

**Learning Outcomes Towards the Formal Training of Nurse  
Case Managers Practising in  
South Africa**

**by**

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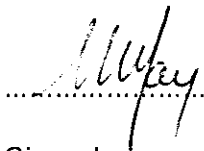
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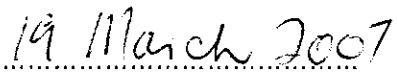
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**Cape Town  
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## DECLARATION

I, Mercia Vanita Jay, declare that the contents of this thesis represent my own unaided work, and that the thesis has not previously been submitted for academic examination towards any qualification. Furthermore, it represents my own opinions and not necessarily those of the Cape Peninsula University of Technology.

  
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Signed

  
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Date

## **ABSTRACT**

This study focuses on the specialised field of Nurse Case Management and the need for formal training for Nurse Case Managers (NCMs). In particular, the study aimed to establish what the outcomes should be of a learning programme for practising NCMs in South Africa.

I used a descriptive survey study design. Data was collected using the Delphi technique. The Delphi technique involves questionnaires to be distributed, collation of the data returned and the distribution of a revised questionnaire for input from the participants. Each questionnaire distributed becomes a 'round' and forms part of the process of data collection. A group of experts working in the field of managed healthcare (MHC) were included as the study respondents. Consensus was reached after three rounds as to what the learning outcomes for NCMs should be. This study found that NCMs practising in South Africa require a specialised set of competencies that are not covered in the basic general nursing training. A learning programme for this area of specialisation needs to include outcomes related to relevant legislation, a code of ethics, managerial and clinical competence, administrative competence in managing contracts, good governance, research, (data analyses) and (business) reporting within the context of MHC.

### **KEY WORDS**

Nurse Case Manager (NCM), Nurse Case Management, managed healthcare (MHC), nursing education, South Africa.

## PREFACE

I completed my general training in nursing in 1979. I moved to Gauteng and completed my midwifery training in 1981 at Boksburg Benoni Hospital. I had the privilege of being at home with my two children for five years but circumstances forced me to return to work. In 1986, I joined a pathology practice as a phlebotomist. A year later I moved to Cape Town and joined an industrial company and my career as an Occupational Health Nurse began. My career was enhanced by the confidence and support that management showed me. I registered on several courses but one in particular was an Occupational Health Nursing course in 1987.

In 1999, while practising as an Occupational Health Nurse at a manufacturing company, it was announced that the company was amalgamating with their main competitor. I was informed that the clinic was to be outsourced within six months. Being a single mother with a child at university I felt concerned. I had a few options, one being to develop a business plan to outsource the clinic or to look for other career opportunities. I regularly looked at the medical/career section of the local newspaper for possible job opportunities. During my search for another position I saw an advert for a 'Nurse Case Manager' (NCM). In observing the job specifications I felt that I may be a suitable candidate, so I casually applied.

Two weeks later I received an invitation for an interview and later was offered the position as a NCM. This was a serious career change for me so late in my career. My employer was an administrator of two medical funds.

In order to gain experience and an understanding of the hospital situation, which I had left 20 years ago, I registered with a nursing agency to work in various hospitals on the general wards over the weekends. I was able to case manage better once these practical assignments were completed.

My employer company was bought out four years later by one of the largest managed healthcare insurance companies in South Africa. This company has a MHC subsidiary company consisting mainly of clinical staff such as professors, doctors, nurses and pharmacists, all from various specialised fields. I was employed as a NCM to manage low cost funds in 2001 to 2005. I worked together with a colleague, an ex theatre trained registered nurse, who taught me to case manage hospital admissions. On the continuum of healthcare, my expertise lay in managing the financial benefits of cases out of hospital.

The obvious differences within the move from manufacturing industries to the administrative, corporate environment needed a mind shift on my part, both in my thinking and my practising as a nurse. The challenges that I faced were intense conflict management, a workload beyond the call of duty, deadlines and constant major changes of processes and protocols with insufficient time for planning and management of the changes.

I began to network with other NCMs at various forums. However, the Western Cape Case Management Forum committee members were particularly supportive of practising NCMs. I found that the nurses attending the meetings had similar problems to mine and the challenges were common to the position of being a NCM.

I discovered that those nurses, who had progressed within the field of MHC, had veered off into administrative positions and furthered their education in public health or had completed Master's degrees in Business Administration. Few, if any, seemed concerned about the plight of the newly appointed NCM in practice.

Being an alumni student on the Advisory Committee of the post-basic Nursing Training Programme of the Cape Peninsula University of Technology (CPUT), I was able to present the problems case managers encounter daily. With the encouragement of this committee I embarked on this research to develop learning outcomes for a post-basic learning programme for professional nurses who would practice as NCMs in South Africa.

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- The participants of the research, thank you for the valuable time spent in taking part in the study and contributing to the enhancement of Nurse Case Management in South Africa. For those who could not take part but wanted to, thank you for your willingness to do so.
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## **DEDICATION**

To my husband Pierre, my daughter Vanita, her fiance Justin Meyer, my daughter Fiona (deceased), and all the practising NCMs in South Africa.

## LIST OF ABBREVIATIONS

MHC	Managed Healthcare
MHO	Managed Healthcare Organization
NCM/s	Nurse Case Manager/s
NQF	National Qualifications Framework (South Africa)
SANC	South African Nursing Council
SAQA	South African Qualifications Authority

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# CHAPTER ONE

## STATEMENT OF THE RESEARCH PROBLEM

### 1.1 BACKGROUND AND INTRODUCTION TO THE NURSE CASE MANAGER (NCM) PRACTICE IN SOUTH AFRICA

Medical insurance has been an active business for about 100 years in South Africa (Metropolitan, 2005). In the early 1990s medical insurance companies, now known as managed healthcare organisations (MHOs), realised that nurses as Nurse Case Managers (NCMs) played a vital role in cost-effectively managing expensive, high-risk hospital cases (Harland, 2003). During this period private hospital consortiums such as Medi-Clinic Holdings, the Life Healthcare Hospital Group and the Netcare Hospital Group were building private hospitals. As the hospitals became ready to be used, management initiated the employment of NCMs to work with insurance companies. The purpose of a nurse in a NCM position was to regulate cost-effective healthcare expenditure (Van Wyk, 2003).

Health services are the responsibility of the state for the majority of people in South Africa. The demand for private medical care has increased and private hospitals have become the venue of choice for members of medical schemes. Simultaneously, the management within managed healthcare companies (MHC), chose to source registered nurses from acute-care nursing environments, e.g. hospital wards, operating theatres and intensive care wards, to become NCMs in the corporate environment (Oosthuizen, 2006). Their function was to manage all high-risk cases clinically and financially, and to manage the medical costs for all diseases.

The majority of registered nurses employed in the corporate environment did not feel proficient as NCMs. The conflicting situations that occurred in the process of case management were partly due to the lack of specific skills required to reach the business objectives. The NCM experienced conflicting situations in terms of administration, bargaining, negotiation, budgeting and assertiveness when managing the member's benefits with good governance.

Traditionally, the nurse has been trained to assist the patient in every way possible to enhance the process of healing. However, conflicting situations occur when the NCM has to deny an authorisation for medical services required by a member – for example when the member's funds have been exhausted. These experiences cause feelings of inner conflict resulting in frustrating situations which need to be managed by the nurse. An example might be when a NCM needs to transfer a critically ill member from a private to a public institution due to financial restraints. The member has to be medically stable prior to transfer as he/she is at risk of harm. The NCM has to ensure the safety of the member as a priority. Once the member has been medically stabilised (not necessarily recovered) and the treating doctor has given consent for the transfer, the NCM arranges transfer from one hospital to another. The potential problem for the NCM is that the costs to the member may have become exorbitant during this stage of care. The NCM must be aware of the financial risks involved and must work pro-actively to prevent the risk from occurring. If this is not adhered to the member might be held liable for additional medical costs towards the service provider. Some cases can become complicated and may have financial implications of more than two million rand for the members (Qualsa, 2006). The situation often leads to

legal action against the member by the service provider. This type of incident should be avoided. By avoiding these situations the NCM's role becomes part of the main objectives of managed healthcare.

The nurse's empathy lies with the member as the patient. Nursing is a caring profession and all nurses are taught that the patient's well-being takes precedence over other matters during the process of caring and managing of the patient's condition (Roper, Tierney and Logan, 1996). NCMs, as nurses, are no exception.

The NCM must be able to manage added complex systems such as Information Technology (IT) as these processes form a major part of their daily task. In the context of MHC, IT systems have a clinical context with an administrative content. IT departments within the MHOs usually develop their own systems according to their business needs. The NCM is trained to use these systems effectively in the process of managing a patient's disease and the financial structure of a medical scheme.

NCMs are expected to manage themselves professionally when confronted with other complexities of corporate dynamics such as competitiveness, negative team interaction and work pressure (Qualsa, 2003-6).

It became a concern of MHC companies that newly employed NCMs found it extremely difficult to adjust to the complex processes of managing the health finances of members.



This topic, amongst many others, was discussed at the Western Cape Nurse Case Management Forum. The purpose of this forum was to assist NCMs in finding solutions to their work problems (Munro, 2002), and to create an opportunity for networking.

During my work as a NCM, I understood the difficulties that the nurses faced in their daily practices. As a result, I approached the Nursing Training Programme Advisory Committee of the Cape Peninsula University of Technology (CPUT) to discuss the development of training for NCMs practising in South Africa (Kitshoff, 2001).

This committee encouraged me to investigate the possibility of formal education for registered nurses who practice as NCMs in South Africa. The research committee, which formed part of the Applied Sciences Faculty of CPUT, then known as the Cape Technikon, approved the study programme to develop outcomes for a learning programme for NCMs practising in South Africa. This was approved on 22 August 2002.

## **1.2 STATEMENT OF THE PROBLEM: LACK OF FORMAL TRAINING FOR NCMs**

MHOs have taken on the role of managing health services. These services included the responsibility to monitor financial risk for the cost of the medical services rendered for the occurrence of ill health incidences, defined as 'cases.' See section 1.6.9.

