Managed care organisations form part of a healthcare delivery system of a country and, therefore, the researcher needs to review aspects related to the healthcare system of South Africa. The literature review covers aspects on managed care, case management, the healthcare system of South Africa, health sector reform and private healthcare.

2.2 HEALTHCARE SYSTEMS

A health system is seen as an institution of 'health service delivery' to promote, protect and restore the health of individuals and populations (Van Rensburg 2004:1). A national health system includes all activities in a nation whose primary purpose is to promote, restore and maintain health. The services rendered are intended to advance health status, prevent disease, provide medical diagnosis and treatment (when prevention has failed), or rehabilitate individuals to maximum social functioning. Components of a health system are resource production, organisation of programmes, economic support, management and delivery of services (World Health Organization 2000:5).

Green (1999:94) states that countries have very different mixes of healthcare financing mechanisms as a result of various factors such as historical reasons, economic basis, international pressures and ideology.

Historical reasons: Financing systems are not easily changed and as such history plays an important role in explaining current patterns. In particular, systems set up by colonial powers often remain a dominant feature of the financing pattern.

Economic basis: Countries that have developed industrially may be more likely to have developed systems such as social health insurance, which are difficult to implement in informal economies.

International pressures: International agencies may advocate particular financing systems. For example, the World Bank favours user charges, the United Nations International Children's Education Fund (UNICEF) advocates community financing, and the International Labor Organization (ILO) prefers social insurance.

Ideology: Different ideologies may be more attuned to different financing mechanisms. In socialist medical systems, the government directly controls the financing and organisation of health services, pays providers directly, owns all facilities, guarantees equal access and bans/restricts private care (Van Rensburg 2004:14). Examples of socialist countries are Cuba and Russia; healthcare in these countries is funded and provided by the state.

South Africa is a developing country characterised by large socio-economic disparities across racial groups and regions. The socio-economic climate in South Africa needs different approaches to financing healthcare in ensuring accessible, equitable healthcare to all citizens. Van Rensburg (2004:14) explains that the South African healthcare system is classified as a free-market system. A free market has both private and public systems of healthcare services; it has facilities that are privately and state-owned, do not guarantee equal access to the general population and are highly inequitable and encourage private care for patients who are able to pay for such services. Free-market medicine is primarily based on wider free-market principles, particularly private financing by fee-for-service, private initiative and ownership, and minimal state or third-party

intervention. Such systems are characterised by a two-track system of financing and of healthcare delivery, i.e. a private track (based on individual purchasing power) and a public track (based on welfare provision).

Considering the free-market system, which does not guarantee equal access to the general population, transformation of the health system was implemented in South Africa since 1994 under the democratically elected government led by the African National Congress. Change in the health system was aimed at ensuring equitable access to quality healthcare to all citizens of South Africa. Transforming the health system had an impact on managed care organisations, with the aim of protecting members of medical schemes and making schemes sustainable.

2.3 HEALTH SECTOR REFORM IN SOUTH AFRICA

Health sector reform is sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector; aimed at greater efficiency, fairness and responsiveness to the expectations of people served by healthcare systems. Propellers of change are the rising costs of healthcare, the quest for greater equity and the search for equal distribution (Gwatkin 2001:720; Van Rensburg 2004:15).

According to Van Rensburg (2004:17), there are specific foci that are currently adopted by countries in attempts to reform their healthcare systems.

Considerable attention is being paid to the cost of healthcare, and controls over such costs are an important aspect of health policy. Preventative medical services are receiving increasing emphasis in developed countries as more attempts are being made to keep people healthy. Efforts are being made to design a more effective administration of large healthcare systems, often resulting in decentralisation or regionalisation. There is a greater demand for and increased responsiveness on the part of governments and policymakers to provide a healthcare system that meets national needs.

South Africa implemented health sector reform to comply with policies of the national government aimed at ensuring equitable access to healthcare to the country's population considering large socio-economic disparities that exist. The Constitution Act No 108 of 1996, section 27(2) states that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights of people to have access to healthcare services. Section 27(3) stipulates that no one may be refused emergency medical treatment whereas section 28(1) C states that every child has the right to basic healthcare services (South Africa 2003).

According to the Department of Health (1997), restructuring the health sector has the following aims: to unify the fragmented health services at all levels into a comprehensive and integrated national health system (NHS); reduce disparities and inequities in health service delivery and increase access to improved and

integrated services based on primary healthcare principles; to give priority to maternal, child and women's health (MCWH); and mobilise all partners, including the private sector, non-governmental organisations (NGOs) and communities in support of an integrated NHS.

2.3.1 Goals of health sector reform

The goals of health sector reform are efficiency, quality, equity, client responsiveness and sustainability (Dmytraczenko, Rao & Ashford 2003:1).

2.3.1.1 Efficiency

Efficiency evaluates the extent to which objectives are met, using minimum resources (Day & Gray 2000:414). Therefore improvements on health should be achieved at the lowest possible cost. In the 1990s, South Africa experienced whole scale transformation by restructuring the health system according to the district health system (DHS) and delivering healthcare according to the principles of primary healthcare (PHC).

The term 'district' refers to the most peripheral unit of local government and administration that has comprehensive powers and responsibilities (Walley, Wright & Hubley 2001:117). In the district health system, patients are encouraged to seek medical attention at the primary healthcare centres/clinics.

Patients can then be referred from a primary healthcare facility to a district hospital or secondary healthcare facility. Patients can only access tertiary or academic institutions upon referral by secondary/district hospitals or primary level care centres according to the criteria of medical appropriateness.

Primary healthcare is the first level of contact with individuals, the family and community, with the national health system, bringing healthcare as close as possible to where people live and work. It constitutes the first element of the continuing healthcare process (Werner & Sanders 1997:21). According to them, primary healthcare includes essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain every stage of their development in the spirit of self-reliance and self-determination.

2.3.1.2 Quality

Quality refers to appropriate and safe clinical services, adequate amenities, skilled staff, and requires essential drugs, adequate supplies and equipment to be available (Dmytraczenko et al 2003:1). Determination of the quality of health in an area can be derived from indices of unnecessary disease, unnecessary disability, and unnecessary untimely death (Wolper 2004:494). According to Day

and Gray (2000:415), quality includes the promotion of evidence-based care, review of clinical audits and skilled care for all.

Promotion of evidence-based care: This refers to the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine involves combining individual clinical expertise with the best available external clinical evidence based on systematic research (Sacket, Rosenberg, Gray, Haynes, Richardson 1996:71).

The review of clinical audits: This is necessary to maintain and improve quality. A clinical audit seeks to identify and understand clinical errors/malpractice and contributory factors, primarily with a view to improve future case management.

Skilled care for all requires increased coverage: Health systems are labour-intensive and need qualified and trained staff to provide quality healthcare.

Health professionals are urged to influence health managers to develop systems that are evidence-based. Such systems should include the use of evidence for rational purchasing, and the use of equipment and drugs that are essential for the provision of health services. Health professionals can also influence the quality of care by making sure that the provision of care conforms to national and international standards of practice.

2.3.1.3 Equity

Day and Gray (2000:415) define equity as referring to whether health services are provided 'justly' within a population. According to Green (1999:50,51), equity includes equal health, equal access to healthcare and equal utilisation of healthcare. Utilisation of healthcare is affected by the physical distance from a health facility and the cost involved when using a health facility. Cost refers to fees charged; travel to and from the facility, drug costs and loss of income as a result of time spent in attending. Other factors affecting utilisation of healthcare include attitudes of employers to absence from work; perceptions of need and of utility of healthcare; cultural constraints on the use of medical care and attitudes of health professionals.

According to World Health Organization (2000:15), financing the health system should be guaranteed and regulated to make "money follow the patient" and to ensure access to the poor. The South African Department of Health (2006) indicates that health districts were set up across South Africa. Since 1994 more than 1 300 clinics and health centres were built and upgraded to enable people to gain access to healthcare across the country. In 1996 fees for first-level care were scrapped to ensure access to health care by the poorest.

2.3.1.4 Client responsiveness

According to South Africa (2003), the South African government contains that the health system should meet people's expectations and protects their rights, including their rights to individual dignity, privacy, autonomy in decision-making, and choice of provider. Responsiveness is considered a social goal and is attributed to the legitimate goals of the population comprising two components, namely respect for persons and client orientation.

Respect for persons includes respect for dignity, respect for individual autonomy and respect for confidentiality.

Respect for dignity entails the interaction of providers with individuals and should be done with courtesy considering one's culture, values and beliefs.

Respect for individual autonomy includes the fact that a health service may not be provided to a user without the user's consent.

Respect for confidentiality includes all information concerning a user; information relating to his or her health status, treatment or stay in a health establishment is confidential.

Client orientation is emphasised in the Batho-Pele Principles according to the Department of Public Service and Administration (1997) by the following concepts:

Prompt attention to health needs – urgent attention to a health need or problem may lead to better outcomes.

Basic amenities – includes provision of a therapeutic environment that promotes and facilitates healing.

Access to social support networks for individuals receiving care – according to the Alma-Ata declaration, health should be made accessible to all.

Choice of institutions and individuals providing care – individuals may want to select the provider of their choice.

2.3.1.5   Sustainability

Sustainability is the ability or prospect to continue, prolong, and keep something up (Day & Gray 2000:414). Developed countries, like the United States of America, have a relatively higher per capita income and gross domestic products values. These enable developed countries to spend more on health for preventative and curative services thus providing better overall health status and improved quality of life for their citizens. In developing countries like South Africa, per capita income is less and health spending from the government is more as the majority of the population are not able to afford health insurance and payment for health services due to poverty and unemployment.

Economic factors determine expenditure on medicines, equipment, and investment in scientific research. Economic factors also affect the ability of countries to generate and provide resources (human and physical), including

distribution, financing and remuneration thereof, and the sustainability of the healthcare system (Van Rensburg 2004:6).

2.4 PRIVATE HEALTHCARE IN SOUTH AFRICA

According to Arnquist (2006), about seven million people in this nation of 47 million have private insurance, entitling them to use a system of private doctors and hospitals that is considered on par in quality with Western nations. The rest, including most of the estimated five million people infected with the HIV/AIDS virus, are stuck with the public system of hospitals and clinics, which are mostly under funded and overwhelmed. Burger (2006) is of the opinion that there are more than 160 medical schemes in South Africa, with a total annual contribution of about R35 billion, servicing about seven million subscribers.

Private healthcare consumers in South Africa are usually subscribers to medical schemes (Seymore 2001:34). The Council for Medical Schemes regulates the private medical aid scheme industry in terms of the Medical Schemes Act No 131 of 1998. The council is funded mainly through levies on the industry in terms of the Council for Medical Schemes Levies Act No 58 of 2000 (Burger 2008).

The Medical Schemes Act 131 of 1998 aims to protect the interests of members of medical schemes by setting out guidelines on terms and conditions for the membership of schemes (Van Rensburg 2004:1). The purpose of the Act is to

prevent unfair discrimination of members in terms of age, race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health. Managed care organisations operate by charging members a predetermined monthly fee that covers a defined, comprehensive set of services (Wright & Carrese 2001:71). Financial contributions paid by members of a scheme are mainly dependent on the member's income, dependants and plan type. Medical schemes are however obliged to charge a flat rate called community rating. Contributions paid by members of the scheme serve as a form of guarantee of payment for certain health benefits covered by the medical scheme or health insurance. The Act stipulates that premiums must be based only on income and/or the number of dependants, and not on any other grounds, such as age, gender or medical history of an applicant.

The Medical Schemes Act makes provision for minimum benefits that medical schemes are obliged to cover. The minimum benefits covered in terms of the Act are called prescribed minimum benefits (PMBs), and were not previously covered by the medical schemes (Van Rensburg 2004:122). According to the Council for Medical Schemes [Sa], PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of any emergency medical condition, a limited set of 270 PMB medical conditions (defined in the Diagnosis Treatment Pairs) and 25 chronic conditions (defined in the Chronic Disease List). The Chronic Disease List includes Diabetes Mellitus, Hypertension, HIV/AIDS, Bipolar Mood Disorder and Asthma. Medical schemes have been expected to provide cover for PMBs

since 1 January 2000. PMBs were introduced to curb "dumping" of medical scheme members when medical benefits were exhausted to the state health sector, which is under-funded and under-resourced.

The medical scheme industry believes that in trying to conform, some schemes will go out of business, some will merge with others, and some will have to charge much higher premiums from their members (Seymore 2001:35). In 2006, there were about 160 medical schemes in South Africa but these have since decreased to about 124 medical schemes servicing approximately seven million people (Burger 2008). The reduction in the number of medical schemes is attributed to the effect of PMBs. Laing (2009:14) reports that government policy to create fewer, bigger medical aids has resulted in the number of survivors whittling down to 112 listed on the website of the industry regulator, the Council for Medical Schemes. The consolidation of the industry has been driven by the Medical Schemes Act over the past decade. Forcing smaller agencies into the arms of fewer bigger players will reduce the risks, according to legislation architects.

