



Case Management for patients with Advanced Kidney Disease

A Guide for Nurses

Editors

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Noel Eichler

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Preface

This guide aims to explain Case Management to nurses caring for patients with advanced kidney disease and risk groups such as patients who have diabetes and hypertension. The guide provides practical information on the development, role and working methods of a Case Manager and it describes the implementation in daily practice.

According to Weil et al.¹ the concept of Case Management has its origins in America in 1863, where Case Management emerged from social work. Subsequently, Case Management has been established in various nursing and caring fields with an individual concept corresponding to these fields. What they all have in common is that there are two levels of action, case and system control level. This guide focuses on the case-level of Case Management work. Note that the case-level cannot be regarded without considering the system control as both levels are closely intertwined.

The health and social service reforms and the increasing multimorbidity of our patients all over the world require a change in the way of work in institutions. The direction is the same in all human service organisations: there is a need for rationalisation, with a focus on ensuring quality, limiting costs, and integrating service delivery.

In order to do this, it is necessary to understand the concept of Case Management, which is explained in Chapter 1 and 2. At the beginning of each section, learning objectives ensure the focus on the essentials. References to further reading at the end of each section allow the interested reader to get deeper into the matter.

In Chapter 3 and 4, the practical relationship to nephrology care is established and explained clearly using examples from daily work.

Chapter 5 provides case studies.

Enjoy reading the guide and good luck with implementing Case Management in daily practice.

1. Case Management for patients with advanced Kidney disease and high-risk groups

1.1 Learning objectives:

1. Be aware of the increasing number of patients with chronic kidney disease (CKD)
2. Know high risk groups for CKD as well as patients with diabetes and hypertension
3. Gain knowledge about different approaches of Case Management programs

1.2 Introduction

The number of patients with chronic kidney disease (CKD) is growing worldwide. In 2010, the number of people with CKD was recorded for the first time in the project "Global Burden of Disease Study (GBD)". Kidney diseases are now listed in 18th place of the most frequent causes of death. This is due to the increase in diabetes and high blood pressure with an increasingly ageing population¹.

In 2019, over 750 million people were affected by chronic kidney disease worldwide. The proportion in different countries varies significantly. The largest number (over 2000 dialysis patients per million population) is found in North America, Iraq, Japan and smaller Asian countries².

Diseases such as diabetes, (422 million people in 2019), and arteriosclerosis caused by hypertension, (1.13 billion people in 2019) and lipid metabolism disorders are the main reasons for commencing renal replacement therapy².

Early treatment of the risk factors can slow down the progression of the disease and delay or even completely prevent the need for dialysis.

Due to demographic change, our patients are getting increasingly older. This often results in multimorbidity, with several healthcare professionals being involved in medical care. New fears and doubts arise with the beginning of dialysis. The family is facing great challenges. This is where Case Management (CM) can act as a

"door opener" and coordinate services. This guide describes how CM can be done and how nephrology care can benefit from it.

In the 1970's, Case Management was established in the US to care for patients with chronic psychological and emotional problems, or those with physical disabilities. The number of beds in inpatient facilities was reduced drastically and people were discharged into their home environment. There they found an uncoordinated coexistence of offers of help. In 1977, the National Institute of Mental Health (NIMH) launched a Community Support Program in which Case Managers played a crucial role for the first time³.

In 2018, Kathryn Havas, Doctor of Philosophy at the Institute of Health and Biomedical Innovation, Faculty of Health Queensland University of Technology, published a thesis "Person-centred care in chronic kidney disease: The CKD-SMS study". Her literature review documented studies of structured self-management programs (SMPs) only for CKD stage 5 (for CKD-classification see publications from EDTNA/ERCA)⁴.

The structured self-management programs have shown to be "effective in improving outcomes for people who are living with a range of chronic health conditions. Positive outcomes of such programs include improved health related quality of life (HRQoL), coping, symptom management, disease specific symptoms, cognitive symptom management, adherence, disease and symptom management self-efficacy, communication with physician, mood, self-rated health, and exercise, as well as reduced healthcare expenditure, service utilisation, hospitalisation, fatigue, health distress, pain, disability, and depression. The authors further highlighted the lack of educational interventions for people with earlier stages of CKD and stressed the importance of the development of structured interventions aimed at "empowering" people with the earlier stages of the disease to self-manage in a way that delays progression to end stage kidney disease (ESKD)⁵.