The nurses, employed as NCMs by MHC companies, have the challenge of transferring their practical caring skill and medical knowledge into a financial

and administrative function within an environment that is not familiar to them. The transition of nursing and practice skills into an environment that is mainly corporate tends to create feelings of detachment from the nurses' normal daily practice in a caring environment. NCMs have to rely on sharp, cognitive and reflective financial decision-making skills for each case. This includes formulating a nurse-care plan per case. In addition, they have to comply with legal and financial complexities related to each registered medical aid company according to the medical scheme's contract (South Africa, 1998). In order to facilitate this transition, most NCMs employed by MHOs and hospitals attend short in-house training (Blair, 2003). The aim of these courses is to update the attendees on processes, procedures, equipment and systems related to the culture within that specific hospital or MHO. However, the courses focused on the practical aspects of the business only (Blair, 2003). They are approved and registered with the South African Qualifications Authority (SAQA).

In South Africa, approximately seven million members contracted with medical schemes and funds are managed by 127 registered medical schemes. The schemes, in turn, are managed by 58 accredited MHOs and 18 accredited medical scheme administrators that are registered with the Council for Medical Schemes of South Africa (South Africa, 2005). Many of the MHC companies and MHOs are managed on a smaller scale than their counterparts. Regarding the training of NCMs in the smaller MHCs, the nurse does not have a guarantee of being offered training opportunities. Much of the formal training material for NCMs has been developed in the United States of America (USA) (Cohen, 1999; Powell, 1996).

The transition from being a nurse carer to being a nurse administrator within an unfamiliar context has given rise to the need for formal training for NCMs practising in South Africa.

### **1.3 RATIONALE**

The rationale for the study is based on the importance of the future formal education and empowerment of NCMs to proficiently and competently practise in South Africa. There is no formal training available at a tertiary level in South Africa (CPUT, 2006). Formal training and education in Nurse Case Management is important as nurses should be able to proclaim that they have acquired the knowledge and skill needed to contribute competently within their role and practice as Nurse Case Managers. Competency in this context means appropriate and safe case management of the client's health needs. This confidence comes from having completed a formal training course (Cesta, Tahan & Fink, 1998:83).

In South Africa, the Higher Education Institutions (HEIs) have developed other formal training programmes for nurses at a post-basic level that integrates theory and practice. The Higher Education Institutions offer courses on a part-time basis and therefore creates opportunities for employees to further their academic education while continuing with their work (CPUT, 2002).

## **1.4 RESEARCH QUESTION**

Given the fact that there are no officially approved courses currently available in South Africa, and, encouraged by the concerns of existing course development committees about the lack of formal training, what then, should the outcomes for a post-basic qualification for NCMs be? Through this study I aim to investigate what those outcomes should be.

## **1.5 PURPOSE**

The purpose of the study then is to investigate and develop outcomes that could form part of the specifications for a qualification registered with the South African Qualifications Authority (SAQA) at a National Qualifications Framework (NQF) level 7.

The objectives are to:

- (a) Determine the professional role and function of the NCM within the South African MHC context.
- (b) Develop outcomes to be used in a learning programme for NCMs practising in the South African MHC environment.

## **1.6 DEFINITIONS**

Within this study, the following definitions will apply:

### **1.6.1 Managed Healthcare Organisations (MHOs)**

MHOs are defined as healthcare systems that 'are responsible for both the financing and the delivery of a broad range of comprehensive health services to an enrolled population' (Kongstvedt, 1997:37). MHC aims, through the channelled pathways of care, to further medical care that may be costly

and/or to prevent over-servicing of the member that is considered to be clinically unnecessary. MHC processes are systems driven and case management processes are people driven (Powell, 1996:3).

### **1.6.2 Medical schemes in South Africa**

The business of a medical scheme is defined in Section 1 of the Medical Schemes Act, No. 131 of 1998 and registered under Section 24 (1) (South Africa, 1998). It reads as follows: The business of a medical scheme means the business of undertaking liability in return for a premium or contribution –

- (a) to make provision for the obtaining of any relevant health service;
- (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any person, in association with or in terms of an agreement with a medical scheme (South Africa, 1998).

### **1.6.3 Nursing practice**

Nursing practice is defined and described in the acts and procedures of Chapter Two, Section 2 of the Nursing Act, No. 50 of 1978, regulation R.2598 as the scope of practice of registered nurses (South Africa, 1978). A registered professional nurse is an individual who has completed a 'course of study.' The course is a programme of education and training approved in terms of Section 15(3). On completion of the programme the nurse acquires a qualification (R.425) which confers on the holder the right to registration as a nurse (general, psychiatric, community and midwifery). This is a four-year course with practical and theoretical assignments.

#### **1.6.4 Nurse Case Management**

Nurse Case Management is 'a nursing care delivery system that supports cost-effective patient care' (Cesta *et al*, 1998:2). It is a collaborative process within the context of MHC, that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs by using communication and available resources to promote quality and cost-effective outcomes (Cesta *et al*, 1998:2,3).

#### **1.6.5 Nurse Case Manager (NCM)**

An NCM is a nurse who has completed the basic nursing training. The majority of nurses who practice as NCMs, have a post-basic qualification indicating that they have specialised in a particular field of nursing. NCMs practise in MHOs as corporate specialist nurses and in hospitals as specialised nurses within the accounts and financial departments (Cohen & Cesta, 1997).

The NCM communicates with various key people, such as members (a member is a person who has been enrolled or registered as a member of a medical scheme), related to the case(s) (South Africa, 2006). Members have dependants who are registered on the medical scheme and who are known as beneficiaries. They are defined as:

- (a) the spouse or partner, dependent children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or

- (b) any other person, who, under the rules of a medical scheme, is recognized as a dependant of such a member, and is eligible for benefits under the rules of the medical scheme.

These are the NCM's patients whose benefits, medical expenditure and illnesses he/she manages (South Africa, 1998).

Other key people that the NCM communicates with are members of the medical multidisciplinary team. In addition, the corporate NCM develops a strong link and works interdependently with the hospital NCM. This is applicable in situations where information on the member's financial and ill health status is exchanged between the service provider and the financial institution (Cohen & Cesta, 1997:31, 33).

#### **1.6.6 Learning programme**

A learning programme comprises a cluster of modules or subjects that lead to a qualification. Learning programmes are accredited by the relevant statutory professional bodies e.g. the South African Nursing Council (SANC) that accredits formal training for nurses. A requirement for the learning programme is to meet the exit-level outcomes and associated assessment criteria of the qualification (Du Pre, 2000:40).

#### **1.6.7 Learning programme outcomes**

Learning programme outcomes are categorised into three sub-groups:

- (a) critical cross-field outcomes which are integrated into all learning programmes;

- (b) exit-level outcomes which characterise the applied competence that the qualifying candidate should possess upon attaining the qualification; and
- (c) specific outcomes which relate to specific aspects of the exit-level outcomes (Du Pre, 2000:31).

#### **1.6.8 Universities of Technology**

Universities of Technology are public Higher Education Institutions that provide higher-level career focused and/or technological education and training. These institutions work in partnership with relevant stakeholders and industries related to their educational programmes. The programmes are structured in such a manner that the student can be encouraged to be creative, acquire skills and produce knowledge on a life long basis. This is achieved by learning the skill of applying, adapting and modifying theory learned at university and within the workplace (Eraut, 1994).

#### **1.6.9 Case(s)**

Cases are defined as acute or chronic ill health events occurring at a certain time during the member's life span (Qualsa, 2003-6). Cases are further defined within the process of case management in the MHC setting. Details of cases are kept in files that may be stored on a computerised or manual system.

#### **1.6.10 Case authorisation**

An authorisation is an agreement between the service provider and the MHC company that manages the scheme. The authorisation will only pertain to that specific event and for the specific service provider caring for the member



at that particular time (Qualsa, 2003-6). The process of authorisation involves communication on the type of procedure and costs involved for the event. A unique number is generated that interlinks the admission, member and type of procedure to be performed if the procedure is considered to be necessary. This information is completed on a computerised software system by the case manager (Kongsvedt, 1997:342). After the event has been completed, an account is sent to the administrative company managing the claims of the scheme, for payment.

Administrative companies are accredited and registered with the Council for Medical Schemes. They function separately from MHCs where the NCMs are employed. Administrators ensure payment of claims. Claims are the accounts that contain the agreed upon authorisations that were made between the NCM and the service providers. The two companies work in support of each other's tasks and functions, *i.e.* comparisons are made against a claim to ensure that what was authorised is paid. If payment is not correctly made, it can result in illegalities and inconveniences for all parties concerned, including the member. This does not constitute good governance within the business of managing medical aids and should be prevented at all costs. The aim of managing the authorisation system is to curb unnecessary costs and ensure appropriate medical care of patients. According to the contract(s) it is the member's responsibility to arrange the authorisation for his/her care. The NCM often assists and guides the member in these matters (Ingwe, 2006; Telemed, 2006).

Authorisations were originally used to manage high-risk cases such as hospital admissions. However, high costs have been identified in other areas of medical care. This has resulted in authorisations now being used for services out of hospital. Several private hospitals have a system of pre-authorisation clinics and have positioned NCMs in these clinics (Du Toit, 2004). Minor procedures are being automated to generate authorisation numbers so that the NCM can focus on high-risk cases such as intensive care admissions. These admissions or incidents are of high cost to the member and can escalate between R8000.00 to R13000.00 per day (Harland, 2006).

## **1.7 CONCLUSION**

Nursing in the 21<sup>st</sup> century is changing with the rest of medical practice. The changing social and economic environment within healthcare is forcing the population to decrease medical inflation and to create new reimbursement models for cost-effective and yet appropriate healthcare.

The NCM plays a key role in the cost containment of healthcare in South Africa. Regarding stakeholders and members of the public, the NCM has a duty to ensure that healthcare is effectively applied within the restraints and dynamics of MHC. Foremost are the professional actions of the NCM in initiating a nursing care plan to guide and support the patient in the process of managing cases.