Since 1994, the agenda for the South African government in the African National Congress's (ANC's) National Health Plan, is the need for a National Health Insurance Plan. The government of South Africa acknowledges that even though medical schemes are regulated, costs in the industry have escalated in recent years. There are many reasons for the rising cost of medical care. Malpractice premiums and defensive medicine, administrative overheads, expensive

technology, unproved therapy, unrealistic patient expectations and excessive drug costs all contribute to the problem (Baldor 1998:3).

The need for the implementation of the National Health Insurance System (NHIS) was affirmed at the ANC National Policy Conference held at Gallagher Estate from 27 – 30 June 2007 and again in Polokwane in December of the same year (Akazili & Ataguba 2010:75; Shisana [Sa]). According to Akazili and Ataguba (2010:75), the South African ruling party committed itself to the establishment of a national health insurance (NHI) system, largely due to concerns about the challenges of the South African health system (within both the public and private sectors). It reflects growing concerns for the poor who sometimes cannot utilise health services due to high costs (not only of health services but also transport to access services), employees complaining about the escalating contributions to medical schemes, and failed attempts in the past to establish such similar schemes.

Compulsory or mandatory contribution towards the NHIS would ensure that the entire population is covered. The financial contribution would come from employers, employees, and the self-employed. Cover would be comprehensive in that people would have access to comprehensive healthcare (private and public) services regardless of employment status (Shisana [Sa]). However, the practical plan and implementation of the NHIS is not currently clearly stated.

2.5 MANAGED CARE

Managed care did not develop in isolation. It has been greatly influenced by the history of the development of the healthcare delivery system and its problems and changes (Finkelman 2001:51).

2.5.1 History of managed care

The roots of managed care development can be found as far back as the 1920s. Development of managed care is one of "drama, effort, pain, and success" (Finkelman 2001:52). One example of an early system of managed care originated in Elk City, Oklahoma in 1929, where rural farmers formed a community organisation to offer healthcare to the members at discounted rates. An annual dues schedule covered costs of medical care. Similarly in 1929, two Los Angeles physicians entered into a prepaid contract to provide comprehensive health service to 2000 employees of the Water Company (Rickel & Wise 2000:10).

Managed care had humble origins and struggled to survive in its early years. To some extent it still struggles today, as evidenced by the controversies, mostly at the state level, surrounding "any willing provider" legislation and other legislative proposals that constrain the development of managed care (Kongstvedt 1997:4).

The managed care evolution developed in two phases, the traditional and present phase. The traditional phase was characterised by services that were mainly paid for by insurers for services rendered by providers. Healthcare costs incurred in or out of hospital were largely covered by the medical aid or health insurer. This led to the collapse of most medical schemes as the method was neither profitable nor sustainable.

Historically, plans were kept simple in an effort to ease explanation to members. More economically sophisticated plans took the tiered plan one step further, implementing percentage co-payments in an effort to drive clinically equivalent but more cost-effective therapies (Walker 2004:369). The present phase requires some form of prepayment from members of medical aid schemes when receiving health services. The present phase was stimulated by the problems encountered in the traditional phase. Members are expected to pay for certain healthcare costs out of their own pockets. Limits may be attached to certain benefits. For example, limits may apply for prosthetic devices used in major surgical procedures like hip replacements resulting in co-payments for health services by members; or medical aid schemes can enter into contractual agreements with certain providers like pharmacies, which charge reduced or recommended rates, thus leaving members with additional fees to pay if they use providers that charge more than the recommended tariffs.

2.5.2 Goals of managed care

The introduction of managed care was influenced by the rising cost of health where the therapist was the sole clinical decision-maker regarding the type, frequency, and/or duration of the services provided. Managed care was the natural response to a healthcare system of waste and expanding expensive technology (Hagen 1999:1; Powell 1996:3). Managed care was introduced as a means to control the rising costs of healthcare. The aim was for managed care organisations to be involved in clinical decisions that are also cost decisions. Hagen (1999:3) indicates that decisions have to be made on who receive health services, what type of services are appropriate, who should deliver the service, where can the service be rendered, when can the service be rendered, and in what quantity and for how long can the service be rendered. This prevents the therapist from being the sole decision-maker.

Managed care has focused primarily on cost containment, secondarily on quality improvement, and has essentially avoided the issue of expanding access to health coverage for the uninsured and underinsured. Managed care holds great promise for those who have healthcare coverage (Gervais, Priester, Vawter, Otte & Solberg, 1999:4).

Hagen (1999:5) agrees that the goal of managed care is cost containment and quality enhancement. According to him, quality retains the focus on functional

independence but adds three new dimensions: (1) outcome durability, (2) prevention of rehospitalisation, and (3) cost of care. The three dimensions mean that the therapist is responsible for ensuring the best possible client recovery, produce results that reduce or prevent the need for future services, and to use minimum resources at the lowest cost.

2.5.3 Managed care ethical principles

Ethics refers to the discipline that examines what is good conduct, the moral standards of a society, and what, all things considered, we should do in a particular situation or when faced with a decision (Novick, Morrow & Mays 2008:150). Modern ethical behaviour, largely embodied in the Hippocratic Oath, is threefold: pursuing truth; providing information to allow individuals to make rational, important decisions about the course of their lives; and giving them the means to do so (Wolper 2004:586).

According to Epstein and Aldredge (2000:7), managed care organisations are based on the following ethical principles:

Equality of access: Managed care physicians should be consistent decision-makers, making the same decisions for individual patients as for group patients.

The doctor-patient relationship should be non-adversarial even when contractually based: Physicians will advocate for the patients and the patients will trust their physicians to work with them within the system.

Quality assurance and utilisation management are educational and confidential: These are done to promote quality of care rather than punish patients or physicians.

2.5.4 Managed care systems

Managed care systems vary widely in the degree in which they exert control over members and the utilisation of healthcare services. Different types of managed care systems exist:

Preferred provider organisations (PPOs) are a group of healthcare providers (which may include both physicians and hospitals) that contract with employers, insurance carriers, or the government to provide services. A PPO is paid on a basis of discounted rates (Hagen 1999:6). PPOs are entities through which employer health benefit plans and health insurance carriers contract to purchase health- care services for covered beneficiaries from a selected group of participating providers (Kongstvedt 1996:35). In South Africa, medical schemes routinely have contracts with different hospitals to provide healthcare to the scheme members. The hospitals and medical schemes agree on terms for covering health care expenses incurred by the schemes' members at hospitals.

Indemnity insurance plans are the traditional insurance plans where the insurer pays 80% of health services rendered and the member incurs 20% (Hagen 1999:6). Indemnity health insurance consists of an employer-paid premium to an

insurance company, who then reimburses providers on a fee-for-service basis. The indemnity plans usually reimburse the individual only a percentage of the incurred charge, typically 80% (Rickel & Wise 2000:33).

Health maintenance organisations (HMOs) are organised systems that provide a defined and comprehensive set of basic and supplemental health maintenance and treatment services (Hagen 1999:6). According to Kongstvedt (1996:34), an HMO can be viewed as a combination of a health insurer and a healthcare delivery system. Healthcare services are provided to covered members by affiliated healthcare providers. Most medical schemes in South Africa are contracted to Primecure. Primecure provides certain health services as contractually agreed between medical schemes and Primecure. Healthcare services are then provided through a network of doctors, mainly general practitioners contracted to Primecure. The general practitioner works as a single point of entry (gatekeeper) and refers members to a specialist, when necessary. Kalish (1998:96) states that compared with HMOs, PPOs offer less restricted access to physicians, less interference with practitioner practice patterns and provide more flexible benefits structure for payers.

2.5.5 Managed care role

The managed care role involves three components namely, managing health-care cost, managing care and managing health (Hagen 1999:2).

2.5.5.1 Managing cost/cost containment

Managing cost refers to managing risk, managing provider and supplier prices and managing utilisation of services.

Managing insurance risk involves benefit design (what services will be covered), underwriting policies (who will be covered under what terms and conditions), product pricing and a marketing strategy.

Managing provider and supplier prices is accomplished by developing networks of providers, negotiating for price discounts and rebates (often in exchange for promises of increased numbers of patients), and adopting drug formularies or preferred drug lists based on price discounts.

Managing utilisation of services is accomplished by the use of techniques such as prior authorisation of services, concurrent review, provider financial incentives, and consumer cost cutting (Hagen 1999:6).

2.5.5.2 Managing care

Managing care refers to the development and implementation of community-wide practice guidelines or protocols by a managed care organisation. Robinson and Steiner (1998:17) indicate that protocols designed should be evidence-based, aimed at prevention and treatment of certain health conditions, and also monitoring and evaluating health outcomes. According to Cesta et al (1998:39), protocols include the care pathways for management of the following:

(1) Acute cases like severe motor vehicle accidents or a very premature newborn. (2) Case management programmes to coordinate care of patients with high risk and high cost implications to improve continuity of care. High-cost cases are those catastrophic cases that exceed routine costs. High-risk cases are medically complex related to multisystem involvement, medical complications, repeated hospitalisations, the risk of a lengthy hospital stay and chronic illness. (3) Disease management programmes to manage cases before, during and after the onset of chronic conditions, potentially shifting utilisation of resources from institutional to outpatient care should be evidence-based, not compromising quality healthcare.

2.5.5.3 Managing health

Managing health refers to the holistic approach to management of a client's health problem. Population-based interventions, including risk assessment, outreach, interventions (counselling, education, and behavioural and environmental modifications), monitoring, evaluation and follow-up are vital to ensure proper diagnosis and appropriate benefit decision by the medical aid scheme (Cohen & Cesta 2005:288).

2.6 CASE MANAGEMENT

2.6.1 History of case management

Case management is an old concept reborn. Aspects of case management were seen in attempts to care for the poor during the late 1800s. Case management has also been used in the insurance industry and in the management of the care of deinstitutionalised mentally ill and developmentally disabled persons (Cohen & Cesta 2005:79). According to Robinson and Steiner (1998:25), case management resembles gate-keeping in the sense that the patient or client has a single point of entry to the system, and that the entry point is via a person who will be responsible for both coordinating and rationing care. Cohen and Cesta (2005:79) state that case management development in healthcare was largely a nursing-driven process initiated to support "cost-effective, patient-outcome-oriented care".

Nursing case management, which began as a community-based model in the early 1900s and was adapted for acute care in the mid-1980s, is considered an outgrowth of primary nursing and allows for quality outcomes-focused care while containing costs (Cohen & Cesta 2005:7). Nursing case management is a collaborative process that focuses on coordination, integration, direct delivery of patient services and places controls on resources used for care.

Case management goals typically focus on five major areas: quality of care, length of stay, resource utilisations, continuity and cost control (Finkelman 2001:127).

2.6.2 Models of case management

The managed care environment is constantly and rapidly changing due to the changes in the national healthcare system. The change in managed care led to the evolution of innovative, rich and successful models of case management. Case management models are based on principles of interdisciplinary cooperation, relationship building, active communication and comprehensive support for continued healthcare needs, client and family support (Cohen & Cesta 2001:49).

The Beth Israel Multidisciplinary Patient Care Model was developed for use within an acute care setting. The model supported the coordination of and management of patient care from admission to discharge. The objectives of the model were to improve quality of care, control resource utilisation, decrease length of stay, increase patient satisfaction and increase staff satisfaction. The model was implemented through reorganisation of the nursing department structure and provided career advancement opportunities for nurses in the United States of America (Cohen & Cesta 2001:26).

A collaborative model of case management was introduced by Vanderbilt University Medical Centre in the United States of America as a tool to ensure a competitive position in a changing managed care environment. This model postulates collaboration centrally as a process of joint decision-making among interdependent parties, involving joint ownership of decisions and collective responsibility for outcomes (Cohen & Cesta 2001:74). According to them, case management was seen as the responsibility of a triad of the nurse case manager, social worker, and utilisation manager.

The role of the nurse case manager according to the collaborative model is clinical coordination, resource utilisation, system management and evaluation/analysis, high-risk screening and discharge planning. The social worker has to provide crisis intervention (e.g. attempted suicide), psychosocial assessment, brief therapeutic interventions, high-risk screening and discharge planning. Utilisation management involves precertification (pre-approval of service), recertification, and concurrent (at the time of service provision) chart review, medical record completion in terms of billing and coding, and quality data control. Spenctor (2004:284) states that a utilisation review safeguards against unnecessary and inappropriate medical care. It allows healthcare providers to review patient care from perspectives of medical necessity, quality of care, appropriateness of decision-making, place of service and length of hospital stay.

However, as financial constraints increased, institutions had to downsize as a cost-saving measure, which resulted in the nurse case manager having to absorb aspects of utilisation, social work and discharge planning.