The Case Management as described below has the same goal as the Queensland CKD-SMS project⁵ which now is a structured program to manage stage 5 CKD patients. For further information, this thesis is highly recommended by the authors.

1.3 High-risk groups and how to identify them

Risk factors for testing people for CKD can be found in NICE – National Institute for Health and Care Excellence (2014) and can be found in Kidney Disease Outcomes Quality Initiative – KDOQI guidelines (2020)⁶.

- Diabetes
- Hypertension
- Cardiovascular disease including ischemic heart disease, chronic heart failure, peripheral vascular disease, and cerebral vascular disease
- Structural renal tract disease
- Multisystem disease with potential kidney involvement, systemic lupus erythematosus etc
- Family history of stage 5 CKD or hereditary kidney disease, Alport syndrome etc
- Opportunistic detection of haematuria or proteinuria

These patient groups may have different access to nephrology care and must be identified early, the risk factors must be addressed, and the people must be monitored continuously. This is the only way to prolong progression and possibly prevent the need for dialysis.

Chapter 3 and 4 describe how Case Management can help to care for these people.

In the next chapter the Case Management Cycle and its different phases are described.

1.4 Case Management Definition – The different approaches of Case Management

To understand how Case Management can be used by a Case Manager in their work with patients with advanced kidney disease, it is important to understand what Case Management is. The literature presents many, sometimes broad definitions of Case Management.

What they all have in common:

- holistic view of a patient problem and not just of individual needs,

- Case Management as dynamic process based on cooperation, involving several professionals whose services are coordinated in a network,
- To "solve problems and achieve defined results"⁷ in their approach through skilful coordination.

The definition of the Case Management Society of America (1995) includes a resource approach and high quality, cost-effective outcomes:

"Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and service to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes"⁷.

In November 2002, the American Case Management Society adopted a definition that is much more focused on health care. It emphasizes cooperation among hospital professionals, uninterrupted communication, coordination of resources, while aiming at achieving the best possible health, access to care and patient choice:

"Case Management in Hospital/Health Care Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination"⁸.

Case Management in the field of health care involves optimising processes in patient care, to manage cases and take responsibility for processes, to activate self-care and to make the entire process transparent. Based on the different definitions, there are also different models of Case Management. In the literature, different classifications are made, e.g. according to service provider, professional function, and area of operation:

1. Home Care Case Management: Coordination of the outpatient care of persons in need of long - term care
2. Geriatric Case Management: medical and nursing care for the elderly
3. Hospital Case Management: care from admission to discharge

4. Emergency Supply Management (Catastrophic Case Management): in acute medical, psychiatric and social crises
5. Long-Term Care Case Management: permanent care of the chronically ill and disabled
6. Psychiatric Case Management (Mental Health Case Management): mentally ill people after acute medical treatments and many more⁹

This guide focuses on Case Management in long-term care of chronically ill people with advanced kidney disease stages 1 to 4 and high-risk groups experiencing kidney failure.

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2. The importance of Case Management in renal care

2.1 Learning objectives:

1. Gain knowledge about the phase-oriented approach
2. Understand the five practice functions of Case Managers
3. Be able to identify the factors creating the need for Case Management

2.2 The Case Management Cycle or Phases of Case Management

The Case Management phases represent the complexity of case work, and its structured process, making the work evaluable and thus transparent for patients and professionals. The result is a framework concept for the Case Management work.

The terms based on the description of David P. Moxley, Professor in the Social Work Department at University of Alaska Anchorage:

- Assessment,
- Planning,
- Intervention,
- Monitoring,
- Evaluation

Can also be applied to the fields of healthcare.

Figure 1 shows the multi-functional framework. Moxley writes in his book: "All the functions are critical to the development of the core of Case Management. This core is labelled as the FOCUS OF CASE MANAGEMENT: this is what the Case Manager is seeking to create through the application of Case Management functions. The focus [...] is the creation of a CLIENT SUPPORT NETWORK ..."¹.