# CHAPTER TWO

## THE LITERATURE REVIEW

### 2.1 INTRODUCTION

In Chapter One I gave an overview of the study and I briefly described the background of practising NCMs in South Africa.

The aim of this chapter is to investigate how NCMs are conceptualised by the international and South African MHC market. Various kinds of literature are focused on, such as scholarly literature; textbooks; websites on course outcomes and various areas of Nurse Case Management practice; MHO documents concerned with Nurse Case Management practice (corporate companies and hospitals in the Western Cape Province of South Africa); unpublished theses; my personal experience; legislative and policy documents; conceptual models in the nursing literature; and other information networks (not necessarily textual).

The approach that I took in terms of this literature study is not conventional. I needed to direct my investigation into the areas mentioned above as I have experienced paucity in the published literature in South Africa. It is important to note that there is virtually no scholarly literature on Nurse Case Management as a field of practice or formal training for NCMs practising in South Africa, therefore this study examines various contexts that deal with Nurse Case Management as a field of practice. Suffice it to say, that this study is the first of its kind to be completed in South Africa. There are, however, others in progress presently at Stellenbosch University in the Western Cape.

Firstly, I will focus the discussion of published and unpublished literature on the international market as Nurse Case Management is well-defined and well-established in the USA. The USA is also the place of origin of NCM. I will then go on to discuss South African published and unpublished literature related to NCM practice and formal training. I have chosen to describe my personal experience within the literature study as it gives insight into the reality of the Nurse Case Management experience. I will briefly touch on the changes affecting the practice of the South African NCM and will summarise the differences between international and South African Nurse Case Management.

MHC Nurse Case Management is a new concept within the health sector in South Africa, and as such it is not defined and has not been profiled. In this chapter, I will present a review of available literature pertaining to NCMs practising in South Africa and internationally. I will focus on publications and literature relating to the training and formal education available for areas of advanced nursing and how that relates to the advancement of NCMs in South Africa.

## **2.2 AN INTERNATIONAL PERSPECTIVE**

MHOs in the USA were the forerunners of MHC globally, both in practice and theory development (Kongstvedt, 1997:3, 4). NCMs have been operational in the USA since the 1980s (Kongstvedt, 1997:258, 259). I focused my research on the available published literature in various states of the USA. I found published scholarly literature in this country only (Cohen & Cesta, 1997; Cesta, Tahan, & Fink 1998; Cohen, 1998; Cohen, De Back, 1999; Powell,

1996; Siefker, Garret, Van Genderen & Weis, 1998). All of the authors are USA based.

### **2.2.1 Published literature**

Concerning the literature, I found relevant and substantial information on the practical and theoretical issues relating to the practice and formal education of NCMs in the USA (Polit & Hungler, 1995:79). I found that the subject matter on Nurse Case Management was documented in the same textbook, *i.e.* I did not find a book only focusing on nursing education for NCMs. However, the books that I did find had education and practice combined into one (Cesta, *et al*, 1998; Cohen *et al*, 1999). My focus remained on textbooks, published journals and websites on the internet where specific information on the roles, practice and education of NCMs were available. The key search words that I used when investigating the websites were Nurse Case Manager education; roles, practice and functions of the Nurse Case Manager. The information I received when applying the keywords always referred to the NCMs as Case Managers only.

In the USA, textbooks on how NCMs function and the related competencies required for proficiency, covered topics on financial reimbursement systems; case management models; the role of the NCM; skills for successful case management; curriculum and the certification in Nurse Case Management; developing case management plans; quality care of the patients; measuring the effective care of case management and legal issues in case management (Cesta *et al*, 1998).

Other subject matter focused on the clinical and administrative practice of Nurse Case Management, the principles of practice, the characteristics necessary for an effective NCM and legal issues in Nurse Case Management (Cesta *et al*, 1998).

The textbooks explained how Nurse Case Management is applied in practice and included the following subjects: contribution made by the NCM to the restructuring of the health care system; creating a foundation for change; nurses and clients as partners in health; the process of nurse case management; the education of nurses from the NCM's view; continuous quality improvement; ethics in Nurse Case Management; change theory; economics; and research and dissemination of knowledge (Cohen, 1996).

Certain textbooks give comprehensive explanation and guidelines on the practical information on nurse case management (Siefker *et al*, 1998). Furthermore, an author specified outcomes (practical) that were advocated for NCMs when in the process of managing cases. The outcomes relate to the best quality of care; collaboration with service providers; fiscal responsibilities; patient advocacy; and outpatient management. The outcomes equip the nurses with the skill of optimally and successfully caring for members of schemes (Powell, 1996:13-15). The evaluation of competence and proficiency of NCMs were documented in the textbook. However, the evaluation related more to quality control of the daily practice of the NCM. Powell (1996) addresses the stages in the process of Nurse Case Management. These stages are: selection of the case; assessment of the case; continuous case management of the case, coordination and development of the

treatment/discharge plan; final evaluation and/or post discharge follow-up and implementation of the final plan (Powell, 1996, 241-244.)

The investigation included documents relating to job descriptions, job specifications and job qualifications for Nurse Case Management (non-textual). I chose to peruse the contents of these documents so that I could reach an understanding and gain insight in what is expected of NCMs in practice. My attention was also directed to those countries abroad that did not have published literature. These countries are offering South African nurses, including NCMs, contracts with handsome remuneration packages and further career opportunities, e.g. the United Arab Emirates (UAE), New Zealand and Australia. I realised that the training and the work ethic that South African nurses have made them 'well sought after' nursing professionals (Cape Argus, 2003-5). The nurses were targeted by recruitment agencies who actively marketed employment opportunities overseas.

### **2.2.2 Training for NCMs**

My investigation of textbooks and websites informed me of accredited learning programmes that are presently available at a level of bachelors and master's degrees for NCMs in the USA. Access to some of the information can be gained on various websites that include the Case Management Association of America's website. I was able to source information on case management certificate, non-certificate and degree (bachelors and masters) learning programmes/courses (Cesta *et al*, 1998:79-85).

### *Certificate of Case Management*

According to Cesta (1998), case management certificate programmes/courses (used interchangeably) are offered as two types. One such course is offered by a health care institution as a seminar or conference over a few days and is available to all nurses irrespective of their educational background (Cesta *et al*, 1998:79). An example of the non-college certificate course is New England Healthcare Assembly's certificate programme (Cesta *et al*, 1998:79). This course contains three three-day modules over a total of nine days. A 'comprehensive examination' is completed by the candidate before acquiring the certificate. The content of the course is information and skills development on managing the processes, procedures and quality control of case management (Cesta *et al*, 1998:79).

Another type of course is offered by an accredited college or university with the curriculum consisting of 'multiple credits'. The credits can amount to twelve. The admission requirement for registration on this programme is a 'post-baccalaureate' certificate (Cesta *et al*, 1998). In addition, a post master's certificate programme is offered. The two post-degree programmes consist of theory and clinical education for NCMs, and on completion the candidates are issued with a *Certificate in Case Management*. An example of a college or university based programme is a course offered at Seton Hall University, USA (Cesta *et al*, 1998:80). The contents of this course consist of theory and practice amounting to six credits in Nurse Case Management theory, three credits of clinical experience/practicum and three credits in nursing resource management. These courses are only offered to candidates with the relevant admission criteria, *i.e.* those with a bachelor's degree in



nursing from an accredited college of nursing; with a B average; and those who have licensure as a registered professional nurse and who have at least one year's clinical nursing experience. On completion of this course candidates acquire a certificate of completion in Nurse Case Management.

#### *Non-certificate programmes for Nurse Case Management*

The non-certificate programmes/courses are offered as 'in-house' training events and can extend up to a few weeks. The aim of the course is to prepare the nurse to be competent and proficient in the processes, policies and procedures of case managing. The agenda that the MHOs have in presenting these courses is to upskill the nurses to meet their specific business objectives (Cesta *et al*, 1998:81)

Additional non-certificate programmes are courses that are available at accredited nursing schools and that consist of three to six credits. These courses are built into the bachelor's or master's degree programmes. The contents of the courses consist of the basic training in Nurse Case Management and are listed as: financial reimbursement systems; roles of case managers; case management plans, variance data collection and analysis; outcomes management; and quality improvement (Cesta *et al*, 1998:81).

Both types of courses mentioned above are recognised by the American Nurses Association's Board of Continuing Education. Continuing education units (CEUs), in this context, can be compared to the South African

educational concept of continuing professional development (CPD), the process of life long learning.

*Nurse Case Management degree programmes/courses*

Nurse Case Management degree programmes in the USA, are 'full graduate-level programmes'. They are available at certain nursing colleges and universities. They are normally pitched at a master's level as once the candidate/student has completed the programme and an examination, they acquire a master's degree (Cesta *et al*, 1998:82). An example of this is a programme offered at Villanova University in Villanova, USA. This university was commissioned by the United States Public Health Service to develop a post-graduate degree in clinical case management. The outcome descriptors for this course were: Health Care Organizations and Nursing Care Systems; Budgeting Concepts for the Clinical NCM; the Role of the Clinical NCM; Marketing in Health Care; Clinical Outcomes course; Patient Education; Practicum in Clinical Case Management. On completion of this course the graduates are equipped to 'apply the theory and advanced knowledge of case management systems in clinical practice' (Cesta *et al*, 1998:82). The entry level for this particular course was one year's practical as a NCM and a bachelor's degree in any field of nursing.

I found a master's degree qualification in Nurse Case Management on a website that was being offered as a distance learning course by Quest University in Alabama, USA (Quest University, 2003-6). The contents of the course included: Advanced Health Assessment; Advanced Nursing Assessment; Advanced Nursing Research; Case Management Role and

Process; Human Relations Management for NCMs; Clinical Research Practicum; Case Management Practicum; Fiscal Resource Management for NCMs.