According to the researcher, the two models cannot be separated and, therefore, the role of the case manager within the managed care environment in South Africa is based on both models. The case manager functions as a clinical coordinator, manages resource utilisation, performs system management and evaluation/analysis, and effects high-risk screening and discharge planning. The aim is to improve quality of care, control resource utilisation, decrease length of stay and increase patient satisfaction.

2.6.3 Role of the case manager

Case managers are coordinators, intermediaries, and advocates in securing service (Kongstvedt 2007:248). The Long Island College Hospital based in Brooklyn in the United States of America, identified the case manager role as an advanced practice role, and clinical nurse specialists are, therefore, best prepared to assume additional responsibilities associated with case management. Nurse case managers are chosen for the role because of their extensive clinical experience and knowledge of patient care (Cesta et al 1998:46). According to these authors, a case manager is the coordinator and facilitator of patient care, consultant, educator, negotiator, patient and family

advocate, outcomes and quality manager, risk manager, helpful change agent, holistic care provider and counsellor. The case manager looks at the patient in a fully integrated way and is prepared to address the full spectrum of services required to meet the patient's needs from the onset of illness until discharge. Cesta et al (1998:46) explain the role of a case manager as follows:

- **The clinical expert**

The case manager should exhibit clinical competence in the assessment of patient and family needs, establish actual and potential health problems, goals for treatment and desired outcomes using the nursing process; planning, implementing, evaluating and coordinating the care and activities to meet the patient and family needs, using advanced treatment modalities and technologies.

- **Coordinator and facilitator of patient care**

The case manager in managed care organisation depends on the treating doctor or the case manager where the patient is admitted (hospital, step-down, rehabilitation facility), to provide information regarding tests and procedures to be performed on a patient. The MCO case manager should therefore ensure that tests and procedures are authorised within expected turn around time (e.g. 24 hours). This function is important in eliminating delays and discrepancies in

patient care. The process also eliminates fragmentation or duplication in the provision of patient care.

• **Consultant**

Nurse case managers, particularly those who work in ambulatory care settings, provide information telephonically, by fax or e-mail to managed care organisations regarding a patient's progress or any information that can assist in the management of the client.

• **Educator**

The role of educator is twofold – to educate the patient and family, and to educate the staff or colleagues. The case manager should ensure that benefits are explained to patients and families to avoid unnecessary claims that are not paid by the insurer. Education regarding alternative healthcare services like the provision of wound care by nurses in private practice, should be communicated to the patient and family to enable them to make informed choices.

• **Negotiator**

The case manager is expected to negotiate the best treatment options available when necessary with the treating doctor, medical advisor of the MCO and other

members of the healthcare team to ensure that the patient gets medically appropriate treatment for the condition. Nurse case managers also negotiate with step-down facilities and companies that manufacture durable medical equipment for needed patient support after discharge from hospital.

- **Patient and family advocate**

Case managers assume responsibility for liaison between patient and family and the healthcare team, making them the best vehicle through which care is advocated, negotiated, agreed on, facilitated and coordinated. Case managers also advocate for the needs and wishes of the patient and family when negotiating with facilities like step-down informing them of the patient's health care needs after discharge from hospital. The case manager should also provide information to the admitting facility regarding member's health benefits available to avoid unpaid claims by the insurer.

- **Outcomes and quality manager**

Monitoring and evaluation of patient care quality and outcomes are an integral part of the case manager's role. They are important because they link case management to quality improvement and evaluate whether the patient and organisational goals are met. The case manager should be able to gather, interpret, and use data to identify problems and trends, and to demonstrate

outcomes and cost-effectiveness. Nurse case managers are expected to communicate variances, delays and undesired outcomes so that the case management process can be revised.

- **Risk manager**

The role of case managers in assessment and monitoring the delivery of patient care activities and evaluation of patient care outcomes makes them important in identifying risk management issues and bringing them to the attention of managers and other divisions like the forensics department in a timely manner, to enable them to investigate fraudulent practices of providers or members .

- **Helpful change agent**

Case managers are expected to be champions of change in the ever-changing managed care environment. The transformation in managed healthcare is influenced by legislative amendments, different contracts between MCOs and providers, diverse benefit designs of MCOs, technological advancements and member expectations. Case managers should be able assist the computer system designers and developers regarding aspects needed to improve current systems and even develop new ones for better case management.

- **Holistic care provider**

The case managers look at the patient in a fully integrated way and is prepared to address the full spectrum of services required to meet the patient's needs both during the acute phase of illness and at discharge. They assess patients and families for any actual or potential health problems regardless of the main complaint or reason for admission. This helps case managers to identify the physical, psychological or other needs of the patient and ensuring that those needs are considered during the management of the patient.

- **Counsellor**

Case managers are astute at providing patients with emotional support, and they can provide counselling especially if a patient has a disease that requires frequent hospitalisations like cancer. They can assist the patient and family with regard to coping with the disease.

- **Researcher**

Research has been made a part of the nurse case manager's role in institutions where the required educational background of case manager is a Master's degree in Nursing. Nurse case managers help nursing departments establish research-based clinical practice, policies and procedures, and standards of care.

According to the researcher, a Master's degree in Nursing is not a prerequisite for a position as a case manager in the South African context because the majority employed have a basic diploma or degree in Nursing.

The role of a case manager is further described by Cohen and Cesta (2005:76) as follows:

- *To identify at-risk populations* for high-cost, extended length of stay, destabilisation, and repeated hospitalisation. High-risk populations include preterm babies, patients with third-degree or full-thickness burns and patients with organ failure. These admissions are associated with high-risk medical complications, prolonged hospital stay and high medical costs.

- *Coordinate resources* to ensure that the necessary services are provided at the most appropriate level of care and that there is a smooth progression of the patient throughout the system during hospitalisation. The case manager should ensure that healthcare is provided in a setting relevant to the condition. For instance, the case manager must ensure that a patient is not admitted for frail-care services (for example, bathing, feeding, turning and administration of oral medication). Frail care is commonly not a covered benefit of MCOs.

- *Initiate a discharge planning process.* The discharge process starts at or before hospital admission to provide safe and comprehensive support for the patient's continued healthcare needs. The case manager should

establish whether a patient has a proper support system (carer) at home before discharge from hospital. If no support is available, the case manager should arrange for alternative accommodation, for example, in a step-down or frail care facility at the family's own cost. This is done to promote patients' well-being and to prevent an unnecessary extended hospital stay.

- *Anticipate potential delays in the healthcare process,* and act proactively to avoid delays. Delays may be related to motivations for special requests of certain treatments/medications that are routinely not covered by the MCO. Such requests usually need the approval of the medical adviser at the MCO. The case manager should liaise with the treating doctor or hospital case manager to avail information as soon as possible to the MCO for benefit decision.

- *Identify obstacles to efficiency and good outcomes,* and intervene to overcome or eliminate these, when possible. If a patient is not responding to a particular treatment, the case manager is expected to phone the treating doctor to inquire or suggest a further management plan for the patient.

Case management is a means of achieving client wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation based on the ethical principles of autonomy and distributive justice (Coffman 2001:287).

2.6.4 Clinical case management tools

Clinical case management tools assist case managers to fulfil their roles, manage care and contain costs while ensuring quality healthcare to members. Tools for case management are managing therapy resources, managing treatment duration, managing service delivery format and managing the level of care (Hagen 1999:46). The author further explains clinical case management tools as follows:

Managing therapy resources refer to the fact that the utilisation of certain health disciplines should be absolutely necessary to achieve expected health outcomes. The services for each discipline should be provided in sequence. For example, in a patient who had a stroke, it is essential to manage a patient medically in an acute setting and when stabilised, physical rehabilitation of the patient in a rehabilitation centre can be recommended.

Managing treatment duration implies that case managers should ensure that the service provided for a particular health condition is absolutely necessary and will produce the desired health outcomes.

Managing service delivery format means that relevant and correct amounts/money should be authorised for specified services rendered aimed at achieving specific health outcomes.

Managing the level of care implies that the case manager must ensure that health services provided correlate with the level of care/setting where the patient is treated. For example, approving admission to an intensive care unit,

rehabilitation centre, out-patient facility and so forth, should correspond with the patient's health condition and should be medically necessary. Therefore, the level of care should be appropriate to achieve desired health outcomes.

Medically necessary is a term used to describe services or supplies that are appropriate and necessary for the symptoms, diagnosis, or treatment of a medical condition (Winegar & Hayter 1998:50). For instance, it is essential to monitor a patient post coronary artery bypass and Graft surgery routinely in a specialised intensive care unit for the first 24 hours post-operatively, due to the need for constant monitoring of the patient after the procedure.

Managing risk for complications requires case managers to be able to identify factors that may impede progress or cause regression from the desired health outcomes. Factors that may delay or hamper a patient's progress can be physical, psychological, life style, and/or environmental.

2.7 CONCLUSION

This chapter discussed relevant literature on the South African healthcare system, health sector reform, and the provision and financing of healthcare in South Africa. The concepts managed care, case management, and the role of case managers in a managed care organisation, were explicated.

The research design and methodology will be described in the next chapter.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The chapter describes the research design and methodology, which includes the population, sampling, instrument pre-test, validity and reliability, and the data collection and data analysis processes. The ethical considerations are also discussed in detail.

3.2 PURPOSE OF THE STUDY

The purpose of a research study is generated from the problem, identifies the goal or goals of the study, and directs the development of the study. In the research process, the purpose is usually stated after the problem, because the problem identifies the gap in knowledge in a selected area and the purpose clarifies the knowledge to be generated by a study (Burns & Grove 2005:80). Polit and Beck (2004:74) state that the specific purpose of nursing research includes identification, description, exploration, explanation, prediction and control.

The purpose of the study was to determine case managers' understanding of their role within a managed care organisation and to develop recommendations for improvement of case management practice. The objectives of this research were to:

- determine case managers' perceptions regarding their role in a managed care organisation; and

- identify the barriers experienced by case managers in relation to effective case management.

3.3 RESEARCH DESIGN

A research design is a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings; a plan according to which research must be carried out. It specifies what observations to make (which variables to focus on), how to make them (which measurement procedures to adopt), and when to make them (Burns & Grove 2005:211; Stommel & Wills 2004:32). A quantitative descriptive approach was followed. The research design guided the researcher to plan and implement the study in a manner that would enable the achievement of the objectives.

Quantitative research is a formal, objective, systematic process to describe and test relationships and to examine cause-and-effect interactions among variables (Burns & Grove 2005:747). The researcher used a quantitative design to collect

data systematically and objectively, to be able to analyse and present data using statistical data analysis methods.

A *descriptive design* may be used for the purpose of developing a theory, identifying problems with current practice, justifying current practice, making judgements, or determining what others in similar situations are doing (Burns & Grove 2005:232). A descriptive design was selected because it involves the identification of a phenomenon of interest and of the variables within the phenomenon, development of conceptual and operational definitions of the variables, and description of variables. The description of variables leads to an interpretation of the theoretical meaning of the findings and provides knowledge of the variables and study population (Burns & Grove 2005:232). A self-administered questionnaire was used as data collection instrument to gather information regarding the role of case managers within a managed care organisation. The data collected was used to identify and validate current case management practices and to make recommendations for improving current practices.

3.4 RESEARCH METHODOLOGY

Research methodology refers to the methods used to conduct the research, the steps, procedures and strategies for gathering and analysing the data (Polit & Beck 2008:758).

3.4.1 Population and sample

Katzenellenbogen, Joubert and Abdool Karim (2002:74) define population as the group you want to gather information from and make conclusions about. Population is the entire set of individuals (or objects) having some form of common characteristics (Polit & Beck 2004:727). The study population consisted of case managers employed in a medical scheme based in Pretoria, Gauteng province.

The sample denotes the selected group of people or elements included in a study, a subset of population, selected to participate in a study (Burns & Grove 2005:341; Polit & Beck 2004:731). The participants were case managers employed in a selected medical scheme situated in Pretoria. The participants had to meet the following criteria to be included in the sample;

1. Case managers selected for the study were professional nurses in terms of the South African Nursing Act No 50 of 1978, as amended.

2. The participants were case managers who had experience in managing patients admitted to private and state hospitals, step-down facilities and rehabilitation centres (physical and mental).

Convenience sampling was used because the phenomenon under investigation was homogeneous and therefore the risk of bias minimal. Convenience sampling is the selection of the most readily available persons as participants in the study

and they are included in the study because they happened to be in the right place at the right time (Burns & Grove 2005:727; Polit & Beck 2004:714). Case managers on leave were excluded from the study. A total of 30 case managers met the criteria set to be included in this research, but only 25 participated in the study.