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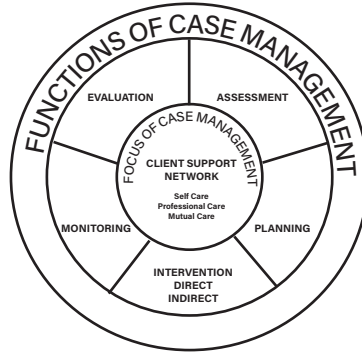


Figure 1: A Multi-Functional Framework of Case Management Practice
Source: David P. Moxley (1989, p. 18)

In 2000, Prof. Dr. Michael Ewers MPH, Director of the Institute of Health and Nursing Science at Charité Berlin, developed the Case Management control loop as a step-by-step model based on the multi-functional framework of Case Management practice. The Case Manager's work with advanced kidney disease patients and risk groups is based on this model. Figure 2 shows this control loop².

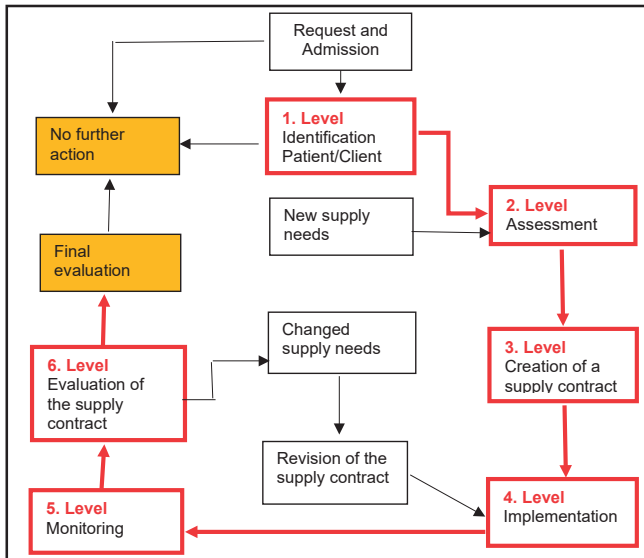


Figure 2: Case Management Cycle
Source: Michael Ewers (2000, p.73)

In this model the patients are the core of every intervention. This procedure is not fixed, it must be adapted to the circumstances. The phases can merge into each other and run in loops.

The Case Management control loop gives an indication of the complexity of the work, presents it and helps to identify and work on the core of the problem.

Due to new insights and information in the help process, the plan always remains preliminary and needs to be adapted, if required. It is still mandatory to negotiate formulated goals and agreements with the patient.

In order to be able to work, a solid network capable of acting must be established, maintained and adapted to changing structures at system level. This includes the outreach and access, to get in touch with patients, customers and parties.

Help from the Case Manager is planned and organised according to the principle of subsidiarity. Consistent involvement of the patients in the entire process, transparency, trust, and cooperation are basic requirements for the success of Case Management.

Like many other health care fields of work with humans, renal care is also working with people who have multiple needs as a result of severe disabling conditions. Patients with advanced kidney disease and their families often have significant disabilities limiting their capability to locate the various help systems and impeding their ability to provide a consistent and effective service for themselves. These fields can be housing, employment, mental health, social service, and health care¹.

Case Management is meant to overcome these problems by offering a mechanism to intertwine services across organisational boundaries. In addition, there is one person (or team) who is accountable for identifying the patients and their needs. The Case Manager should be responsible for guiding the patient through the system of health care service.

The next chapter explains Case Management functions to achieve these objectives in patients with advanced kidney disease.

2.3 The Case Management Functions

This part describes the phases following Ewers (2000) and Moxley (1989), and how they interact see Figures 1 and 2 on p. 16, respectively. Table 1 identifies the phases and describes them.

Phase	Description
1. Intake	First contact to get information needed to work with patients, to assess the complexity of the situation
2. Assessment	Daily needs, physical mobility, social and interpersonal skills, mental health status, capacities to advocate for themselves
3. Planning	Aim for improvement of patient skills and capabilities, plan for improvement of functional status and quality of life
4. Intervention	Teach patient, if possible, to advocate for own needs and interests, teach patient to become more involved in own care
5. Monitoring	Monitor factors indicating patient skill and capability building
6. Evaluation	Evaluate whether the patient's functional status, quality of life and satisfaction with services are improving ^{1,2}

Table 1: Case Management Phases

Source: David P. Moxley (1989, p. 18); Michael Ewers (2000, p. 74)

Based on the circumstances under which Case Management is used, support processes of varying lengths can be set up¹.

The diagnosis of CKD not only has an impact on the lives of patients but can also result in major changes in daily family life. Sometimes people cannot deal with the situation and need support in coping with the new challenges.