The time span over which the textbook literature was written and published ranged from the early to the late 1990s. As far as websites are concerned I found information on Nurse Case Management formal training, e.g. Quest University courses are still being offered.

Over and above investigating the practice of NCMs and their formal education I also looked at the schooling and education from pre-school to a master's degree in countries such as Australia, New Zealand, England, USA and UAE. I did this because I wanted to understand the educational background of the individual residing in countries where the South African nurse was immigrating to. The reason for this was to look at the quality and standard of education so that the outcomes developed from this study and used in a learning programme could put South African nurses on a par with their foreign counterparts. I specifically looked at the national qualification framework (NQF) in each country mentioned above (Lemmer & Badenhorst, 1997:430).

Other than in the USA, I found a post-graduate (bachelor's) nursing degree in case management being developed at the University of Melbourne in Australia. Presently, that degree is not being offered. I could find no published literature on formal education for Nurse Case Management in New Zealand, England or the UAE.

In surveying the areas and sources of various types of literature I found that presently (2006) there are no post-basic formal training courses for NCMs offered outside the USA, except for Canada where the Case Management Association of America advertises post-basic courses for the perusal of the Canadian public on a Canadian website.

Once my international search was completed, I turned to the internet to further investigate what was available on the practice and education of NCMs in South Africa.

### **2.3 A SOUTH AFRICAN PERSPECTIVE**

In surveying literature in South Africa, I found a different scenario when I compared Nurse Case Management in South Africa to countries abroad. I found no textbook material that had been published in South Africa relating to the practice and education of NCMs. The kinds of literature that I searched were internet websites, South African based MHO documents in the form of job descriptions, job specification and qualifications, unpublished South African based theses that focused on advanced nursing and nursing education in other fields of nursing. I turned to legislative and policy documents within the Department of Education and the Department of Health. I did this to gain an understanding of and greater insight into the health and educational framework of the country in relation to the practice of Nurse Case Management. My intention was to gain insight into what relevant contributions NCMs were making to the country by being in practice. Being an underrated and specific field of nursing practice, the NCMs' value to business and their contribution in managing the finances related to healthcare

were not known outside of MHC environments. If at all, the public, medical service providers and educators of Higher Educational Institutions misunderstood the valuable role that NCMs played in containing costs and managing chronic illnesses. I continued to search and eventually decided that I would have to relate my personal experience as an NCM and document relevant information that I gained from personal interviews with experts in the field of MHC.

The conceptual framework for this study comprises of four nursing models. I have chosen the models that can best describe the role of the NCM in South Africa.

### **2.3.1 Published literature**

My investigation of the South African MHC arena and the various Higher Education Institutions found very limited, if any, published literature on the roles, practice and education of the South African NCM. Information on how the NCM adds value to the business of MHC and their roles within the business remain within the boundaries of MHC business units. Information in South Africa on NCM's competencies, knowledge and skills was limited to job advertisements in the printed media, *i.e.* local newspapers (Cape Argus, 2003); a five-day coding course available to NCMs at Witwatersrand University (Fourie, 2003) (but which is no longer offered); Nurse Case Management courses that include one- or two-day seminars and workshop courses on Case Management (no longer available) (Health Advance Institute, 2006; Western Cape Case Management Forum, (Weeks) 2003-6); 'In-house' training events previously mentioned and the training manuals

thereof were not for public perusal and as such I could not access them. However, I did access hospital documents pertaining to job descriptions, job specifications and qualifications.

### **2.3.2 Training for NCMs**

Nurse Case Management training in South Africa comprises comprehensive 'in-house' training events that are practical and workplace specific. There are, however, case management forum meetings where NCMs are given general updated case management information, *i.e.* the oncology case management monthly meetings established by Aventis, a pharmaceutical company that supplies oncology drugs to service provider hospitals and healing centres. The NCMs throughout South Africa manage the costs of these drugs according to benefits available to the member/s and therefore forms an integral part of the multi-disciplinary team. Oncology cases per year can accumulate to approximately R400000.00 per case. *Aventis* is a pharmaceutical company that recognises the value that the NCM brings to the team by managing the expenses of oncology cases. As such, *Aventis* ensures ongoing monthly training for NCMs. However, NCMs require additional formal training on financial management as their basic training does not equip them to be competent in this area of business.

A financial auditing case management forum for NCMs was established in the Western Cape Province, South Africa. The forum meets on a monthly basis. The purpose of the forum was to discuss financial issues within cases arising from MHC companies (Everton, 2003). This forum has stopped functioning since (Oosthuizen, 2006). However, one of the key performance areas of the

NCM in practice is the auditing of accounts prior to the accounts being paid (Qualsa, 2003-6).

Other South African Nurse Case Management forums in progress are the Western Cape Case Manager Forums and two forums in Gauteng, one specifically for oncology (Weeks, 2006).

NCMs who are interested in expanding their formal education do so independently to the MHC environment. Presently, the only qualifications that they can work towards are diplomas or degrees in administration, public health and/or risk management. These courses are mostly administrative.

The majority of nurses practicing as NCMs have qualifications or formal training in Intensive Care Nursing (ICU), hospital theatre training, or have post-basic additional qualifications in other relevant areas of nursing such as oncology, psychiatric, primary health or occupational health (Qualsa, 2003-6). They are employed as nursing specialists.

### **2.3.3 Personal experience**

Despite the fact that there is no published scholarly and academic literature on the roles, functions, practice and work-life of the NCM practising in South Africa, NCMs have been practising in the country for some time before this study began (Munro, 2002). In emphasising the vastness of MHC I have previously mentioned in section 1.2, there are 58 MHOs registered with the Council for Medical Schemes. One such organisation is *Qualsa Pty Ltd*. There are some 90 case managers of which approximately 20 are

pharmacists while the rest are NCMs. They are managing 18 schemes with 1.2 million members (Qualsa, 2006). This is 17% of the population of individuals who are members registered with medical schemes in South Africa. These figures account for only one sixth of this particular health sector. Hypothetically speaking then, one can assume that there are approximately 500 nurses practicing as NCMs in the country. In its simplicity, the example of the statistics relating to this one company indicates the need for nurses to be positioned and trained as NCMs. The relevance of this point is noted in the fact that many nurses in South Africa are leaving their specialised fields of practice and are shifting their expertise to be used within MHOs. The reasons for this shift are many and individually based. However, common factors are attractive remuneration packages and rewarding work opportunities.

As part of the study I signed on for practical assignments within the private hospital setting and worked at these health institutions in my time off work. I 'shadowed' the NCMs in the hospital environment and spent time as a researcher observing and documenting the daily functions and practice of the hospital NCMs working in the accounts departments. This occurred at five hospitals in the Western Cape Province, one being a public hospital. These experiences enlightened me on the differences of the two types of NCMs, one that works in a hospital setting and the other in a MHC corporate setting. I received literature on the hospital NCM in the form of job descriptions and job specifications. Beyond this, I gathered information via personal interviews with experts in the field of MHC.



My findings were that the practice and key performance areas of the hospital NCM relate to managing financial losses per case per scheme; updating the schemes with relevant medical and clinical information with regard to each case, e.g. length of stay estimated for members admitted to hospital and level (quality) of care (monitored and adjusted according to the patient's needs); coding of medical and surgical procedures related to the admissions by using the International Classification of Diseases and related health problems, 10<sup>th</sup> revision (ICD 10), and current procedural terminology coding systems (Vorster, 2003).

As an example of the interdependence between the two NCMs, the hospital NCM needs to inform the corporate NCM of the expenses related to complicated admissions, e.g. the use of expensive prosthetics (internal devices used for elective and emergency cases such as cardiac conditions needing stents or orthopaedic cases needing joint replacement prosthetics), the use of specialised medication, i.e. *Rocephin*, a broad-spectrum intravenous antibiotic medication (R2 000.00 - R4 000.00 per day), and specialised suction wound care to manage severe sepsis in wounds that can cause the death of patients. The hospitals have their own internal systems for quality control by the hospital NCMs (Van Wyk, 2003, Bloom, 2003).

As previously stated in this chapter, the NCM within the corporate setting is dependent on the hospital NCM to share the correct information on the member's clinical condition (Qualsa, 2003-6). I mention this again to bring attention to the fact that this does not always occur as the business objectives for each type of NCM differs as does the work context. i.e. strategies used to

reach profits vary per environment and NCMs find themselves in opposing camps regarding the achievement of business objectives.

I made several attempts to access published literature to present in this study. However, the reality of the situation was that there was paucity of published literature of any kind in South Africa. As a result of this problem I arranged to have various *ad hoc* interviews with NCMs, their senior managers and executives, followed by further information via electronic mail, *i.e.* Nurse Case Management job descriptions, job specifications and key performance areas. My practice as an NCM provided me with many opportunities to probe and question various experts in the field of MHC on their expectations of the competency, knowledge and skill of NCMs practising in South Africa. Basically, what I found was that the key performance areas of the NCM practising within the MHC setting in South Africa are pre-authorisation (same as case authorisation in Chapter One, section 1.6.9); concurrent review; retrospective review of claims; co-payment application; and care plans for each hospital case (Qualsa, 2003-6). Quality control of work performance is assessed internally (Blair, 2003, Van Wyk, 2003; Qualsa, 2003-6).

I discovered that much has been written on all aspects of the MHC business to ensure that NCMs are able to practise competently and efficiently. However, this information is confidential and often forms part of the business strategy enabling companies to remain competitive within the macro MHC environment. These are considered trade secrets and are therefore not shared outside the particular company. This information also supports in-house training programmes.

In 2003, due to the limited literature available in terms of Nurse Case Management in South Africa, I used a published master's thesis by Erica Greathead (2003) to compare the quality and level of performance of the specialised nurse. I did this because NCMs are employed by MHOs specifically for their expertise in a field of nursing – mostly the acute care setting, e.g. intensive care training and surgical operating theatre training, and in positions as unit managers managing all types of wards. It was my experience that NCMs were not recognised within their field of expertise as NCMs. The NCM needs recognition by the public, nursing educational institutions, their colleagues in other fields of nursing, and by SANC.