3.4.2 Tool construction

The researcher found no data collection instrument in the literature review that met the specific requirements of the study. The researcher developed a self-administered questionnaire based on the role of a case manager according to the literature review. The researcher ensured that questions were clear, simple and self-explanatory for easy completion by respondents. The questionnaire consisted of three sections. Section 1 comprised demographic data. A checklist (nominal measurement level) was used in this section; respondents were requested to tick the applicable boxes. Burns and Grove (2005:372) state that the nominal-scale measurement is used when data can be organised into categories of a defined property, but the categories cannot be ordered.

Section 2 focused on the respondents' perception of a case manager's role in a managed care organisation. Section 2 was divided into five dimensions namely; perception of own skill and knowledge, role within managed care organisation, awareness regarding case management tools, relationship with direct supervisor

and the role of the employer. In this section, a Likert-type scale was used and a numerical value was allocated to each category. The items were rated as follows; **1 = agree, 2 = neither agree nor disagree, 3 = disagree.** The Likert-type scale is designed to determine the opinion or attitude of a subject and contains a number of declarative statements with a scale after each statement (Burns & Grove 2005:402).

Section 3 contained open-ended questions in which the case managers were requested to provide their own comments regarding the following: Perception of own skills and knowledge, role within a managed care organisation, awareness regarding case management tools, relationship with direct supervisor, role of employer. They also had the opportunity to comment on other issues not highlighted in the questionnaire.The aim of section 3 was to allow respondents to communicate their thoughts and experiences as case managers in a managed care organisation. According to Burns and Grove (2005:398), a questionnaire is a printed self-report form, designed to elicit information that can be obtained through the written responses of the subject. Stommel and Wills (2004:256) state that self-administered questionnaires do not involve an interviewer, but rely on the respondent to provide written responses.

A disadvantage of written questionnaires is that misunderstandings are difficult to correct. Respondents completed self-administered questionnaires as requested and the questionnaires were then individually collected by the researcher.

3.4.3 Measures to ensure reliability and validity

Reliability implies that a measure is reliable if it gives the same result each time the same situation or factor is measured, and a measurement procedure is considered valid if it measures the characteristics or attributes that it is intended to measure. Reliability of a data collection instrument entails that it should have stability, measure accurately; give consistent results and that all items are to measure the same variable (Burns & Grove 2005:215; Stommel & Wills 2004:222). The researcher ensured the reliability of the measurement instrument. All questionnaires were distributed under the same conditions, on the same day and the researcher explained to the participants how to complete the questionnaire. To minimise data collector bias, the researcher was the only one who administered the questionnaire and who explained to respondents how to complete the questionnaires. The questions were clear, simple and self-explanatory for easy completion by respondents. The questionnaires were distributed personally by the researcher to the respondents to ensure consistency.

Validity is the degree to which an instrument measures what it is supposed to measure (Polit & Beck 2004:422). Questions on various aspects of case management based on an extensive literature review were included in the questionnaire to ensure content validity. The questionnaire was pre-tested by experts in case management to ascertain content validity.

Polit and Beck (2004:424) state that content validity is the degree to which an instrument has an appropriate sample of items for the construct being measured.

3.4.4 Pre-testing the questionnaire

Pre-testing is the collection of data prior to the experimental intervention, involving the feasibility of using a given instrument in a formal study (Brink & Wood 1998:259; Polit & Beck 2004:728). The researcher pre-tested the questionnaire on four case managers employed at a selected medical scheme. The four case managers were not part of the main sample for data collection. The purpose of pre-testing the questionnaire was to identify problems and determine the reliability and validity of the questionnaire. The researcher initially proposed that questionnaires would be collected from a divisional head in the case management department. During the pre-testing of the questionnaire, the case managers raised concern about confidentiality and the researcher decided to collect questionnaires directly from the participants. Questions were clear and understood by participants. No changes were made to the questionnaire and thus questions included in the pre-testing phase were the same to the questionnaire used in the final stage of data collection.

3.4.5 Data collection process

Data collection refers to the gathering of all information that is relevant to the research questions or hypotheses (Stommel & Wills 2004:362). Burns and Grove (2005:732) define data collection as precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypotheses of a study.

The researcher used a self-administered questionnaire as data collection instrument to obtain accurate information regarding the perception of case managers regarding their role within a managed care organisation. The researcher explained the reason for the study, how to complete the questionnaire and the nature of the questions to the participants and the participants' anonymity was guaranteed. The explanation to the participants was done in groups of five at their work stations to avoid interruption of routine. The participants were asked to complete questionnaires in their own time. The researcher explained the types of questions included in the questionnaire according to the different sections. The researcher distributed 30 questionnaires to the respondents individually. Only 25 were completed and returned. Respondents were notified that the researcher would collect questionnaires individually from them, once completed, to ensure confidentiality. The data obtained was used to assess current case management practices within a

managed care organisation, identify barriers to effective case management and make recommendations for future improvements.

3.4.6 Data analysis

Data analysis is conducted to reduce, organise, and give meaning to data; it is the systematic organisation and synthesis of research data, and the testing of research hypotheses using those data (Burns & Grove 2005:733; Polit & Beck 2004:716). Descriptive data analysis involves organising, and summarising representative characteristics or values. When interpretation was done, the responses in section 2 were given averages as follows; **below 1.5 = disagree, 1.5 to 2.4 = neither agree nor disagree, above 2.5 = agree.** Section 2.2 was divided into subsections for better reporting. The data collected was captured and analysed using the Statistical Package for Social Sciences (SPSS).

The statistician assisted the researcher to code and summarise data from the open-ended questions in section 3. This enabled the researcher to extract the core meaning from the information provided by the respondents.

3.5 ETHICAL CONSIDERATIONS

In research, researchers' paramount responsibility is to informants. When there is conflict of interest, these informants, as individuals, must come first. Researchers must do everything in their power to protect the physical, social, and psychological welfare, and to honour the dignity and privacy of those studied (Van der Wal 2006). Burns and Grove (2005:735) indicate that ethical rigour requires recognition and discussion by the researcher of the ethical implications related to the conduct of a study.

Approval to conduct the study: Ethical clearance was received in writing from the Research and Ethics Committee of the Department of Health Studies, University of South Africa (see annexure A). Permission was obtained in writing from the Clinical Executive Manager of the medical scheme based in Pretoria (see annexure C).

Informed consent: Consent from the case managers who participated in the study was obtained in writing. Informed consent describes the nature of the research project, as well as the nature of one's participation in it (Leedy & Ormrod 2005:102). The purpose of the research was explained by the researcher. Participants were informed that participation is voluntary and they had the right to withdraw from the study at any time.

Confidentiality: Burns and Grove (2005:731) state, confidentiality is the management of private data in research so that participants' identities are not linked with their responses. The researcher ensured confidentiality during the study by not revealing the participants' identities when reporting the research findings. The researcher only numbered the questionnaires after data was collected.

Anonymity: According to Stommel and Wills (2004:382), anonymity means that the researcher has no way to link the identifying information of study participants. Participants were informed that they would not be asked to write their names when completing the questionnaires.

3.6 CONCLUSION

This chapter described the research design, research methodology and ethical considerations. The next chapter discusses the research findings.

CHAPTER 4

Research findings and discussion

4.1 INTRODUCTION

This chapter presents the research findings. A self-administered questionnaire was completed by a total of 25 case managers in a selected managed care organisation. The findings are presented in categories, namely perception of own skills and knowledge, role within managed care organisation, awareness regarding case management tools, relationship with direct supervisor and role of the employer. The research objectives were to:

- determine case managers' perceptions regarding their role in a managed care organisation; and

- identify the barriers experienced by case managers in relation to effective case management.

4.2 DEMOGRAPHIC DETAIL

A total of 25 respondents out of an intended target of 30 participated in the survey giving a response rate of 83%. There was only one male who participated, that is, 4% of the sample. Thus 96% of the respondents were female. The disparity in gender equity may be attributed to the fact that nursing is a female- dominated field. The age distribution indicated in figure 4.1 shows that the majority of the respondents are middle-aged.

26%   22%

52%

☐ 25 – 34 years

☐ 35 – 44 years

☐ 45 – 54 years
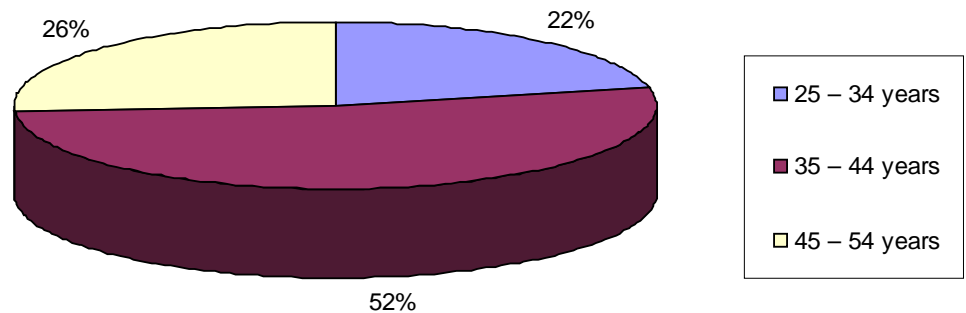
Figure 4.1 Age range in years (N = 25)

Most of the case managers are professionally mature and thus were able to give reliable information.

The following table displays the educational qualifications of the respondents:

Table 4.1 Respondents' educational qualifications (N = 25)

Qualification	Percentage
Diploma as a nurse (General, Psychiatric, Community and Midwifery)	40% (n = 10)
Diploma in general nursing	32% (n = 8)
Diploma in general nursing & midwifery	20% (n = 5)
Post-basic courses	12% (n = 3)
Other	12% (n = 3)
Degree as a nurse (General, Psychiatric, Community and Midwifery)	8% (n = 2)

Respondents had to indicate what post-basic qualifications in nursing they had. It can be observed that most of the respondents have diplomas in the nursing field. Other qualifications given which were related to nursing were the following:

- ➢ Degree in nursing education and community nursing science
- ➢ Degree in nursing administration/management
- ➢ Diploma in community nursing science
- ➢ Diploma in nursing education
- ➢ HIV management course
- ➢ Diploma in critical care nursing
- ➢ Diploma in occupational health nursing
- ➢ Diploma in theatre nursing

A total of 76% of the case managers had more than 5 years' experience in managed care, thus only 24% had less than 5 years' experience as shown in figure 4.2.

8%   8%
16%

☐ 2 years and below
■ 3 - 4 years
☐ 5 - 10 years
☐ Above 10 years

68%
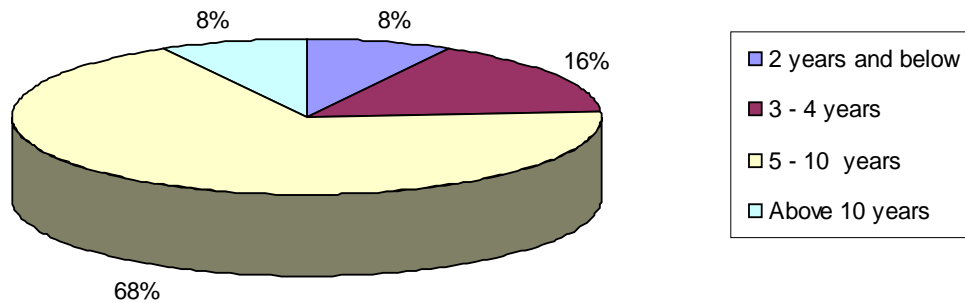
Figure 4.2 Number of years in managed care (N = 25)

A total of 84% of respondents had at least 5 years' prior experience as a nurse, whilst only 16% had less than 5 years.

16%

44%

☐ 3 - 4 years
■ 5 - 10 years
☐ Above 10 years

40%
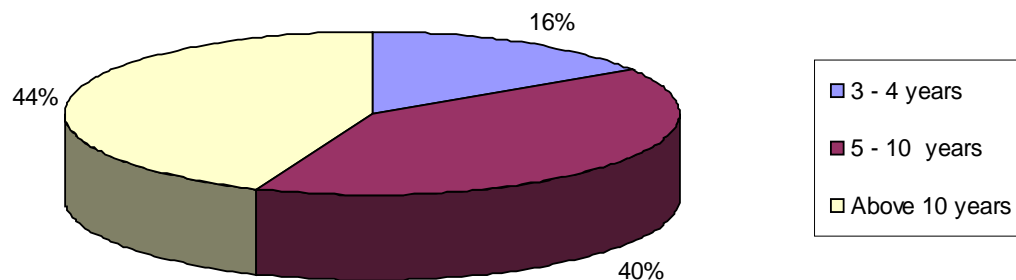
Figure 4.3 Previous years experience as a nurse (N = 25)

The majority of respondents were therefore able to comment about case management since they had a lot of experience as nurses and also in managed care.