The Case Manager will develop an assistance network together with the patients following a comprehensive case history. The aim of all efforts is to help people to help themselves, also known as empowerment.

According to Moxley (1989), Case Management is necessary due to six main factors. Table 2 gives an overview¹:

Main factor	Description
1. Deinstitutionalization	Many different institutions at several places are responsible for different needs
2. Decentralisation	The necessary (medical) services are often decentralized, even over long distances and only obtainable through appointments and often long waiting times
3. Population with multiple needs	Mental retardation, mental illness, physical disability or serious medical problems can create various needs
4. Fragmentation	Many of our human services are organised categorically: age groups, functional areas, etc.
5. Social support and network	The growing awareness among human service professionals of the effects on quality of life ³ .
6. Cost containment	Growing concern of containing costs in the health care system while maximizing the impact of service delivery within the constraints of scarce resources ⁴ .

Table 2: Main factors in Case Management Process
 Source: David P. Moxley (1989)

What that means for the patients with advanced kidney disease and high-risk groups will be discussed in the next chapter.

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3. The aims and tasks of Case Management with practice examples – Strategies to achieve optimum care outcomes from the nursing perspective

3.1 Learning objectives:

1. Understand that patients and their families are the core of work
2. Learn about the work of a Case Manager with patients
3. Be aware of the objectives and goals of Case Management
4. Identify the six direct service roles/tasks can support nursing work

3.2 The aims of Case Management in renal care

A Case Manager in renal care must be a practitioner and a well-trained professional with knowledge in the renal field and knowledge about nearby supporting facilities. The aim is to offer assistance that intervenes as little as possible in the familiar environment of the affected people. The people's own resources and their surrounding network are the starting point for the assistance¹.

The care of people with chronic diseases has increased in scope and importance in recent years. This includes the care of people with diabetes, hypertension, and kidney disease. Chronic disease includes disorders that cause permanent or recurring discomfort, disability, or other limitations to well-being².

This description shows that quite different and difficult problems are expected, which affect people's well-being and require changes in everyday life.

The transition between health and illness is smooth, with the whole spectrum ranging from subjective well-being to the most serious experience of illness. The objective impairments are independent of this. The interactions of the two levels are complex and play a key role in coping with illness. For example, severe objective impairments only lead to a low subjective experience of illness and conversely.

The care of people with chronic disease is the responsibility of a multi-professional, interdisciplinary team. Ideally, it is characterised by continuity in care, a broad multi-disciplinary range of care and individuality, focused on the individual patient and their needs.

It is still a reality that kidney dysfunction is more likely to be diagnosed accidentally because the patient consults a doctor for another illness or when they are examined for a new job.

This raises the legitimate question of how patients can be identified and treated early in order to prevent or delay kidney failure. In many countries, guidelines exist for health care professionals like the NICE Guidelines from 2014³ in the UK. They aim for goals such as preventing ill health, promoting, and protecting good health, improving the quality of care and service, adapting, and providing health and social care services. These are also the aims in Case Management work.

Which outpatient clinics can perform such a complex task with decreasing human resources? How can we succeed in identifying patients at an early stage, transmit knowledge, establish integrated care in the environment and enable patients and families to take care of themselves?

What we need is a person, highly educated in the renal field and with an additional education as a Case Manager.

3.3 The tasks of Case Management in renal care

In American Case Management the different functions are described: "problem solver, advocate, broker, planner, community organizer, boundary spanner, service monitor, record keeper, evaluator, consultant, collaborator, coordinator, counsellor, and expeditor." All these functions can be bundled in three core functions: Advocacy, Broker, Gate-Keeper⁴.

Moxley named in his publication "The practice of Case Management" six direct tasks of a Case Manager – Implementer, Teacher/Instructor, Guide/Collaborator, Processor, Information Specialist and Supporter. These functions can be transferred to the renal care work. Figure 3 shows the self-direction increase in relation to direct intervention of Case Management.