Greathead's (2003) thesis was a research document on the competencies, knowledge and skill of Unit Nurse Managers (advanced nursing) within the acute care setting and other health services environments of South Africa (Greathead, 2003). I particularly chose to study her thesis as I was investigating the competencies, knowledge and skill of NCMs practising in South Africa. Greathead (2003) divided the competencies for Unit Managers into 173 tasks. In comparing what NCMs do in terms of knowledge, skill, responsibility and expertise, I discovered that they performed 153 (88.5%) of the 173 tasks that Unit Nurse Managers do. The remaining 20 tasks (11.5%) that NCMs do not do are the tasks related to disciplinary action of subordinates. NCMs are not involved with line function responsibilities. My investigation gave me an awareness of the fact that NCMs function as advanced trained professional nurses.

In my personal experience, as I entered the Nurse Case Management field I felt that I was not equipped as an NCM. Instead, I became an expert in this field through trial and error as my expertise lay in Occupational Health. I was initially employed as a Health Nursing Manager to manage the MHC department of a company (Reliance Administrators, 2001-3).

#### **2.3.4 Changes affecting the roles and practice of the South African NCM**

In 2003, there was uncertainty as to whether the South African government would develop a national health care system. Instead, the Department of Health has developed its own private healthcare contract called the Government Employee Medical Scheme (GEMS) and contracted it out to experienced MHC and scheme administrative companies within South Africa (Metropolitan, 2005). GEMS membership has grown from a few hundred members to 100,000 presently (Metropolitan Healthcare, 2007).

Due to the fact that MHC, as a health sector, is expanding, the skills and knowledge base of the NCM within South Africa needs to expand to include greater and varied business needs. This means that the function of case management is not bound to managing high-risk cases such as hospital admissions only, but will extend to all areas of risk management related to medical care. The types of new MHC products being managed have been discussed in section 2.3.2. (Qualsa, 2003-6).

#### **2.4 COMPARING INTERNATIONAL AND SOUTH AFRICAN PERSPECTIVES**

Once I had completed my search, I made a comparison of Nurse Case Management both internationally and nationally.

As previously mentioned, in 1995, the USA quota of registered members of schemes was 36.7 million, whereas the quota of membership for schemes and funds in South Africa was approximately 7 million out of a population of approximately 40 to 45 million. These figures remain unchanged (Masobe, 2006). The fact that only about 7 million out of the present approximate 49 million South Africans can afford medical insurance is indicative of an imbalance particularly between public healthcare and private health care systems. However, NCMs are employed to manage the health requirements of the 7 million who can afford to be on private medical insurance. In doing so the NCMs still experience the effects of inefficiencies related to managing the health needs of the entire population.

I discovered that due to the limited health infrastructure in South Africa, particularly in public hospitals, South African NCMs had far greater challenges in their daily practice than their international counterparts. An example of this would be a situation in which the public hospital's medical equipment, such as Magnetic Resonance Imaging machines, commonly known as MRI machines, are outdated, need repair and are regularly out of action, possibly due to over-usage. During the time that it takes to repair the MRI machine, emergency and elective cases are put on hold and hence, quality care is not given. In managing this type of case the NCM has to ensure the best outcomes for the member. This is an experience I encountered in 2003 while managing a member of a fund. The member belonged to a low-cost fund and benefits stipulated that this member be cared for in a public medical facility. The member had developed acute epileptic seizures. The neurologist caring for the member suspected a brain tumour. The member was supposed to

have an MRI test immediately as an emergency case. Due to the MRI scanning machine of the public facility not being available for the reasons already explained, the member had to be referred to a private hospital urgently where results of an MRI scan confirmed that he did have a brain tumour, and required brain surgery immediately. The cost of the test was the member's liability and I had to negotiate a reduction in the cost of the test for this member while simultaneously managing all the other aspects of the case (Qualsa, 2004). The cost of MRI tests can vary between R6000.00 to R10000.00.

In the USA, in contrast, there are sufficient financial reserves to maintain the MRI machines and in the process prevent break downs of this nature, thereby preventing medical and health risks to the patients who need to be tested. The NCMs practising in the USA focus their attention on relevant case management issues and are not side-tracked by the above-mentioned issue. In South Africa, members registered with schemes regularly run out of their private benefits and need to be cared for in public hospitals. This was but one experience, out of many, that the South African NCM has to manage differently to their international counterparts.

I found that the key performance areas and expected competencies internationally were similar to those of the NCMs practising in South Africa. However, the legislative framework differed, and were not only country specific, but state specific as well, e.g. Australia and the USA. The statutory bodies, such as the Nursing Councils, were accredited to offer various types and levels of training for nurses. This included Nurse Case Management

training. South Africa has one statutory body for nurses, *i.e.* SANC, servicing the nursing professionals practising in all of the regions of the country. Nurse Case Management training has not been formulated as part of the courses offered by SANC. In addition, I found that the educational and qualifications framework of the international countries differed from the South African NQF, except for New Zealand and Australia, which were similar.

## **2.5 REQUIRED LEGISLATIVE FRAMEWORK FOR THE SOUTH AFRICAN NCM**

Nurses have a specific scope of practice regulated by the Nursing Act, No 50 of 1978, which is the law governing the practice of nursing. This Act would have to be considered at all times while in practice (South Africa, 1978). The legislative framework governing NCMs in South Africa is not limited to the Nursing Act, No 50 of 1978, but extends to a larger legislative framework. Working interdependently with other professionals on a multi-disciplinary team, the NCM's daily practice is influenced by an extensive legal framework. The types of cases being managed extend across all disciplines of medical and surgical practice. See Addendum I.

### **2.5.1 The South African Nursing Council (SANC)**

SANC is the statutory governing body for all nurse categories in South Africa. SANC approves and accredits Nursing Education Institutions and the training programmes presented by those institutions under regulation R.425.

SANC has the power to do this under two different forms of legislation, *i.e.* the Nursing Act, 1978, and through their legal obligation to the South African Qualifications Authority (SAQA). SAQA is the educational governing body

over all educational programmes presented in South Africa. SANC has been authorised with the task of quality assurance of nursing education. This function includes accrediting educational service providers and the learning material they wish to use for the training of nurses (South Africa, 1978). In addition, SANC issues annually renewable licenses to nurses in practice and registers nurses once they have completed a qualification. This is legislated under regulation R.3589 of the Nursing Act, 1978.

The basic training and education needed to become a registered nurse involves a four-year course that includes general, psychiatry, community and midwifery nursing science. The education of the professional nurse is controlled under regulation R.425 (South Africa, 1978).

I will now address the influence that SAQA has on nursing education in South Africa and particularly on Nurse Case Management.

### **2.5.2 The South African Qualifications Authority (SAQA) and the National Qualifications Framework (NQF)**

The purpose of the SAQA Act, No. 58 of 1995, was to constitute and construct education and training in such a manner that grants South Africa the opportunity to be recognised as an international economic role-player.

The influence that SAQA could have on nursing education for NCMs in South Africa would be to accredit a developed learning programme designed for NCMs.



Another function of SAQA is to oversee the development and implementation of the National Qualifications Framework (NQF) (South Africa, 1995).

The NQF is a set of specifications and guidelines for the purpose of recording learner achievement so as to register the national recognition of the skills and knowledge base that the learner has achieved in a process of lifelong learning (South Africa, 1995).

How specifically SAQA and the NQF influence the future education of NCMs practising in South Africa is as follows: The outcomes defined by this research could be part of the specifications of a qualification registered by SAQA on the NQF. Once registered by SAQA, the qualification could be registered as an Additional Qualification for NCMs under regulation R.118 of the Nursing Act (South Africa, 1978).

I now turn to the conceptual framework chosen for this study in which the competencies and skills related to the practice of Nurse Case Management are grounded.

## **2.6 CONCEPTUAL MODELS FOR THE PRACTICE OF NURSE CASE MANAGEMENT IN SOUTH AFRICA**

In surveying the literature on conceptual frameworks for NCMs, I chose the Activities of Daily Living (ADL) model (Roper, Logan & Tierney, 1996; Pearson, Vaughan & Fitzgerald 1996), the Botes Model of Ethical Decision-making in Nursing (Muller, 1998:96), the Marie Muller's Model of Professionalism (Muller, 1998:17), and the Botes Nursing Research Model (Van Belkum, 2001:10). I felt that these conceptual models encompass the

competences and values of NCMs who are practising in South Africa, thereby making the research findings meaningful and generalisable (Polit & Hungler, 1995:111). I carefully selected the models as I knew that the practice of NCMs would be defined. The models chosen will form the conceptual framework that will guide this study.

### **2.6.1 The Activities of Daily Living Model**

The Activities of Daily Living model was originally designed by Virginia Henderson in 1966, and changed slightly when three authors worked on it in 1970 (Roper *et al*, 1996). The model consists of 14 identified activities of living. They are defined as breathing, eating, elimination of body wastes, moving, sleeping, dressing, maintaining body temperature, cleanliness, emotional expression by appropriate communication, worshipping, achieving, recreation and learning. These activities symbolise humanity's simplest, but most fundamental and essential activities of daily living and simultaneously embrace the biological, psychological, socio-cultural, environmental and politico-economic status of the patient (Roper *et al*, 1996).

These activities define whether the individual is unhealthy (impaired and dependent) or healthy (not impaired and independent). Health, in relation to the Activities of Daily Living model, is measured on the continuum of independence or dependence and impaired or not impaired.

Roper (1980) republished the model as it was seen to assist student nurses to develop a 'broad spectrum' of thinking in their practice.

This model remained popular internationally and particularly in countries such as the United Kingdom, Europe, Australia, India and the Far East (Roper *et al*, 1996:72).

NCMs can use this model to base their decisions on the patient's condition and needs per individual case. The model assists with the understanding and assessment of the physical and mental impairment of functions and disability within patients. This leads to sound decisions in authorising treatment (Qualsa, 2005). In addition, NCMs have the responsibility to alter or influence the environment along the continuum of care in such a manner that it is conducive to the well-being and healing of the member at all times (Fitzpatrick, 1993:88-90). Using their experience as nurses, they apply their knowledge and skill in managing the complexities of medical cases and maintain a high quality of care in the process.