4.3 PERCEPTIONS REGARDING THE ROLE OF A CASE MANAGER IN MANAGED CARE ORGANISATION

A total of 25 respondents completed the questionnaire, but one of them did not answer all the questions as will be reflected in the tables which follow. When interpretation of data was done, the responses were given averages as follows; **below 1.5 = disagree, 1.5 to 2.4 = neither agree nor disagree, above 2.5 = agree.** An aspect with the highest percentage was ranked first whereas the least rated item was allocated last position.

4.3.1 Perceptions of own skills and knowledge

The respondents were asked to comment on the following aspects with regard to skills and knowledge.

Table 4.2 Case managers' perceptions of own skills and knowledge (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.1.8) I know what is expected of me as a case manager	91.7 (n=22)	4.2 (n=1)	4.2 (n=1)	2.88	1
(Q2.1.2) Specialised nursing experience is beneficial	88 (n=22)	8 (n=2)	4 (n=1)	2.84	2
(Q2.1.1) A basic nursing qualification is necessary	76 (n=19)	16 (n=4)	8 (n=2)	2.68	3
(Q2.1.6) Formal training as a case manager is necessary	69.6 (n=16)	17.4 (n=4)	13 (n=3)	2.57	4
(Q2.1.5) I received informal training	64 (n=16)	8 (n=2)	28 (n=7)	2.36	5
(Q2.1.3) A post basic nursing qualification is beneficial	56 (n=14)	28 (n=7)	16 (n=4)	2.40	6
(Q2.1.7) Informal training as a case manager is necessary	39.1 (n=9)	17.4 (n=4)	43.5 (n=10)	1.96	7
(Q2.1.4) I received formal training as a case manager	12 (n=3)	36 (n=9)	52 (n=13)	1.60	8

It can be noted that most of the respondents knew what their job entailed as supported by 91.7%, and 88% felt that specialised nursing experience was really necessary for a case manager. About 69.6% of the case managers indicated that they should have formal training in case management. However, most of them did not manage to undergo formal training, except for only 12% who did.

In terms of a basic nursing qualification, most respondents confirmed that it was the baseline for case management as supported by 76% of the respondents. Case managers obtain their case management experience on the job. It means

that for effective case management to take place, case managers should work in harmony with their supervisors since these are the people who are sometimes providing informal training to case managers.

The respondent, that is 56%, also felt that a post-basic nursing qualification was essential for case managers. From the researcher's own experience in managed care, a post basic nursing qualification or experience in areas such as Intensive Care Nursing, Nephrology Nursing and Theatre Nursing assist the case manager to manage medically complex cases and patients in specialised hospital units efficiently. However, one can conclude that case managers are in need of formal training in case management.

4.3.2 Role within managed care organisations

The respondents were asked on the part they played in the various aspects of managed care, namely assessment, planning, coordination of activities, implementation, negotiation, advocacy, monitoring and evaluation of care, communication, and involvement in case management programmes.

Section 2.2 contained 36 questions. When interpretation was done, section 2.2 was divided into subsections (indicated as sub headings and tables) for better reporting.

4.3.2.1   Clinical expert role

A clinical expert role involves the ability to assess patient and family needs, establish actual and potential health problems, goals for treatment and desired outcomes using the nursing process (Cesta et al 1998:46).

- **Assessment and planning**

The views of the respondents on assessment of patients and planning interventions were as follows:

Table 4.3 Assessment and planning (N= 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.2.1) Competent to assess patients and family needs	91.7 (n=22)	4.29 (n=1)	4.2 (n=1)	2.88	1
(Q2.2.4) Able to plan activities to meet the patient's needs	87 (n=20)	8.7 (n=2)	4.3 (n=1)	2.83	2
(Q2.2.2) Able to establish actual problems of the patient	79.2 (n=19)	16.7 (n=4)	4.2 (n=1)	2.75	3
(Q2.2.3) Able to identify potential patient problems	79.2 (n=19)	16.7 (n=4)	4.2 (n=1)	2.75	3

The majority of the case managers were able to assess a patient. A clear majority, that is 91.7%, indicated that they have the expertise needed in determining patient and family needs and 79.2% indicated they can establish

actual and potential patient problems. Thus, one can conclude that most of the respondents were able to identify the needs and problems a patient may encounter holistically. The slight incidence of disagreement and uncertainty about the role as indicated in table 4.3 needs to be addressed as all case managers should be able to assess patients properly.

Planning is one of the critical processes of case management (Cesta et al 1998:46). If the plan of a patient is not put in place, this may lead to a person staying in hospital for a long time or even sending a patient to a step-down instead of a rehabilitation facility. Improper planning may also lead to a patient incurring high costs because there was no plan of action when the person was admitted. Only 4.3% of the case managers indicated that they were not able to plan a person's activities, whilst 8.7% were unsure. There is a need to train these case managers in planning, since planning is a very critical aspect of case management.

4.3.2.2   Coordination of resources

Coordination of resources is aimed at eliminating fragmentation or duplication in the provision of patient care (Cesta et al 1998:46). The views of the respondents on coordinating resources were as follows:

Table 4.4 Coordination of resources (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.2.9) Ensure care for the patient in an appropriate setting	91.7 (n=22)	4.2 (n=1)	4.2 (n=1)	2.88	1
(Q2.2.7) Proactively establish correct clinical information	79.2 (n=19)	16.7 (n=4)	4.2 (n=1)	2.75	2
(Q2.3.1) Able to manage treatment duration according to patient's needs	78.3 (n=18)	17.4 (n=4)	4.3 (n=1)	2.72	3
(Q2.3.2) Authorise correct amounts for a specific health service	70.8 (n=17)	20.8 (n=5)	8.3 (n=2)	2.65	4
(Q2.2.6) Able to coordinate care o meet patient's needs	65.2 (n=15)	30.4 (n=7)	4.3 (n=1)	2.63	5
(Q2.2.8) Able to coordinate resources to reduce fragmentation	62.5 (n=15)	37.5 (n=9)		2.61	6
(Q2.2.5) Able to implement activities to meet patient's needs	62.5 (n=15)	29.2 (n=7)	8.3 (n=2)	2.54	7

The majority of the case managers were able to determine the level of care, determine correct clinical information and coordinate care using advanced treatment modalities to meet a patient's needs. However, there seem to be a growing uncertainty in 37.5% of respondents when it comes to coordinating resources to reduce fragmentation. The process of coordinating resources is important in case management to eliminate fragmentation or duplication in the provision of patient care.

4.3.2.3   Educator

The role of educator is twofold – to educate the patient and family, and to educate the staff or colleagues (Cesta et al 1998:46). The views of the respondents on education were as follows:

Table 4.5 Educator (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q.2.2.18) Provide admitting facility with member's health benefits	83.3 (n=20)	8.3 (n=2)	8.3 (n=2)	2.75	1
(Q2.2.12) Able to educate patients and families concerning alternative health services	79.2 (n=19)	16.7 (n=4)	4.2 (n=1)	2.69	2
(Q2.2.36) Share skills and expertise with case management team	66.7 (n=16)	16.7 (n=4)	16.7 (n=4)	2.50	3
(Q.2.2.34)Teaching patient's family the necessary skills to cope	62.5 (n=15)	20.8 (n=5)	16.7 (n=4)	2.46	4
(Q2.2.11)Educate the patients and families regarding health benefits	58.3 (n=14)	25.0 (n=6)	16.7 (n=4)	2.42	5

The majority of the case managers, representing more than 58%, were able to advise patients and family regarding health issues. However, 16.7% of respondents did not educate patients and families regarding their health benefits, and 25% of respondents were uncertain. This needs to be addressed, as patients have the right to be enlightened about their benefits.

4.3.2.4   Negotiation

The case manager is expected to negotiate the best treatment options available, when necessary (Cesta et al 1998:46). Most of the patients under case management incur high costs due to the expensiveness of treatment and equipment they use. It needs a case manager who is able to negotiate for the patient's welfare in order for the patient's cost to lessen. The views of the respondents on negotiating were as follows:

Table 4.6 Negotiation (N = 25)

Aspect	Percentage			Average	Rank
	Agree	**Neither agree nor disagree**	**Disagree**		
(Q2.2.14) Able to negotiate with facilities for discounts on patients' admissions	79.2 (n=19)	4.2 (n=1)	16.7 (n=4)	2.62	1
(Q2.2.13) Negotiate best treatment options available	70.8 (n=17)	25.0 (n=6)	4.2 (n=1)	2.67	2
(Q.2.2.15) I am able to negotiate with suppliers of durable medical equipment	70.8 (n=17)	16.7 (n=4)	12.5 (n=3)	2.58	3

At least more than 70% of the respondents were able to negotiate for the patient's welfare. There also seemed to be at most 25% of the respondents who were not sure about whether they could negotiate treatment options available for members of the medical schemes. Case managers should be encouraged to negotiate on behalf of patients to ensure the provision of cost-effective health care.

4.3.2.5 Patients' advocate

Case managers need to assume responsibility for liaison between patient and family, and the healthcare team (Cesta et al 1998:46). A clear majority, that is 91.7% of the respondents, said they were able to intervene on the patient's behalf as indicated in table 4.7.

Table 4.7 Patients' advocate (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.2.17) Advocate for the patient's needs with facilities	91.7 (n=22)	4.2 (n=1)	4.2 (n=1)	2.88	1

4.3.2.6 Identify obstacles to efficiency and good outcomes

Cohen and Cesta (2005:76), state that a case manager should identify obstacles to efficiency and good outcomes, and intervene to overcome or eliminate these, when possible. The views of the respondents are illustrated in table 4.8.

Table 4.8 Identify obstacles to efficiency and good outcomes (N = 25)

Aspect	Percentage			Average	Rank
	Agree	**Neither agree nor disagree**	**Disagree**		
(Q2.2.24) Communicating delays in patient's progress to relevant individuals or authorities	70.8 (n=17)	25 (n=6)	4.2 (n=1)	2.67	1
(Q2.2.23)Communicating discrepancies/ variances, like claims for services not rendered	66.7 (n=16)	29.2 (n=7)	4.2 (n=1)	2.63	2
(Q2.2.16) Liaise with patients and their families for best results	66.7 (n=16)	20.8 (n=5)	12.5 (n=3)	2.54	3

It can be noted that 70.8% of case managers communicated more on issues that delay a patient's progress rather than liaising with patients and their families. However, case managers that were not sure on how to communicate or disagree need to be encouraged to communicate variances and liaise with patients and families as it forms part of their work.

4.3.2.7 Holistic care provider

A holistic care provider looks at the patient in a fully integrated way (Cesta et al 998:46). The views of the respondents are illustrated in table 4.9.

Table 4.9 Holistic care provider (N = 25)

Aspect	Percentage			Average	Rank
	Agree	**Neither agree nor disagree**	**Disagree**		
(Q2.2.32) Able to identify the needs of a patient holistically	70.8 (n=17)	25.0 (n=6)	4.2 (n=1)	2.67	1
(Q2.2.33) Able to recommend that the entire patient's needs be included in management of the patient	41.7 (n=10)	37.5 (n=9)	20.8 (n=5)	2.21	2

The majority of case managers, that is 70.8%, were able to identify the needs of the patients holistically. However, they were not able to recommend the holistic management of the patients. Case managers should be encouraged to motivate holistic management of the patients as it is not helpful to identify a problem without the ability to manage the challenge at hand.

4.3.2.8 Identify at-risk populations

Case managers should be able to identify at-risk populations for high cost, extended length of stay, destabilisation, and repeated hospitalisation (Cohen & Cesta 2005:76). The views of the respondents are as follows:

Table 4.10 Identify at-risk populations (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.2.28) Evaluate patient outcomes to identify risk to the MCO	83.3 (n=20)	4.2 (n=1)	12.5 (n=3)	2.71	1
(Q2.2.27) Monitor delivery of patient care activities to identify risk for the MCO	79.2 (n=19)	8.3 (n=2)	12.5 (n=3)	2.67	2
(Q2.2.26) Monitoring delivery of patient care activities to identify risk to the patient	62.5 (n=15)	25 (n=6)	12.5 (n=3)	2.50	3
(Q2.2.25) Communicate undesired outcomes like multiple infections post-operatively	58.3 (n=14)	29.2 (n=7)	12.5 (n=3)	2.46	4

A clear majority, that is 83.3% of the respondents, said they were able to identify risk to the medical aid scheme. However, only 62.5% of case managers were able to monitor delivery of patient care to avoid risk to the patient and 58.3% were able to communicate undesired patient outcomes. Thus, one can conclude that the respondents seemed to be more protective of the medical aid scheme. Powell (1996:5) states that the nature of managed care dictates that healthcare services be limited; it is economics-driven. Case managers need to ensure that the right service is given to the right client.

4.3.2.9 Initiate a discharge plan

Cohen and Cesta (2005:76) state that the discharge process starts at, or before hospital admission to provide safe and comprehensive support to the patient.