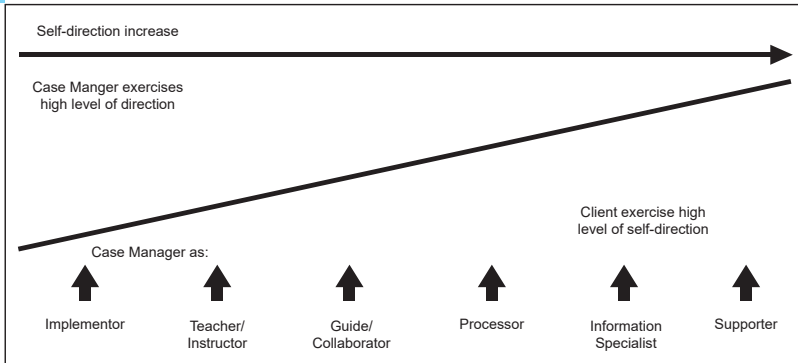


Figure 3: Direct intervention roles
 Source: Moxley, D. P. (1989, p. 80)

What we see is that Moxley (1989) emphasizes that the Case Manager can adopt several different direct service roles designed to increase the effectiveness of the Case Management process itself by enhancing the patient's capability to fulfil their own needs. The Case Manager seeks to enhance the patient's ability to be autonomous and self-directed⁵.

Often people may have "learned to be helpless", they may have learned to see themselves as lacking power and skills due to experiencing rejection, mistreatment, outright discrimination, with a chronic disease that increasingly restricts the social and professional life of those people affected. Decreasing self-confidence promotes learned helplessness. The complexity of circumstances will be reduced through the Case Manager's work. We see this in renal care as well as in other settings.

Self-direction is a positive concept in contrast to the focus on the deficits of the patient. It can be defined as a patient's expectancy that they have the capability to change their situation by using or acquiring skills, abilities, and resources to manage life by themselves. When we have a look at different roles of a Case Manager, we must recognise that every role varies according to how much the Case Manager exercises guidance and how much self-direction is exercised by the patient.

According to Moxley (1989), the individual roles can be described as shown below and can be used for case control in the care of patients with advanced kidney disease⁵.

You will find a brief description of the role followed by an example for each individual role.

Case Manager as **Implementer** has a high direction over the patient. This role is necessary in case of high depression and in phases of helplessness. It seems as if that is contrary to the desire of Case Management to promote a patient's self-direction. But during a crisis period it is reserved for working with a patient. We see this situation in the moment of diagnosis of acute renal failure, for example. This should rarely be the rule in advanced kidney disease through early treatment and care. If necessary, the Case Manager must implement several activities to establish a stable situation. A rapid assessment of informal and formal resources, a view of all need areas and agreement of basic resources such as mental health care, income or temporary housing are the tasks of an Implementer.

If the patient's life situation is stable and the patient can take over personal responsibility again, the Case Manager can terminate the role as Implementer. In most of these cases it is a short-term intervention.

• **Example 1:** The medical staff of a renal outpatient clinic establishes contact with a patient who is 78 years old and has recently lost his wife. His laboratory results have been stable so far but have become acutely worse in recent weeks and there is an expectation of impending dialysis requirement. The man is in a poor general condition, unappeased, malnourished and seems confused. The children live far away and cannot take care of him. In order to prevent his condition worsening, a suitable form of care for the man must be found.

The Case Manager has different options to organise informal and formal help. All interventions must be in accordance with the wishes of the patient. Possibilities include a short-term domestic help, housing with a neighbour, or short-term care.

The Case Manager as **Teacher/Instructor** can be a strategy in moving a patient closer to autonomy. He can make use of structured learning in helping patients to cope with the situation and identify skills. In this moment, the Case Manager can use other professionals to fulfil other duties such as a nutrition specialist, social worker, or the knowledge of other renal patients. The first step is to identify the

skills which the teaching will focus on. The main task in this role is, in most cases, to induce a change in behaviour.

The role is a powerful one as it involves a high degree of Case Management direction. The Case Manager can individualize the process by teaching basic living skills as well as more complex social, interpersonal, and decision-making skills.

The Case Manager's duty in a renal outpatient clinic could be to organise an educational program for new patients – kidney school – to learn more about renal failure and how to live healthier to slow down the progression of kidney disease, diabetes, heart failure etc. Or to integrate the patient in an already existing external program.

- **Example 2:** A 36 year old woman with high blood pressure comes into the renal outpatient clinic for combined therapy and has a body weight of 106 kg. The weight has increased in the last months, and now the patient can hardly walk up the 2 floors to her apartment. First, the Case Manager's task is to address the patient's self-care skills, in order to be able to plan the required support together. This could be nutritional advice, contacting a cardiac sports group or helping to find an apartment on the ground floor.