Considering that nurses are professionals, who work independently within a unique health system, Roper (1996) showed how intensely focused the nurse is when caring for patients by describing the relationship that nurses have with their patients in the following way (Fitzpatrick, 1996).

'The nurse is temporarily the consciousness of the unconscious, the love of life for the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the infant, knowledge and confidence for the young mother, a voice for those too weak or withdrawn to speak' (Fitzpatrick & Whall, 1996:82).

NCMs, as professional nurses, are no different in their consideration and care for members (patients) of schemes.

## **2.6.2 The Muller Model of Professionalism**

I chose the Marie Muller Model of Professionalism as it was appropriate to this study. This study concerns the nursing profession and the education related to a specific nursing discipline.

Muller's (1998) theory comprises eighteen international criteria documented for professional nurses in every speciality of practice (Muller, 1998). The eighteen criteria are directly sourced from Muller's textbook *Nursing Dynamics* (1998) and characterise the professional nurse by:

- Having extensive and well-developed specialised skills that have a theory-content with technical skills;
- Utilisation of the theory of physical science, as well as other disciplines related to the practice thereof;
- Specialised preparation over a long period at a recognised educational institution;
- The testing of professional competence prior to admission to the ranks of the profession;
- Some form of registration and licensure to practice;
- Self-organisation, which leads to the establishment of a professional association and a self-governing body to exercise control over professional standards;
- Having ethical control of professional conduct as a member of the specific profession;

- A service motive based on the needs of the client who requires professional assistance, regardless of her or his ability to pay for services, because the well-being of the client is the primary consideration;
- A high degree of accountability for professional acts towards the public, the client, the employer and other members of the profession;
- Exclusiveness within their profession;
- An acknowledged status in terms of legislation;
- A high social status and considerable power in society;
- The performance of activities that are based on an understanding of what these activities involve, so that the consequences of acts or omissions can be predicted;
- Sustained critical analysis of activities, which leads to a change in practice on the basis of such analysis, with the result that a profession is always subjected to change and development and is never static;
- The ability of its members to select, in a responsible manner, the activities which are of material importance to the practice thereof, and where the mastering thereof falls within the realistic reach of members of the profession;
- The individual member being allowed the maximum discretion and initiative in the practice, while independent functions and accountability for the performance thereof are inherent;
- The obligation of its members to use their best endeavours in meeting the needs of the patient;
- A sustained striving towards excellence because competence alone is not enough;

I have chosen to mention each of the criteria as presented in the textbook that has been referenced because each criteria is relevant and applies to the NCM as a professional nurse. For the future development of training for NCMs, all of these criteria need to be incorporated into the proposed learning programme for NCMs.

Muller (1998) describes the characteristics of professionalism as having knowledge and skill; the art of practising scientifically; leadership qualities; self-regulatory and self-control ability; professional commitment; social values; service directedness (Muller, 1998:25 - 27).

Muller (1998) further describes a profession as practitioners who comply with the norms, traditions and expectations of their profession (Bowman, 2001:28 - 29).

NCMs have received a basic nursing qualification in which they are taught about professionalism. They bring their professionalism to the MHC environment.

### **2.6.3 The Ethical Decision-Making Nursing Model**

The ethical model chosen as part of the conceptual framework for NCMs is the Botes Ethical Decision-making Model of Nursing (Muller 1998:96).

Ethical decision-making is vital for a professional nurse and Botes (1999) writes about a lack of ethics when caring for patients, in many South African nurses. This is clarified in the next few paragraphs (Botes, 1999).

Firstly, Botes (1999) describes South Africa as a developing country having evolved out of an 'apartheid' era where, at that time, many citizens within the country were in 'survival mode' (Rossouw, 1994:8). Botes (1999) goes on to explain that from Rossouw's (1994) perspective when people are in 'survival mode', they do not consider, respect or care for other people as they can only consider their own needs. In her opinion this influenced nurses to be inclined to be unethical (Botes, 1999).

The second factor from Rossouw's (1994) perspective was that some individuals who behave morally and ethically do so reactively only because legislation demands it; not necessarily because they believe in it. They do this to prevent themselves from getting into trouble, such as facing lawsuits (Rossouw, 1994:8).

The third proactive phase of ethical behaviour explains that ethical behaviour is not bound by legislation, but is an innate belief and value within the individual (Rossouw, 1994:8). Botes (1999) argued that nursing education should embrace proactive ethical behaviour and incorporate training that would leave the nurses equipped to think and behave as such when making ethical decisions. I have chosen Botes's (1999) model of ethical decision-making because the NCM is a professional specialist nurse who has to uphold ethical values, not only within each case but in all areas of their practice within the MHC environment.

Nurses are professional carers who have been trained to accommodate the total well-being of each individual and are committed to serve within an ethical behaviour as this is the foundation of commitment (Botes, 1999).

In researching ethical behaviour related to the South African nurse, Botes (1999) asked the following two questions:

'Does the behaviour of nurses in health services in South Africa comply with the principles of ethics?' and

'How can ethical behaviour be facilitated in nurses in South Africa?'

NCMs are professionals who are consistently faced with ethical issues within their daily practice. Ethical challenges often involve confrontational and conflicting situations with various role players in the process of case management. The conflict causes internal emotional discomfort as their training teaches them to respect and work side by side with service providers, assisting them at all times. They also experience inner conflict when they have to deny a benefit that the member does not have available. As professionals, NCMs should be clinically accountable in their decision-making during the process of managing their cases (Qualsa, 2005). Ethical decision-making reduces the legal risk associated with managing cases.

The three models of nursing, being the Activities of Daily Living, the Professional Nursing model and the Nursing Ethical Decision-making model, apply to the NCM's daily practice. The Activities of Daily Living model relates to clinical care of the patient, whereas the Professional Nursing model refers to the independent function of the NCM taking accountability in making



decisions that provide the best care available to their members (patients). The Nursing Ethical Decision-making model guides them to make moral and correct decisions relating to the care of their patients (Cesta *et al*, 1998:52; Botes, 1999).

#### **2.6.4 The Botes Research Nursing Model**

I chose the Botes Research Nursing Model for this study as the model consists of a broad approach to research. The first, second and third order of the model gives guidance to the research activity. The model's perspective on how research should be completed is appropriate for what I chose to research and how I chose to go about completing this study.

By this I mean that the first order stipulates that the researcher should be practising as a nurse while completing nursing research. I am a NCM investigating a topic that would contribute to the enhancement of nursing education for NCMs in practice (Van Belkum, 2001).

The second order stipulates that the theory of nursing and the research methodology become the activity of the research. This means that the focus of the research is on the practice of nursing. The focus of this research is on the NCM in practice within the MHC environment.

The third order stipulates that the research has a paradigmatic perspective. The focus of this study is on the phenomena of Nurse Case Management. This study's objective is to highlight what the NCM does (practice), who she/he is (roles) and the value that is brought to the business (function).

## **2.7 CONCLUSION**

This literature search has investigated available sources on Nurse Case Management activities, learning programmes and included unpublished sources due to the paucity of published literature.

The review includes global literature on the Nurse Case Management practice as well as the much more limited local literature concerning the South African context. I have noted that South African NCMs have distinct differences in the private and public health sector in comparison to countries abroad. Extensive literature on case management stems from the USA and confirms that Nurse Case Management originated from this country.

The legislative framework required for the daily practice of NCMs in South Africa was briefly described. This framework guides and protects the NCM in managing and reducing the legal risks within the cases being managed.

The conceptual framework provided a guide to the context of the study and assisted in defining the research question.

This literature survey may be regarded as part of my research methodology as the survey was a form of data collection. The methodology itself will be described in Chapters Three and Four.

# CHAPTER THREE

## RESEARCH METHODOLOGY

### 3.1 INTRODUCTION

In the previous chapter, the literature review confirmed there is no official Nurse Case Management formal training programme available at a Higher Education Institute in South Africa. Furthermore, available literature indicated the paucity of publications on this matter, particularly in South Africa. The aim of this chapter is to discuss the research methodology applied to attain the research goal.

### 3.2 RESEARCH METHODOLOGY

The overall methodology includes the literature review as discussed in the previous chapter. To complement the literature review, I used a descriptive survey study design (Uys, 1995:38) together with the Delphi technique (Dalkey, 1969).

I chose this study design as my aim was to ensure that the data collected for this study would be fact-based, authentic and precise. I was able to reach those objectives by applying the requirements and characteristics of a descriptive survey study design (Uys, 1995:38).

The descriptive survey is a data producing logical process of investigation (Uys, 1995:47). This approach to research requires a systematic (logical with a formal procedure) and impartial collection of the data that is representative of the study population, can be self-monitoring to identify bias when it

appears, is contemporary (applicable to the present) and is duplicable (research repeatable with the same results) if need be (Uys, 1995:47, 48).

As part of the process of a descriptive survey, questionnaires are used to investigate what the opinions and attitudes of the target population are. The contents of the questionnaires consist of data collected, collated and interpreted from participants taking part in a study (Uys, 1995:48). In this study three different questionnaires were designed and used for three different rounds (Uys, 1995:48). The first questionnaire is described in this chapter, while the questionnaires for round two and three are included as addendums. The details of those questionnaires are described in this chapter. See Addendums II and III.

I chose the Delphi technique to complement the study design. The Delphi technique suited the procedural guidelines expected from a descriptive survey. This enabled me to measure the responses by experts in the field of Nurse Case Management and MHC, and to subjectively evaluate learning outcomes required for a learning programme for NCMs practising in South Africa.

The nominal group technique was considered, but I was unable to arrange a meeting of all the experts to be in one place, over a few days, and to accurately use the protocol of the technique to make the research valid (Dalbecq, Van de Ven & Gustafson, 1971).