Table 4.11 Initiate a discharge plan (N = 25)

Aspect	Percentage			Average	Rank
	Agree	**Neither agree nor disagree**	**Disagree**		
(Q.2.2.10) Able to initiate a discharge plan	75 (n=18)	20.8 (n=5)	4.2 (n=1)	2.71	1

It can be noted that 75% of the respondents were able to plan for patients' discharge. However, there was a significant uncertainty amongst 20.8% of the respondents when it came to discharge planning. Case managers need to be educated on the importance of discharge planning for efficient management of patients.

4.3.2.10 Outcomes and quality manager

The case manager should be able to gather, interpret, and use data to identify problems and trends, and to demonstrate outcomes and cost-effectiveness (Cesta et al 1998:46). The views of the respondents were as follows:

Table 4.12 Outcomes and quality manager (N =25)

Aspect	Percentage			Average	Rank
	Agree	**Neither agree nor disagree**	**Disagree**		
(Q2.2.21) Analyse data to identify trends such as repeated admissions	95.8 (n=23)		4.2 (n=1)	2.92	1
(Q2.2.19) Monitor and evaluate patient care based on clinical information	91.7 (n=22)	4.2 (n=1)	4.2 (n=1)	2.88	2
(Q2.2.20) Gather data to identify trends such as repeated admissions	87.5 (n=21)	8.3 (n=2)	4.2 (n=1)	2.83	3
(Q2.2.22) Interpret data to identify trends such as repeated admissions	79.2 (n=19)	16.7 (n=4)	4.2 (n=1)	2.75	4

It can be observed that most of the respondents, that is 95.8%, were able to identify and interpret data linked to trends such as repeated admissions. Ability to identify problems will assist the case managers in planning for proper interventions. For example, if a patient has diabetes mellitus, a case manager can refer a patient to be enrolled on the disease management program for management of the condition outside the hospital to prevent unnecessary hospitalisation.

4.3.2.11 Helpful change agent

Case managers should assist the computer system designers and developers regarding aspects needed to improve current systems and even develop new ones for better case management (Cesta et al 1998:46). The views of the respondents were as follows:

Table 4.13 Helpful change agent (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.2.29) Assist in system development and enhancements	37.5 (n=9)	50 (n=12)	12.5 (n=3)	2.25	1
(Q2.2.30) Given opportunity to contribute yearly in benefits design	25 (n=6)	29.2 (n=7)	45.8 (n=11)	1.79	2
(Q2.2.35) Assist or draft guidelines for the standards of case management	25 (n=6)	25 (n=6)	50 (n=12)	1.75	3
(Q2.2.31) Provide inputs in designing/amending contracts between MCO and hospitals	12.5 (n=3)	20.5 (n=5)	66.7 (n=16)	1.46	4

The majority of respondents were not involved in system development and enhancements; they were not provided the opportunity to contribute in members' health benefit design, did not draft guidelines for standards of case management and had very little input in designing contracts between the MCO and hospitals. The scenario raises concern as the respondents are involved daily in managing the patients in different facilities, work with the computer systems and also with the different hospital groups. Improved involvement of case managers in these areas is crucial. Cesta et al (1998:46) indicate that case managers are expected to be champions of change in the ever changing managed care environment. According to Jones and George (2003:55), authority should go with knowledge, whether it is up the line or down. If workers have the relevant knowledge, then workers, rather than managers, should be in control of work processes, and managers should coach and facilitate.

4.3.2.12 Anticipate potential delays

Anticipating potential delays refers to acting proactively to avoid delays (Cohen & Cesta 2005:76). The views of the respondents were as follows:

4.14 Anticipate potential delays (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.3.3) Identify factors that may delay patient's progress	91.7 (n=22)	4.2 (n=1)	4.2 (n=1)	2.88	1
(Q2.3.4) Act proactively to avoid delays in recovery process	73.9 (n=17)	12 (n=3)	12 (n=3)	2.69	2

It can be noted that 91.7% of the respondents were able to identify factors that might delay a patient's progress. However, there was uncertainty amongst 12% of the respondents. Another 12% of the respondents were not able to act proactively to prevent delays. This needs to be addressed to empower case managers to be proactive in managing patients effectively.

4.3.2.13 Support from supervisors and employer

The views of the respondents on their relationships with direct supervisors and support from the employer were as follows:

Table 4.15 Relationship with direct supervisor (N = 25)

Aspect	Percentage			Average	Rank
	Agree	Neither agree nor disagree	Disagree		
(Q2.4.2) My supervisor understands the problems/ difficulties I encounter	66.7 (n=16)	29.2 (n=7)	4.2 (n=1)	2.63	1
(Q2.4.1) My supervisor fully supports me in my work	58.3 (n=14)	25 (n=6)	16.7 (n=4)	2.42	2
(Q2.5.2) My employer supports career advancement of staff	45.8 (n=11)	25 (n=6)	29.2 (n=7)	2.25	3
(Q2.5.3) I get recognition for good performance	45.8 (n=11)	25 (n=6)	29.2 (n=7)	2.25	3
(Q2.4.3) I get the opportunity to attend workshops and/or in-service training on managed health care	41.7 (n=10)	41.7 (n=10)	16.7 (n=4)	2.17	4
(Q2.5.1) My organisation provides me with sufficient resources to support my work performance	29.2 (n=7)	58.3 (n=14)	12.5 (n=3)	2	5

It seemed as if the supervisors understood the problems the case managers were having but only 58% of the respondents indicated that they were fully supported by the supervisor. This implied that less than half the number of staff was not fully supported by their supervisors. Jones and George (2003:50) state that managers should encourage the development of shared feelings of comradeship, enthusiasm, or devotion to a common cause. The participation by case managers in workshops/in-service training was also limited. The respondents indicated that they did not have sufficient resources and the level of recognition by the employer was very low. The majority of respondents also felt that the employer did not support career advancement of staff.

4.4   ANALYSIS OF OPEN-ENDED QUESTIONS

Respondents gave more than one response in most questions.

4.4.1   Perceptions of own skills and knowledge (Q3.1)

4.4.1.1   Necessity of basic nursing qualification for case managers (Q3.1.1)

The respondents were asked to indicate whether a basic nursing qualification is necessary for case managers. They confirmed this and gave the following reasons:

Seventeen respondents said it enabled one to be knowledgeable and understand the medical terms and nursing management. A total of seven respondents indicated that it enabled them to diagnose and manage the patients well with ease and on time, and five respondents agreed that it enabled them to identify patients' health needs.

4.4.1.2 Benefit of specialised nursing experience to case managers (Q3.1.2)

A total of nine respondents indicated that it enabled them to manage patients in specialised units, six respondents said they were able to understand and check clinical information before authorising the right level of care and downgrade

promptly the level of care where necessary, five respondents mentioned that they were able to anticipate a patient's length of stay and cost implications.

4.4.1.3 Benefit of post-basic nursing qualifications to case managers (Q3.1.3)

A total of eight respondents indicated that a post-basic nursing qualification enabled them to acquire more information and further their skills and knowledge. A total of seven respondents said a post-basic qualification or experience did not guarantee excellence in the way the cases were handled. However, six respondents agreed that it allowed the case managers to give a more specialised service to the members. Some respondents felt that one enhanced one's knowledge and skill whilst others felt it did not guarantee excellence in case management.

The author, being a case manager herself, agrees with the respondents that a basic nursing qualification allows one to identify a patient's actual and potential problems and manage them accordingly. However, a post-basic nursing qualification or experience allows case managers to give more specialised attention to a patient's needs and intervene appropriately.

4.4.2   Role within managed care organisation (Q3.2)

4.4.2.1 High-risk cases (Q3.2.1)

Fifteen respondents indicated that the ICU and high-care patients (ventilated, head injuries, unstable patients) were high-risk cases. A total of nine respondents mentioned high-risk cases as complex medical cases due to HIV/AIDS, persons above 80 years, repeated admissions and cancer treatment. Major surgeries (knee-and-hip replacements, spinal surgery and cardiac operations) were mentioned by another nine respondents as high-risk cases. A total of eight respondents said that all the prescribed minimum benefit conditions and co-morbidities, for example, diabetes mellitus, asthma, chronic obstructive pulmonary disease, and neonatal cases are high-risk cases. The respondents were able to comment correctly on examples of high-risk cases. Kongstvedt (1996:274), states that high-risk cases include admission related to cancer, acquired immunodeficiency syndrome (AIDS), cerebral vascular incidences, organ transplants, head injuries, severe burns, high-risk pregnancies, high-risk neonates, spinal cord injuries and neuromuscular diseases.

4.4.2.2 Ways of managing high-risk cases (Q3.2.2)

Constant monitoring of the patient's condition, level of care, length of stay, interim amount and making proper recommendations were indicated by nineteen respondents as crucial in managing high-risk cases. A total of eight respondents said that communication with providers, members, families and colleagues about

the patient's welfare is vital. Five respondents mentioned the provision of highest quality medical care and advice on early referral to a specialist or relevant health facilities (step-down) as significant. A total of three respondents were of the opinion that constant review of a patient's condition by the specialists/general practitioners, and negotiating fees with the suppliers and providers were important. Case managers need to develop systems to identify and manage high-risk cases from day one to ascertain that these admissions are managed effectively.

4.4.2.3 High-cost cases (Q3.2.3)

Major operations such as brain surgery and spinal surgeries that require expensive prosthesis, were indicated by 13 respondents as high-cost cases. 11 respondents said ICU and high-care admissions fell under this category. A total of seven respondents mentioned neonatal/preterm/premature babies, and knee and hip replacements as high-cost cases, while six respondents agreed that cardiac and respiratory cases fell under the same group. However, another criterion for high-cost cases at the selected medical scheme applies to cases that cost more than R100 000, 00 per admission. None of the respondents commented on this standard.

4.4.2.4 Ways of managing high-cost cases (Q3.2.4)

Seventeen respondents said continuous monitoring of a patient's progress, level

of care, length of stay and the interim amount in relation to the type of care provided was vital. Eight respondents indicated that the introduction of co-payments and negotiating cost effective tariffs for the patient was also crucial. Seven respondents mentioned that giving advice regarding transfer to facilities (e.g. step-down), identification of cases on time, their characteristics and ability to make a decision based on appropriate clinical information from the facility were important. Five respondents stated that communication with the treating doctor and the medical advisor was the key to managing high-cost cases efficiently.

Therefore, constant monitoring of the patient's progress in all aspects is the best strategy in managing high-cost cases to reduce financial risk to the medical scheme. Kongstvedt (1996:275) indicates that the case management process should be designed to promote quality of care and contain costs around all lines of medical approach within a managed care organisation.

4.4.3   Awareness regarding case management tools (Q3.3)

4.4.3.1 Authorisation of correct amounts (Q3.3.1)

Seven respondents indicated that a patient or child admitted with pneumonia may stay in hospital for less than a week and they may authorise stay. Five respondents said that they were able to authorise the correct amount for wound care services and also approve prosthesis according to patients' limits. The examples provided by the respondents indicated that they were aware of the

importance of authorising the correct service for the right patient. Powell (1996: 5) states that case management involves the process of getting the right service for the right client.

4.4.3.2 Identification of factors that delay a patient's progress (Q3.3.2)

Eleven respondents indicated that existing co-morbidities might delay patent's progress. Six respondents said incorrect level of care like placing a patient in a step-down facility rather than rehabilitation, and misdiagnosing and incorrect treatment of the patient might aggravate the situation. Therefore, the case managers acknowledged that pre-existing conditions, management in a wrong facility and misdiagnosis, might delay the patient's improvement.

4.4.3.3 How respondents avoid delays in recovery process (Q3.3.3)

Sixteen respondents said they were able to make appropriate arrangements for transferring the patient to a rehabilitation facility as soon as the patient was stable, for example, post cerebral vascular incident. Nine respondents indicated that they assessed patients on admission, planned, discussed the plan with the doctor and then implemented a discharge plan as soon as the patient was admitted to the hospital. Four respondents said discouraging hospitals to keep patients for long periods, and communicating with a patient's family alleviated delays in the recovery process. Therefore, most of the respondents indicated that

they avoided delays by fast-tracking the transfer of the patients to rehabilitation, the minute they were stable.

4.4.3.4 Factors delaying a patient's progress (Q3.3.4)

Nine respondents mentioned unnecessary delays in transferring patients to relevant disciplines by service providers. Six respondents indicated placement in an inappropriate level of care, for example, placing a patient in a sub-acute facility instead of directly in a hospital, and inefficient medical staff, misdiagnosis, ineffective treatment and a patient not being treated holistically. Five respondents stated that socio-economic factors and lack of knowledge regarding healthcare resources and lack of resources played a part. Therefore, an unnecessary delay in transferring a patient to relevant disciplines by services providers was the most high-ranked factor for delaying a patient's progress.