The Case Manager as **Guide/Collaborator** works directly with the patient to identify human service resources the patient requires to fulfil their needs and then guides them through the process of obtaining these supports. Forming a collaborative relationship with the patient is an important process for the Case Manager. The patient is directly involved in obtaining service and support. Consequently, this builds and strengthens the patient's self-direction, and this can help the patient learn more about skills and abilities required to successfully meet their needs.

- **Example 3:** A young woman of 18 years appears in the renal surgery with several problems. Her diabetes is poorly controlled, and her kidney function is decreasing, and she develops depression. In the past, she was often too sick to attend school. She has no school degree and no job. She is worried about her future and seeks help from the Case Manager. After an assessment, the first step is to clarify the order of urgency for the intervention.

The Case Manager will work closely with the nephrologist to stabilise her health situation. In cooperation with the patient, an agreement is made about the service provider, service and support required to

meet the patient's needs. These can be evening classes, nutrition scientist, diabetes training, kidney school, contact with jobcentre etc. The Case Manager and the patient will meet other professionals and social network members to discuss the situation and to negotiate provision of the service and support.

The Case Manager as **Processor** means, to recognise and understand whether the patient is prepared to act with a high level of self-direction. The Case Manager is available to the patient to help them to choose alternatives for meeting needs and to help them choose an appropriate service and support. The Case Manager offers expert knowledge and guides the patient through the process of problem solving. Now it is up to the patient to take autonomous action to engage with the identified resources. The patient has a resource of knowledge, expertise and experience they can use to meet their needs.

- **Example 4:** Our woman from **example 2**, 36 years old, weighing 106 kg, from the Teacher/Instructor phase has learned to seek support to meet her needs. She is under the care of a cardiologist, and her blood pressure is now nearly normal. She has lost weight since last contact and is regularly active in a heart sports group. She has learned to use her knowledge. She informs the Case Manager that, following the advice of the nutrition scientist, she has joined a cooking course. This shows her self-organisational skills.

The Case Manager as **Information Specialist** evolves out of specialised knowledge, benefit systems, and opportunities available to their patients within the community. The information system is often formalised by Case Managers by transforming it into resource database like file cards, card catalogues, resource books, flyer or business cards, or computer data bases. In this role the Case Manager is not very intrusive. He/she is merely involved as the patient has enough information.

- **Example 5:** The Case Manager keeps in touch with the patient and supports them with information. He/she sorts, organises, and systemises his/her database to keep it up to date. He/she is building up his network and can offer support at any time.

The Case Manager acts as **Supporter** when the patient can exercise a high level of self-direction. The role is cumulative to the previous ones and requires the patient to engage in self-advocacy.

The essence is that the Case Manager supports the self-advocacy of the patient. He can be available for the patient by listening to feelings like frustration and anger and can offer a sympathetic ear. He can use his influence to help the patient to contact an administrator at a higher level in an organisation so that the patient can address his request. Empathy, enabling, and sustaining become major strategies the Case Manager employs in supporting the self-advocacy of a patient⁶.

The next chapter describes potential professionals for Case Management in renal care. It outlines how they interact and what the role of nurse has.

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4. The professionals involved in the care and control mechanisms – Role of the nurse in a multidisciplinary Case Management Team

4.1 Learning objectives:

1. Keep in mind that parties involved in renal care are very heterogeneous
2. Be aware that Case Management is a quality management-controlled process
3. Learn about Case Management as teamwork

4.2 The professionals involved in care of patients with advanced kidney disease

There are three questions: firstly, who are the stakeholders in the supply process, secondly, how do the stakeholders learn about the Case Manager, and thirdly, how can the stakeholders be integrated.

We distinguish between formal and informal support. Informal help is low-threshold and comes from the patient's social network. Formal help is offered by institutions, authorities and other. Access is clearly regulated by law and in most cases limited.

The stakeholders vary from patient to patient and we also see stakeholders who are repeatedly involved in the process. They make the Case Manager's work easier because their workflow is known, their quality can be checked and proven, and because their cooperation has already been tested in other processes.

To manage care in patients with advanced kidney disease, the Case Manager must know what is important for this patient group (Figure 4)¹. That is why the knowledge in renal care is mandatory for the Case Manager. He/she must know interfaces, have contacts and be able to work interactively. This requires the support of management.