### **3.3 DELINEATION OF THE STUDY**

The study included MHOs and service providers in both private and public health sectors throughout South Africa, particularly in Gauteng and the Western Cape Province where the majority of the corporate environments were positioned. Rural and urban hospitals were represented by managers taking part in the study.

### **3.4 STUDY POPULATION**

The target population in this study consisted of the NCMs in MHC environments, their management and service providers both in the public and private health sectors.

### **3.5 STUDY SAMPLE**

Participants were selected for the study, using the following inclusion criteria:

- Experience in case management in South Africa and practising within the public and private hospitals and MHC environments;
- Administrators sharing interest in the academic advancement of Nurse Case Managers;
- Employees of MHOs and hospitals;
- Nurse Case Management forum members;
- The ability to unambiguously communicate in English in writing, using electronic mail;
- Objective judgments as experts in knowledge, skill and experience;
- Willingness to voluntary participation and remain committed to the research.

The multistage sampling process was followed. First, a stratified purposive sampling (Polit & Hungler, 1995:284) method was used whereby research respondents were selected by myself for their knowledge on the subject of Nurse Case Management. The three strata were:

Nurse Case Management forum associates,

MHO working environments, and

Service providers who contracted with MHOs.

It was after I had selected respondents from each of these strata (by applying the inclusion criteria) that further study respondents were included using the snowballing sampling process. This was a natural development process whereby I was referred to other experts in the field by the selected respondents (Polit & Hungler, 1995:297). A total of 58 respondents were enrolled for the study, representing a 16% (8/50) over-sample, easing the effects of respondents possibly withdrawing their participation.

My professional experience and knowledge of these respondents gave me confidence that the study sample represented the total study population.

### **3.6 PERMISSION FOR THE STUDY**

Permission to conduct the study was granted by the Research Committee of the Faculty of 22 August 2002.

Individual informed consent was obtained from each research participant via electronic mail (Polit & Hungler, 1995:140). With each electronic mail that was sent to each participant, a letter contained in a Microsoft Word document was sent with the following detailed contents:

- An attachment with an explanation of who I was;
- My request for their participation and an explanation of the type of contribution they were to make;
- A brief explanation of the goals of the study;
- The type of data to be collected and the process;
- Confidentiality and commitment;
- Participation as a voluntary decision with the right to withdraw; and
- My contact details.

I assured them that they could withdraw from the study at any time with no threat of victimisation. This was part of informed consent (Polit & Hungler, 1995:140).

### **3.7 ETHICAL CONSIDERATIONS**

The ethical considerations in the process of engaging the participants in the study were respected and requirements to conduct a Delphi study were adhered to. The process was guided by the four ethical principles of anonymity, confidentiality, beneficence and maleficence (Meckanic, 1999).

These requirements included areas of confidentiality and anonymity of the participants' identity within the process of data collection. As previously explained in section 3.6, informed consent was obtained formerly by means of an introductory document sent to participants via electronic mail.

### **3.8 PILOT STUDY**

The data collection began with eight participants to test the reliability and validity of the initial two open questions used to collect the data (Brink, 1997:73, 174). The result of the pilot study showed that the questions were understood and that there was no need for change. These participants became part of the total study sample.

### **3.9 DATA COLLECTION METHOD: THE DELPHI TECHNIQUE**

The Delphi technique was chosen as the data collection method for this study as it is an innovative way to involve busy experts and specialists who may not be able to come together to brainstorm new ideas, but who needed to interact with each other, via the researcher, on a topic or phenomenon (Dalkey, 1969).

I chose to reference Dalkey (1969) as I found Dalkey's (1969) literature suitable and comprehensive enough to reference in this study. Updated literature on the Delphi technique was reviewed (Rowe, Wright & Bolger, 1991).

The purpose of the Delphi technique is to find consensus amongst the participants. A questionnaire is designed with the various descriptors required to make a decision, and it is printed as a questionnaire. The questionnaire is distributed with clear guidelines on how to complete and where to return it to. The rounds are repeated until consensus has been reached. There are usually three rounds, but five rounds may be exceeded. An important feature of the Delphi technique is the '*statistical group response*'



that has been designed to prevent '*group pressure for conformity*'. In the feedback it is necessary to give a summary of the group's response with explanation (Pill, 1971; Rowe, Wright, & Bolger, 1991). The Delphi technique has specific features. An explanation of these features follow below.

The Delphi technique is used specifically for focused group research, where the members do not have physical contact or any interaction and where the researcher acts as the centre and communication point for all participants. This ensures *anonymity* (Dalkey, 1969).

The Delphi technique suited my circumstances within the research process as all of the participants were spread throughout South Africa. They were not in touch with each other and they answered the questionnaires independently while remaining anonymous. In addition, this technique was chosen as it avoids dominance by one or more experts as participants (Jones & Hunter, 1995:311; 376-380). The technique allows for the elimination of information that is not relevant and eliminates pressure on the members of the group to agree with what any of the other members have shared. Authors who wrote on the Delphi technique call this '*group pressure toward conformity*' (Dalkey, 1969). This is a natural part of group dynamics that is managed with fairness in the Delphi technique. This will be mentioned in further detail in the next few paragraphs.

The Delphi technique is also about members taking part in the study as a group of hand-picked experts and specialists within a specific culture, field or environment (Dalkey, 1969). The participants chosen for this study were

experts employed within the specific environments of MHC and hospitals with MHC departments.

The technique is made up of a unique series of surveys using a questionnaire. Each survey is known as a round. In each round, participants are issued with new ideas related to the previous round. This is called *iteration* and allows for the participants to change their opinions (Jones & Hunter, 1995).

Every time the data from all the questionnaires return, the information is collated and a summary of the results are included into another questionnaire that is sent out. This is called *controlled feedback* (Dalkey, 1969, Rowe *et al*, 1995).

### **3.10 DATA COLLECTION PROCESS**

At the start of round two and three of the Delphi technique process I informed the participants of the information that was collected, collated and interpreted. A new questionnaire was designed and contained the interpreted data from the previous round. In addition, at the beginning of each round I would give each participant a telephone call to encourage them to complete the next round being sent to them as I knew that, without exception, they were all busy with various projects and production deadlines.

#### **3.10.1 Round One**

In Round One, two open questions verified during the pilot study were sent off to 58 participants via electronic mail (e-mail) and 32 (55%) responded in the given timeframe. The two questions were:

**Question One:** What are the key performance areas of an NCM practising in South Africa?

Please list five major key performance areas.

**Question Two:** What other non-theoretical capabilities and competencies should an NCM have while practising in South Africa?

Please list at least five capabilities and competencies.

Of the 58 questionnaires sent out, 26/58 (45%) participants did not reply to Round One.

### **3.10.2 Round Two**

The responses I received from Round One were collated and interpreted and another questionnaire was designed. The newly created questionnaire consisted of nine main descriptors related to tasks and skills combined. I did not distinguish between tasks and skills. However, I did specify in the questionnaire and in my telephonic conversations with the participants that they needed to choose an option that best described what the NCMs should be capable of doing, and what skills were needed in their daily practice according to the list of descriptors. On the questionnaire the main descriptors were typed in bold. The sub-descriptors were listed below each of the main descriptors. On the questionnaire the heading for column one was named Descriptors. The column next to Descriptors at the top of the questionnaire said 'options.' This was to indicate to the participant where to choose their options. See Addendum II. I gave an explanation of the input received from all participants (Rowe *et al*, 1991:39, 235 - 251). I reiterated what the aim of the study was, namely to reach consensus on the content required for

learning programme outcomes for formal training of NCMs practising in South Africa. I asked the participants to complete the questionnaire electronically and to return it to me via electronic mail by a specific date (15 working days).

#### *Lickert Scale*

I instructed and supported the participants on how to complete the questionnaire using a Lickert Scale format on a Microsoft Excel document (Leedy, 1997:203). A Lickert Scale is a scale of criteria to measure what participants' choices are relating to the criteria. The options used for the Round Two questionnaire were *Most definitely*, *Definitely*, *Occasionally* and *Not at all*. An additional column, called *Comments*, was included. The reason for this was to give the participants an opportunity to add detail. The participants were to select an option. Two spaces were left blank below the last main descriptor called *Others*. This was done purposely to give the participants the opportunity to add more descriptors if they so wished.

A total of 32 questionnaires were sent out to the participants who had responded in Round One. I received 15/32 (47%) replies, while 17/32 (53%) did not reply for Round Two.

#### **3.10.3 Round Three**

The data I collected from the 15 respondents from Round Two I collated, interpreted and compiled into a questionnaire that was sent out to the participants on Round Three. See Addendum III.

This time the document was designed according to the SAQA requirements. The SAQA requirements included exit-level outcomes, related specific outcomes and assessment criteria that should be in a learning programme for NCMs practising in South Africa.

The questionnaire was typed on a Microsoft Word document using a table format consisting of three columns in which to place the data. Column one had a heading named *Exit-Level Outcomes*. Six main outcomes were listed in column one. Column two was named *Specific Outcomes* and contained the various specific outcomes related to the exit-level outcome placed next to it in the first column. Column three was named *Assessment Criteria* and contained the various assessment criteria related to the specific outcomes in column two. I relied on the expertise of my supervisors to guide me in creating this questionnaire. The questionnaire was sent out to the same 32 participants to whom I had sent the questionnaire for Round Two. I chose to do this purposely as I was concerned that the responses would be too little to justify a decision on the outcomes for a learning programme for NCMs practising in South Africa, despite the fact that the participants were experts in their fields. The questionnaire was sent as an attachment within an electronic mail. No further rounds were necessary as consensus was reached on Round Three. I received 19/32 (59%) responses for this final round. Consensus was unanimous regarding the contents of the questionnaire for Round Three *i.e.* the outcomes on the questionnaire should be used as part of a learning programme for NCMs practicing in South Africa. The responses were answered by a 'Yes' in each section of the questionnaire next to each outcome (exit-level and specific) and each assessment criterion.