4.4.3.5 Examples of how delays in recovery process can be avoided (Q3.3.5)

Early diagnosis and referral to appropriate health service for treatment was given by 17 respondents as an example to avoid delays in recovery process. Seven respondents indicated the need for a comprehensive patient-centred approach by the multidisciplinary teams in management of patients to avoid complications or a delay in a patient's progress. Another seven respondents said the service for each condition should be managed in sequence, updates done frequently and

the correct level of care be authorised. Therefore, the most examples given were early diagnosis and referral to appropriate health service for treatment.

4.4.4   Relationship with direct supervisor (Q3.4)

4.4.4.1 Support from supervisor (Q3.4.1)

The majority of the case managers, that is 75%, indicated that they got full support from their direct supervisors with 10% indicating that they did not, whilst 10% said sometimes and 5% said partially. One can say only 10% were not receiving any support from the supervisors. The reasons given were:

Ten respondents said that the supervisors communicated regularly and offered support and the resources to use so that one is able to perform duties effectively. Four respondents indicated that the supervisors advised on proper management, encouraged them to do research projects and implemented work processes. However, they also stated that the supervisors lacked experience, were always busy and overloaded with work, and "we learned by trial and error".

4.4.4.2 Understanding of problems encountered by case managers (Q3.4.2)

The majority of the respondents, that is 68%, indicated that the supervisors understood their problems whilst 21% indicated sometimes and 11% indicated not always. The following reasons were given:

Six respondents reported that supervisors were cooperative, supportive and tried to resolve problems. They also made follow-ups on problems reported and evaluated to make sure that the work progresses. Therefore, some of the supervisors were cooperative and they did follow-up on problems reported.

4.4.4.3 Barriers that hinder effective case management (Q3.4.3)

Eleven respondents cited computer systems that were not user-friendly as a barrier to effective case management. Incomplete or limited information from service providers, lack of resources and a too heavy workload were indicated by six respondents as an obstacle. Five respondents said barriers were linked to staff shortage; lack of in-service training; knowledge and experience; and team leaders with no management skills and who were not knowledgeable were allocated to supervise work. Four respondents said that there were no guidelines or protocols, therefore, case managers used their own discretion which created inconsistency. Therefore, the most barriers seemed to be computer systems not being user friendly, inadequate information from service providers and lack of resources, and a too heavy workload.

4.4.4.4 Awareness of problems by supervisors (Q3.4.4)

Nine respondents indicated that no help or feedback was received from the supervisors and that the supervisors were limited in ability to rectify problems and problems had to be reported somewhere. Six respondents mentioned that cases

were handled as they came and some problems were resolved. Monthly team meetings were held where the system and most of the delays were discussed. The respondents indicated that there was no feedback from some supervisors and they were also limited in ability to rectify problems. Therefore, communication and problem-solving skills of the supervisors need to be addressed to foster good interpersonal relations between case managers and their supervisors. Jones and George (2003:515) indicate that the communication process consists of the transmission phase and feedback phase. In the transmission phase, the information is shared between two or more individuals and in the feedback phase, a common understanding is ensured.

4.4.5 Role of employer (Q3.5)

4.4.5.1 Support from employer in career advancement (Q3.5.1)

Fourteen respondents said study loans/bursaries were made available to employees by the employer. A total of 11 respondents indicated that study leave was provided to the staff members and six respondents were of the view that in-house in-service training was offered. Therefore, most respondents were being supported by the employer by being given study loans/bursaries, and study leave availability. Three respondents mentioned that the employer was not really supportive, did not encourage further studies and did not grant study leave for courses not related to your work. It is the researcher's view that the employer needs to provide support to the employee in terms of medium- and long-term

career plans because an employee might study further in a totally different field and use the newly acquired skills in the same company.

4.4.5.2 Staff recognition by employer (Q3.5.2)

Eleven respondents said that incentive bonuses need to be given to hardworking staff. Nine respondents mentioned that informing colleagues of achievement and giving a token of appreciation (gifts) should be done and awards or certificates of excellence be given to staff performing well. Five respondents indicated that the development of staff for senior positions/promotions needs to be encouraged. Therefore, most of the respondents said that the employer should recognise employees by giving incentive bonuses to hardworking staff. A staff recognition team was recently established to recognise outstanding performance by staff members from different departments. According to Jones and George (2003:500), managers can rely on a combination of individual or group incentives to motivate members of groups or teams to work towards the achievement of organisational goals and a competitive advantage.

4.4.5.3 Ways for an employer to assist in improving case management process (Q3.5.3)

Eleven respondents said that the employer should provide in-service training for staff on systems and procedures, upgrade their IT (seven respondents), promote case management forums and conduct regular workshops (seven respondents), and supply protocols for proper guidelines for new case managers to facilitate the

smooth running of services (four respondents). Jones and George (2003:49) state that managers must create a well-defined system of rules, standard operating procedures, and norms so that they can effectively control behaviour within an organisation. Standard operating procedures are specific sets of written instructions about how to perform a certain aspect of a task.

4.5 FURTHER COMMENTS (Q3.6)

The respondents further suggested the following:

- Supervisory staff should have sufficient knowledge in all areas.
- Staff with potential must be identified, groomed and paid accordingly.
- Attending case management courses will improve recognition of the nurses by employer.
- Case managers should be encouraged to visit facilities where patients are admitted at least once or twice a month that is on site case management.

4.6 CONCLUSION

In this chapter, the perceptions of case managers regarding their role in a selected medical scheme in Pretoria were discussed. The role of the supervisor and employer, including barriers to effective case management, was mentioned.

The findings indicated that the majority of case managers were aged between 35 and 44 years, had multiple nursing qualifications and mainly had diplomas in general nursing, psychiatry, community and midwifery.

The majority of case managers indicated that they knew what their job entailed. This was supported by the fact that most of them had more than five years' clinical nursing and managed care experience. However, most case managers did not undergo formal case management training and had limited opportunity of attending workshops and in-service training. Most of the case managers indicated that they got full support from their immediate supervisors but supervisors had limited ability to resolve problems. The participants also indicated that the employer supported career advancement of staff by providing loans/bursaries and study leave.

Chapter 5 concludes the study, discusses limitations and provides recommendations for practice and further research.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter concludes the study, discusses limitations of the study and makes recommendations for case management practice in a managed care organisation, nursing education and further research.

The purpose of the study was to determine case managers' understanding of their role within a managed care organisation and to develop recommendations for the improvement of case management practice. The objectives of this research were to:

- determine case managers' perceptions regarding their role in a managed care organisation; and

- identify the barriers experienced by case managers in relation to effective case management.

A quantitative explorative and descriptive design was used to conduct the research. The researcher used a questionnaire with both open and closed-ended questions to collect data from the respondents. The questionnaire was based on

the aspects of a case manager's role according to the literature review. Utilising the survey for descriptive purpose, the researcher used a questionnaire to obtain information regarding the respondents' demographics and their role as case managers in a managed care organisation and to identify their perceived barriers to effective case management.

5.2 CONCLUSIONS

5.2.1 Demographic information

The demographic data of the respondents revealed that the majority of respondents, 76%, had more than five years' experience in managed care, thus only 24% had less than five years (see figure 4.2), and the majority of respondents, 84%, had at least five years' experience, as nurses with only 16% who had less than five years' nursing experience (see figure 4.3). The majority of the respondents were therefore in a position to comment about case management since they had a considerable number of years' experience as nurses and as case managers.

5.2.2 Conclusions concerning the perceptions of case managers regarding their role in a managed care organisation

From the research findings, there was an indication that the majority of case managers knew what was expected of them in their job. The perceptions of case

managers regarding their role in a managed care organisation was influenced by the following; how they perceive their own skills and knowledge (see 4.3.1), their role as clinical experts, coordinators of patient care, educators, negotiators, patients' advocates, identifying obstacles to efficiency and good outcomes, holistic care providers, outcomes and quality managers, ability to identify at risk populations, initiating discharge plans, helpful change agents and anticipating potential delays (see 4.3.2). However, 64% of the respondents received informal training as case managers and only 12% of them received formal case management training (see table 4.2).

There appears to be uncertainty with quite a number of respondents regarding certain aspects of their role. With regard to the coordination of resources, 62.5% of the respondents agreed that they were able to coordinate care and implement activities to meet patients' needs or to coordinate resources to avoid fragmentation (see table 4.4). 16.7% of the respondents neglected their role in educating patients and relatives regarding coping skills and health benefits (see table 4.5), 29.2% of respondents were unsure on how to communicate discrepancies such as claims for services rendered and 20.8% were uncertain on how to liaise with patients and their families for best results (see table 4.8). Some respondents, that is 25%, were unsure about their ability to monitor patient care activities and to identify risk to the patient and 12.5% of them could not communicate undesired patient outcomes such as multiple infections (see table 4.10) to the relevant authorities like the supervisors, medical advisors and forensics department dealing with investigating discrepancies in member claims.

Some respondents, that is 20.8%, lacked the ability to recommend the holistic management of the patient to the treating doctor or hospital case manager (see table 4.9). These functions are very important because the goals of case management focus on quality of care, length of stay, resource utilisations, continuity and cost control (Finkelman 2001:127).

5.2.3 Conclusions pertaining to barriers to effective case management

Barriers that hinder effective case management were explained as being mainly related to computer systems that were not user-friendly, incomplete or limited information from service providers, lack of resources and a too heavy workload (see 4.5.4.3). Therefore, the medical scheme may expect poor work output as these factors affect turnaround time and may prolong a patient's length of stay in a hospital unnecessarily. However, there was a lack of formal training of case managers, limited opportunities to attend in-service training and no protocols/guidelines (see 4.5.4.3). A lack of training and protocols leads to inconsistency in how cases are managed by case managers, which may lead to the company paying for unnecessary health services rendered. It seemed as if the supervisors understood the problems the case managers were having but only 58% of the respondents indicated that they were fully supported by the supervisors (see table 4.3.2.15). This implies that 42% of the staff was not fully supported by their supervisors.

5.3 LIMITATIONS

The study was done among nurses employed as case managers at a selected medical scheme in Pretoria. Data was collected in a single institution and the 25 respondents out of a projected target of 30 participated in the study.

5.4 RECOMMENDATIONS

In relation to the perceptions of case managers in a managed care organisation the researcher proposes the following recommendations for case management practice, nursing education and further research.

5.4.1 Case management practice

- Opportunities to attend formal/informal/in-service trainings or workshops should be offered to keep case managers abreast with new developments in medical science and managed care practices. Attention should be paid to the job-specific training needs of case managers and the employer should support the need for staff training. Case managers need to be educated and encouraged to monitor the coordination of resources and patient care activities, educate and liaise with patient and families, identify risk to the patient, communicate undesired patient outcomes and discrepancies regarding claims and recommend for holistic management of the patients.

- Case managers need to be provided with relevant resources to allow them to work efficiently and effectively. Computer systems need to be upgraded to be user-friendly and improve work output.

- Communication is a vital tool for business customers. It is essential for the medical scheme and different service providers to communicate on a regular basis to strengthen working relations, improve turnaround time and lead to satisfaction of parties concerned.

- Workload or targets need to be structured in a way that promotes fairness in terms of case manager/patient ratio. This will improve productivity and prevent unnecessary financial errors.

- Evidence-based protocols are essential for the smooth functioning of a department and the organisation to prevent unnecessary financial errors. It is therefore vital to have protocols in place for uniformity within the department and organisation.

- Case managers need to be supported fully by their immediate supervisors and their employer. The role of immediate supervisors and support from the employer is important to the optimum productivity of employees. Therrien (2006:2) states that a supportive manager engages in two-way communication with their subordinates -- shares information, asks employees' opinion, gives regular feedback and has frequent face-to-face meetings.

5.4.2 Nursing education

Most of the case managers employed in managed care organisations have a basic nursing qualification. Provision of managed care education will empower nurses with knowledge to function in managed care organisations. An introductory course in managed care should be incorporated into the nursing curriculum as managed care forms part of the national healthcare system. This will create awareness in the student nurse about the role of a nurse in a managed care organisation. Reneau (2006) states that the practice of nursing continues to evolve with the changing healthcare market. Evidence that nurses are adequately educated about managed care is lacking. The literature substantiates the need to teach and promote managed care competencies among new practicing nurses. Since few source experts currently exist in the nursing faculty, innovative partnerships between MCOs and nursing programmes can help provide some managed care education for nurses.

5.4.3 Further research

Further research should be done in the following areas:

- Research to be repeated in other MCOs to determine whether case managers experience different barriers.
- The nurse educators should explore the need for an introductory course in managed care to be included in the basic nursing programme.

- Partnerships between MCOs and nursing institutions should be established to provide managed care education.