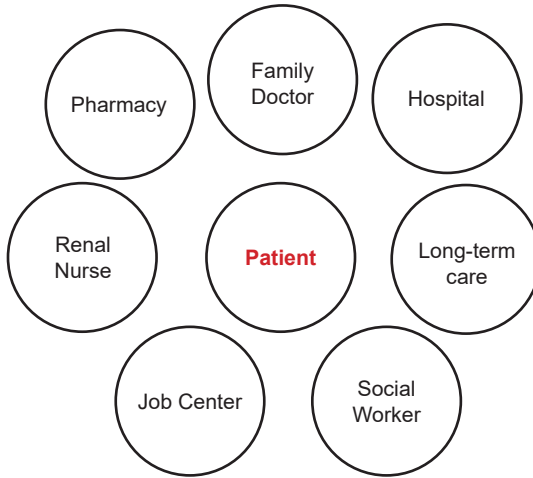


Figure 4: Patient and potential professionals
 Source: Wendt, 2008 p. 70

4.3 Quality management in Case Management work

In renal care and human services in general, the requirements and standards are subject to a process of individual understanding. This means that a clarification must be given between the quality criteria and the examination of whether these are met in individual cases. The DIN EN ISO 9001: 2000 norm can be the basis for a quality management system². This is comparable to other areas in medicine.

Also, a distinction is made between structural, process and outcome quality. That means, the Case Manager implements the care tailored to the individual and situation, and according to the standards of the outpatient clinic, if a quality management system is established.

- **Structural quality** means services are provided under certain conditions that are inherent in the structure of an institution. These include structural conditions, enough staff, technical equipment, communication and information rules.
- **Process quality** means, in a Case Management process, the modality of service provision. Process quality affects the efficiency of workflow, the use of resources and cooperation between all professionals, internal and external.

- **Outcome quality** means to what degree and at what level the objectives set have been achieved. Outcome quality is measured with a variance analysis. In the health sector, this measurement can be done by a survey of user satisfaction and can also consist of determination of the health-related quality of life.
- **Quality assurance** is understood as the continuous systematic control and verification of compliance with quality standards. Various controlling tools can be used for quality assurance. Agreement on objectives, assistance planning, surveys to explore patient and/or professional as well as employee satisfaction can be used in the same way as the evaluation of the Case Management process for this purpose^{1,5}.

There are different quality management systems, for outpatient clinics and hospitals. With Total Quality Management (TQM), a comprehensive instrument can be used that strives for a culture of problem solving and task completion. The Case Management procedure is TQM in action³.

4.4 The multidisciplinary team and the role of nurses

Renal nurses are used to working in multidisciplinary teams. Nurses are the employees who are mostly responsible for all activities regarding to patient care. In many countries there are no regulated access requirements for working in dialysis. Due to the shortage of professionals, an increasing number of assistants are hired and insufficiently trained⁴.

Even international analysis of teams has shown that working in a multidisciplinary team is more a fiction than fact as Professor Jessica Corner wrote in the European Journal of Palliative Care⁶.

What is the role of the nurse in a multidisciplinary team? Cooperation and a skill mix are necessary for the care of chronically ill people. The problems are multi-layered, complex and cannot be dealt with in only one specific way⁶.

The high level of nursing education allowed or even recommended nurses to reposition themselves in a more independent/interdependent role⁴. This can be a leading position as a Case Manager. The scope of duties in nephrology care depends on the physician's understanding of Case Management and how they support it. This leaves a negotiation process in which the position of

the Case Manager in the supply process must be clarified. Ideally, the Case Manager is the interface between the practice, the dialysis clinic, and part of management. This ensures a smooth transition for the patient when dialysis treatment can no longer be prevented.

The created supply plan then becomes the basis for the dialysis care plan. The nurse has extensive foreknowledge, which is beneficial for their work as the Case Manager. They have worked closely with the patient over a long period of time, knows their environment, previous illnesses and the level of training and knowledge about dialysis. The choice of procedure has already been made based on solid advice in cooperation with the nurse and because of shared decision making. Benefits of an effective Case Management are that the patient comes to the dialysis department as a well-informed "partner", with a suitable, functional vascular access, diagnostic findings are complete, and duplicate examinations are avoided. These factors affect patient satisfaction, which again affects the start of dialysis. Home therapy procedures can be better organized and planned. Patients feel in good hands and understood.

There are also impacts on self-management in CKD-stage 5 as shown in the introduction. This facilitates the work of all caregivers, and nurses in renal outpatient clinics can build on it. The coping strategies as described by Elisabeth Kübler-Ross are already well established, and the patient and their family can accept the situation, which may result in an increased adherence to the therapy⁷.

In the next and final chapter, two case studies are presented.

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5. Examples from outpatient care

Examples of Case Management in everyday practice

• Case study 1

A 22-year-old woman with an 8 month old infant, and her 56 year old father, come to the nephrology practice. The father is a widower and the daughter, who takes care of everything, is a single parent.

The father is the patient to be treated. The medical history shows poorly regulated diabetes. His blood pressure is extremely high and untreated. The man has cardiac rhythm disturbances, is a smoker, overweight and has been feeling weak and tired for some time. He is afraid that if he does not go to work anymore, he will lose his work and will not be able to support his daughter and grandchild.

The nephrologist calls a cardiologist and endocrinologist in to assist with the treatment. He informs the Case Manager in order to arrange the social security. After a blood sample has been taken, the patient receives an appointment to discuss the findings and a certificate of temporary disability.

The Case Manager talks to the man in detail, records the social support network and resources, and then looks for formal support. The daughter as informal support is included in this process. A follow-up appointment is arranged for the day of the findings meeting. By this time, the patient should have seen the specialists and the daughter should have sorted out the child maintenance for her daughter. The Case Manager will ensure that all findings are fully documented and will liaise with the competent authorities and the employer to clarify the situation.

The state of health has become even worse. Both the endocrinologist and cardiologist suggest hospitalization to identify the causes and to adjust medication. It is found that kidney function is already limited. For the man, the treatment of the symptoms is in the foreground. He now agrees to be admitted to hospital. The social worker of the clinic will organize a follow-up treatment to stabilize his condition. After discharge, the Case Manager will arrange a place in a program to stop smoking, join a cardiac sports group and an appointment with a nutritionist.

Together with the employer, continued employment in the company is sought. These interventions can stop the progression of the kidney function impairment. The patient recovers gradually. He remains in regular contact with the nephrology clinic and the Case Manager. The Case Manager documents the agreed measures and discusses compliance or adjustment during the meetings. For the daughter, an application for child maintenance is submitted to the appropriate office. Thus, the financial situation of the three individuals relaxes. In the further contacts, the Case Manager will initiate help for self-help in order to gradually promote self-management.

• Case study 2

A 64-year-old woman has been under nephrology treatment for several years and comes to the surgery for a check-up appointment. Her kidney function has been decreasing for six months. The preparation for initiating dialysis treatment is discussed with her. This is difficult for her to cope with so close to retirement age. She had planned a long trip, and now she fears not to be able to travel.

The patient receives an initial consultation from the doctor and is then referred to the Case Manager. A first orientation admission interview takes place and the next steps are planned. First, both decide on a detailed consultation on dialysis treatment to find the most suitable procedure. During subsequent appointments, the Case Manager organizes meetings with patients who know the different dialysis procedures from their own experience and can report on them from their personal perspective. The personal discussions lead to the decision for CAPD.

Since there is a training program for new patients, the Case Manager registers the patient for this course. During 5 sessions over a 5-month period, the patient and her relatives receive structured information on the individual procedures, nutrition, the establishment of a dialysis access, living with dialysis and social-legal advice. Patients who are already on dialysis tell about their life with the disease and travel. There is information on sports activities and support groups in the neighbourhood.

After 3 months, the psychological situation of the patient has stabilized through conversations with a psychologist. Doctor and patient are now planning the insertion of a PD catheter. All necessary appointments

are arranged by the Case Manager and the examination results are then documented and summarised.

Patient and Case Manager visit the PD training department, and the PD team is introduced. From here, all further measures, such as the initial visit and care, are organised by the PD team.

For the patient, the transition from advanced kidney disease to CAPD is smooth and with in-depth knowledge of the disease, treatment, and other support options the PD treatment is less stressful for her. After initial fears, she can cope with the new situation quickly and gain self-confidence in the self-management of the situation and her future life.

The Case Manager remains the person of contact for questions and assistance for the entire duration of renal replacement therapy. For the nursing staff, this means a reduction in administrative tasks, in favour of professional care. Nurses benefit from a planned transition and well-informed patients. Members of staff also receive professional support from the Case Manager at any time.



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