5.5 SUMMARY

The study found that the majority of case managers in a selected medical scheme knew what was expected of them. Most of them had various nursing qualifications, were middle-aged (35 – 44 years) and had more than five years' experience in nursing and managed care. The participants were therefore able to give reliable information regarding their role as case managers. The participants were 25 out of 30 and the response rate from the case managers who had experience in managing patients admitted in different facilities, was 83%. The descriptive and explorative data was collected quantitatively using a survey. The researcher therefore generalises the findings as they are a reflection of perceptions of case managers regarding their role in managed care organisation.

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Annexure A

Approval from University

UNISA
university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee (HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date: 7 October **2009**

Project No: **3245 916 5**

Project Title: **THE ROLE OF A CASE MANAGER IN A MANAGED CARE ORGANISATION**

Researcher: **KM Kgasi**

Supervisor/Promoter: **Prof E Potgieter**

Joint Supervisor/Joint Promoter:

Department: **Health Studies**

Degree: **MPH**

DECISION OF COMMITTEE

Approved [√]

Conditionally Approved [ ]

Date: 7 October 2009

Prof VJ EHLERS
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

Prof E Potgieter: SUPERVISOR

Annexure B

Letter seeking permission from the selected medical scheme

DEPARTMENT OF HEALTH STUDIES

SCHOOL OF SOCIAL SCIENCES

COLLEGE OF HUMAN SCIENCES

Enquiries: Prof E Potgieter

Tel: 012-429 6545

E-mail: potgie@unisa.ac.za

12 October 2009

The Clinical Executive

Metropolitan Health Group - QUALSA

PO Box 57277

Arcardia

Pretoria

0007

Dear Sir/Madam

APPLICATION TO CONDUCT THE RESEARCH STUDY AT QUALSA

I am a registered student at UNISA busy with Master's degree in Public Health. I am currently engaged in a research project entitled: "The role of a case manager in managed health care organization", under the supervision of Prof E Potgieter of the Department of Health Studies at UNISA.

The purpose of the research is to explore the perceptions of case managers regarding their role in a managed health care organization and identify barriers that hinder effective case management in order to formulate recommendations for improved case management practices.

1

The research is quantitative in nature and therefore the researcher will need a bigger sample of case managers to assist the researcher to generalize the findings to the broader population of case managers in managed health care settings. In order to complete the study, I will require permission to distribute the questionnaires among the case managers that manage patients admitted in different facilities (hospital, step-down, mental & physical rehabilitation centers).

The researcher will distribute questionnaires at times convenient for the department to avoid interruptions with routine. Once the data is collected, it will be analyzed using the Statistical Package for Social Sciences (SPSS). The results of the study will be made available to QUALSA upon request.

I trust that my application will receive your favorable attention.

Yours sincerely

Kate Mamokgati Kgasi
RESEARCHER: RN, MPH Student

E Potgieter
SUPERVISOR: RN, PhD

Annexure C

Letter of approval from the selected medical scheme

Our Ref : 324 459 165
Date : 12 May 2010

Attention : Kate Mamokati Kgasi
CC : Prof E Potgieter

Dear Kate Mamokati Kgasi

RE: APPLICATION TO CONDUCT A RESEARCH STUDY AT QUALSA

1. Your email dated the 12 October 2009 requesting permission to conduct research study at Qualsa has reference

2. This letters serves to confirm that your application/request to conduct research study at Qualsa was approved.

Looking forward to the research findings

Yours Faithfully,

Mashudu Sadiki
Clinical Executive
Qualsa (pty) Ltd
A subsidiary of Metropolitan Health Group
Tel: 012 304 2639
Email: msadiki@mhg.co.za

INVESTOR IN PEOPLE

Annexure D

Questionnaire

THE ROLE OF A CASE MANAGER IN A MANAGED CARE ORGANISATION

Dear colleague

I am a registered student at UNISA busy with Masters' degree in Public Health, the title of my study is: *The role of a case manager in a managed care organisation*. The purpose of my research is to explore the perceptions of case managers regarding their role in a managed health care setting and the barriers that hinder effective case management in order to formulate recommendations to improve current case management practices.

Please note that completion of the questionnaire is voluntary and that all information is confidential. You are free to withdraw from the research at any time without penalty.

Any questions regarding the questionnaire should be directed to Kate Kgasi, 012 304 3243.

It will take almost 30 minutes to complete the questionnaire.

After completion of the questionnaire, the researcher will collect forms personally from the case managers.

Signature:.....................   Date:................

Instructions:

Please read the whole questionnaire and write down your answers according to your experience as a nurse working in a managed care organisation as a case manager. The questionnaire is divided into 3 sections:

Section 1: Mark appropriate response with a cross (x).

Section 2: Mark appropriate response with a cross (x).

Section 3: Write your own comments in the lines provided.

SECTION 1 - Please mark the appropriate box with a cross (x) below and fill in the spaces where necessary.

1 DEMOGRAPHIC DATA

1.1 Gender

☐ Male

☐ Female

1.2 Age range (in years)

☐ Below 25

☐ 25 – 34

☐ 35 – 44

☐ 45 – 54

☐ above 54

1.3 Educational qualifications (mark applicable boxes)

☐ Diploma in General Nursing

☐ Diploma in General Nursing and Midwifery

☐ Diploma as a Nurse (General, Psychiatry, Community & Midwifery)

☐ Degree as Nurse (General, Psychiatry, Community & Midwifery)

☐ Post basic courses (specify)...........................

☐ Other (specify) ....

1.4 Number of years in managed care

☐ 2 years and below

☐ 3 – 4 years

☐ 5 – 10 years

☐ above 10 years

1.5 Previous years of experience as a Nurse

☐ 2 years and below

☐ 3 – 4 years

☐ 5 – 10 years

☐ above 10 years

SECTION 2 – The statements below refer to your perception regarding the role of a case manager in managed care organisation.

Please mark the appropriate box with a cross (x) as follows:

1 = Disagree

2 = Neither agree nor disagree

3 = Agree

2.1 Perception of own skills and knowledge

2.1.1 A basic nursing qualification is necessary for case managers

1	2	3

2.1.2 Specialised nursing experience is beneficial to case managers

1	2	3

2.1.3 A Post basic nursing qualification is beneficial to case managers

1	2	3

2.1.4 I received formal training as a case manager

1	2	3

2.1.5 I received informal training as a case manager (trained by supervisor during work time)

1	2	3

2.1.6 Formal training as a case manager is necessary

1	2	3

2.1.7 Informal training as a case manager is necessary

1	2	3

2.1.8 I know what is expected of me as a case manager

1	2	3

2.2 Role within managed care organisation

2.2.1 I am clinically competent to assess patient & family needs

1	2	3

2.2.2 I am able to establish actual problems of the patient

1	2	3

2.2.3 I am able to identify potential problems the patient may encounter

1	2	3

2.2.4 I am able to plan activities to meet the patient's needs

1	2	3

2.2.5 I am able to implement activities to meet patient's needs

1	2	3

2.2.6 I am able to coordinate care to meet the patient's needs using advanced treatment modalities

1	2	3

2.2.7 I proactively establish correct clinical information from doctors or providers regarding the patient to eliminate delays in the patient's progress

1	2	3

2.2.8 I am able to coordinate resources to reduce/eliminate fragmentation

1	2	3

2.2.9 I ensure that care for the patient is provided in an appropriate setting or level of care

1	2	3

2.2.10 I am able to initiate a discharge plan for the patient

1	2	3

2.2.11 I educate patients and families regarding health benefits

1	2	3

2.2.12 I am able to educate patients and families concerning alternative health services available apart from hospitalization

1	2	3

2.2.13 I negotiate best treatment options available with treating doctors, the health team & Medical Advisor at the Medical Aid Scheme when necessary

1	2	3

2.2.14 I am able to negotiate with facilities for discounts on patients admissions

1	2	3

2.2.15 I am able to negotiate with suppliers of durable medical equipments for the equipments needed by patients

1	2	3

2.2.16 I liaise with patients and their families when necessary to achieve the best possible results for the patient according to the patient's health benefits

1	2	3

2.2.17 I advocate for the patient's needs with facilities like step-down or rehabilitation centres when negotiating for admission or transfer from hospital

1	2	3

2.2.18 I provide the admitting facility with information on members' health benefits to avoid unpaid patient claims

1	2	3

2.2.19 I monitor and evaluate patient care based on clinical information provided by providers

1	2	3

2.2.20 I gather data to identify trends such as repeated admissions

1	2	3

2.2.21 I analyse data to identify trends such as repeated admissions

1	2	3

2.2.22 I interpret data to identify trends such as repeated admissions

1	2	3

2.2.23 I communicate discrepancies/variances like claims for services not rendered to relevant individuals or authorities for improved results

1	2	3

2.2.24 I communicate delays in patient's progress to relevant individuals or authorities for improved outcomes

1	2	3

2.2.25 I communicate undesired outcomes like multiple infections post-operatively in a facility to relevant individuals or authorities for improved outcomes

1	2	3

2.2.26 I am able to monitor delivery of patient care activities to identify risk to the patient

1	2	3

2.2.27 I am able to monitor delivery of patient care activities to identify risk to the medical aid scheme.

1	2	3

2.2.28 I evaluate patient outcomes to identify risk to the medical aid scheme.

1	2	3

2.2.29 I assist in system development and enhancements for improved case management

1	2	3

2.2.30 I am given the opportunity to contribute to members' health benefit design annually

1	2	3

2.2.31 I provide inputs in designing/amending contracts between hospitals and medical scheme when necessary

1	2	3

2.2.32 I am able to identify the needs of a patient holistically

1	2	3

2.2.33 I am able to recommend that the entire patient's needs be included in management of the patient

1	2	3

2.2.34 I am able to teach a family the necessary skills to cope with a patient's disease condition

1	2	3

2.2.35 I am able to assist or draft guidelines for the standards of case management within MCO

1	2	3

2.2.36 I share skills and expertise with the case management team by giving feedback after attending in-service training or workshops

1	2	3

2.3 Awareness regarding case management tools

2.3.1 I am able to manage treatment duration according to patient's health needs

1	2	3

2.3.2 I am able to authorise correct amounts for a specific health service rendered

1	2	3

2.3.3 I am able to identify factors that may delay patient's progress

1	2	3

2.3.4 I am able to act proactively to avoid delays in recovery process

1	2	3

2.4 Relationship with direct supervisor

2.4.1 My direct supervisor fully supports me in my work.

1	2	3

2.4.2 My supervisor understands the problems/difficulties I encounter on a regular basis.

1	2	3

2.4.3 I get opportunity to attend workshops and/or in-service training on managed health care.

1	2	3

2.5 Role of employer

2.5.1 My organisation provides me with sufficient resources to support my work performance

1	2	3

2.5.2 My employer supports career advancement of staff

1	2	3

2.5.3 I get recognition for good performance

1	2	3

SECTION 3 - Please write your own comments in the lines provided.

3.1 Perception of own skills and knowledge

3.1.1 A basic nursing qualification is necessary for case managers. Why?

_____

_____

_____

_____

3.1.2 Specialised nursing experience is beneficial to case managers. Substantiate your answer.

_____

_____

_____

_____

3.1.3 A post basic nursing qualification is beneficial to case managers. Provide reason.

_____

_____

_____

_____

3.2 Role within managed care organisation

3.2.1 What do you consider as high risk cases? Give examples.

_____

_____

_____

_____

3.2.2 How can high risk cases be managed effectively?

_____

_____

_____

_____

3.2.3 What do you consider as high cost cases? Give examples.

_____

_____

_____

_____

3.2.4 How can high cost cases be managed successfully?

_____

_____

_____

_____

3.3 Awareness regarding case management tools

3.3.1 I am able to authorise correct amounts for a specific health service rendered – please give examples.

_____

_____

_____

_____

3.3.2 I am able to identify factors that may delay patient's progress – please give examples.

_____

_____

_____

_____

3.3.3 I am able to avoid delays in recovery process– please substantiate.

_____

_____

_____

_____

3.3.4 Mention factors which you regard as delaying patient's progress.

_____

_____

_____

_____

3.3.5 Mention one example of how delays in recovery process can be avoided?

_____

_____

_____

_____

3.4 Relationship with direct supervisor

3.4.1 Does your direct supervisor fully support you in your work? Please explain.

_____

_____

_____

_____

3.4.2 Does your supervisor understand the problems/difficulties you encounter on a regular basis.

_____

_____

_____

_____

3.4.3 List the barriers that hinder effective case management.

....

....

....

....

3.4.4 Were these factors brought to the attention of immediate supervisors?

....

....

....

....

3.5 Role of employer

3.5.1 How does your employer support career advancement of staff?

....

....

....

....

3.5.2 What do you consider as staff recognition by the employer?

....

....

....

....

3.5.3 How can the employer assist in improving the case management process?

....

....

....

....

3.6 Please comment on other issues not highlighted in this questionnaire.

_____

_____

_____

_____

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.