The data collection period took eleven months in total. The time was taken up with the preparation and creation of the questionnaires. In collecting the responses, collating and interpreting the data from the rounds and resending the newly created questionnaires, the time planned stretched further than anticipated. The original time planned for this phase of the study was six months.

As additional support, I gave my personal details (as previously mentioned) which included contact numbers for clarity on the questionnaires. An explanation detailing the responses to the rounds is given below.

### **3.11 DATA COLLECTION: PARTICIPANT RESPONSE**

The final study sample size was 58 study participants. I received 32/58 (55%) responses from study participants included in Round One. I sent out 32 questionnaires for Round Two. I received 15/32 (46%) from the study participants. See Addendum IV. After all the questionnaires for Round Two were returned, the descriptor named *Others* was filled in with *Data analysis* and *Business reporting*. The responses to this round are demonstrated in Addendum IV. To demonstrate the responses I have combined the options in the *Most Definitely* and *Definitely* columns of the original questionnaire into a column of *Definitely* only. The column that says *Occasionally used* was adjusted simply to *Occasionally*. The *Comments* column was used to total the responses. There are nine main descriptors with sub-descriptors that interrelate, e.g. legislation as a main descriptor relates to the scope of practice of the NCM in that there are limitations and expectations within their

scope of practice that legally affect their decision-making in each case. I have attached percentages to the answers so as to demonstrate the importance and value placed on those descriptors by the participants in each of the answers. Some appear more relevant than others, some are unanimously chosen and others not.

For Round Three I sent out 32 documents to the same 32 participants of Round Two. See Addendum III. I received 19/32 (59%) responses. The questionnaire for Round Three consisted of the main descriptors which were now written as six exit-level outcomes. In addition, I wrote the associated specific outcomes and assessment criteria. As previously mentioned consensus was reached on Round Three. The questionnaires that were returned had the word 'Yes' typed in each section of the questionnaire next to each outcome (exit-level and specific) and each assessment criterion.

As consensus was reached on this round, no further rounds were necessary. In the electronic mails that were returned, several participants expressed their delight in the quality of the outcomes that could be used for a learning programme for NCMs practicing in South Africa.

In Table 3.1. I have given a demonstration on the responses from all three rounds as part of the data collection process.

**Table 3.1 Summarised responses per round and per stratum**

<b>Strata</b>	<b>Round One n (%)</b>	<b>Round Two n (%)</b>	<b>Round Three n (%)</b>
<b>NCMs</b>	16 (27.8%)	6 (18.8%)	10 (31.3%)
<b>MHOs managers</b>	8 (13.7%)	5 (15.6%)	5 (15.6%)
<b>Service providers</b>	8 (13.7%)	4 (12.5%)	4 (12.5%)
<b>Number of participants who did not respond</b>	26 (44.8%)	17 (53.1%)	13 (40.6%)
<b>TOTAL (N)</b>	<b>58 (100%)</b>	<b>32 (100%)</b>	<b>32 (100%)</b>
<b>Number of days for each round</b>	<b>18</b>	<b>42</b>	<b>107</b>

In the first column I have listed the study population (strata). I included those participants who did not respond. I added the *Number of days for each round* as the item in the last row of all of the columns as these were the days it took to complete the rounds.

In columns two (Round One), three (Round Two) and four (Round Three) I have shown the responses related to the strata and placed a percentage value on the particular amount of responses per round and included the amount of participants that did not respond. In the row that says *Total* I have entered the amount of participants to whom I have sent questionnaires for that round. In the last row the days it took to complete the rounds have been filled in. I have not included the time spent between the rounds in preparing the questionnaires that were sent out.



### **3.12 LIMITATIONS OF THE STUDY**

I work in an MHO, and as a result there was the possibility of introducing bias during data collection interpretation (Leedy,1997:85,132). However, I was mindful of this and managed to limit introducing bias at any stage of the research process by using the Delphi data collection technique and by involving my study supervisors (Brink, 1996:202). The Delphi technique allowed each participant the opportunity to relate their perception and in so doing limited the introduction of bias at any stage of the research process.

### **3.13 CONCLUSION**

A descriptive survey study design is used with the Delphi technique as a data collection tool. The Delphi technique aimed to reach consensus among experts in the field of MHC. The study purposive sample aimed to ensure representation of the study population and this was done by sufficient distribution and by a process of snowball sampling.

By using the Delphi technique I was able to manage the process of data collection. My aim was to encourage the participants to reach consensus on what the outcomes for a learning programme for NCMs should be, and to simultaneously manage and prevent bias within the study.

The mode of communication was via electronic mail followed by phoning the participants and encouraging them to respond, particularly in rounds two and three. Data received from each round was analysed and presented. As consensus was reached after round three, no further rounds were necessary.

In chapter four discussion on the findings and application thereof, on the practice of NCMs in South Africa, will be presented.

# CHAPTER FOUR

## FINDINGS AND DISCUSSION

### 4.1 INTRODUCTION

In this chapter, data obtained from Round Three using the Delphi technique will be presented. Based on the Nurse Case Management practice and guided by Botes Conceptual framework (Van Belkum, 2001:10,11), I will apply the final round document (Addendum III) by giving examples from the MHO workplace in South Africa.

The main objective was to find consensus amongst experts as to what the outcomes should be for a learning programme for NCMs practising in South African MHOs (corporate) and MHC departments situated in hospitals.

As previously mentioned the response to Round Three clearly showed that consensus was unanimous and that the exit-level outcomes, the specific outcomes and the related assessment criteria were what the experts in the field of MHC wanted as part of a learning programme for NCMs practicing in South Africa. See Addendum III.

I will now proceed to discuss each of the exit-level outcomes showing specific ways in which these outcomes help to articulate the specialised competences of a NCM. The assessment criteria are included. My discussion should make it clear, firstly, that a basic nursing qualification does not address these competences and, secondly, that this specialised competence would best be acquired through a formal programme designed for Nurse Case Management.

See Addendum III. My discussion views the outcomes as they apply to the practical workplace situation and the assessment criteria are viewed as used within a learning programme for NCMs practising in South Africa.

Furthermore, I have included the integration of the eight critical cross-field outcomes specified by SAQA as part of the discussion. Critical cross-field outcomes are outcomes developed by SAQA for the purpose of integration into all learning programmes (SAQA, 2000).

The outcomes classified as generic outcomes are to be embedded into all learning programmes (SAQA, 2000). The critical cross-field outcomes are to:

- Identify and solve problems, be a team player;
- Have good organisational skills;
- Be able to critically evaluate information in related systems;
- Communicate effectively;
- Be able to understand technology related to field of practice; and
- Have an understanding of related systems by recognising that problem-solving contexts do not exist in isolation (SAQA, 2000).

#### **4.2 EXIT-OUTCOME ONE: LEGISLATION**

Legislation, as a developed outcome resulting from this study, relates the work of the NCM to relevant legislation applicable to the cases that are being managed.

The legal framework for NCMs practising in South Africa consists of twenty-three different acts that govern their practice in managing cases. See

Addendum I. These acts have been referenced in Chapter Two, section 2.5. of this study. The specific outcomes required to apply the legislation to their daily work are demonstrated in their (NCMs') ability to compile a database consisting of the twenty-three acts for quick and efficient referencing purposes; to analyse and engage with the relevant legislation in context and within the process of managing cases; and, in the process, to manage the workplace environment resulting in good governance within their practices as NCMs.

The legislation taught to nurses in their basic training is not as extensive as the legislation needed for Nurse Case Management where specific acts apply to their daily practice as specialist nurses. See Addendum I.

The nurses who have completed their basic nursing course have been trained specifically on psychiatry, midwifery, community health and general nursing. At this stage of training they have not specialised in these fields. However, they have the ability to apply the legislation as professional nurses.

The practice of Nurse Case Management requires a specialised broad-based knowledge and clinical skill related to legislation in nursing.

The cases that the NCMs are managing are from diverse fields of nursing, e.g. an intensive care trained registered nurse may have to replace an occupational health nurse and will have to manage an occupational health related case on disability, or an occupational health nurse may need to manage high-cost admissions-to-hospital cases. It is my experience that, the

NCM needs to be versatile experts. As paradoxical as this may seem, it is the realistic expectation from senior management of MHOs.

#### **4.2.1 Legislation: A practical application**

The NCM complies with the legal bindings of specific contracts by adhering to the service level agreements made within the contract to their clients and service providers. A service level agreement is the time span within the agreement for obtaining authorisations for services between a hospital and an MHC company, and this is seventy-two hours. Consideration has been given to the fact that NCMs work within office hours. However, members may be admitted to hospital at any time. If a member is admitted over a weekend, authorisation will only be granted on a Monday morning. If the NCM does not issue an authorisation within seventy-two hours from the time of admission the account for all services rendered for that admission will be liable to the member. Members have a responsibility, according to their contracts, to inform their schemes of admissions that occur over the weekend. A family member or the hospital NCM usually phones the corporate NCM on the Monday or the first working day following the admission to report such admission.

Furthermore, concerning admissions, if a hospital does not have a license for a specific specialised field of medicine, e.g. a psychiatric license to admit psychiatric cases, the psychiatric patients may not be admitted and treated within that hospital. Similarly, a hospital has to have a paediatric licence to admit children under the age of thirteen. Unfortunately, there are some paediatricians who admit children under the age of thirteen into adult wards

as day cases for tonsillectomy operations. The NCM should deny authorisation for such a case. The risk involved is that the child could have a reaction to the anaesthetic drug and would need specific paediatric equipment for treatment during an emergency. There is no guarantee that suitable paediatric equipment would be available for such an emergency in a hospital that does not have a paediatric license.

In the two examples of the psychiatric and paediatric cases, I have involved several bits of relevant legislation for NCMs to consider when managing cases, namely the Mental Health Act, the Health Act, the Health Professionals Act, the Medical Schemes Act, the Nursing Act, the Children's Act, the Constitution and the Pharmaceutical Act.

#### **4.2.2 Assessment criteria**

In the learning situation the following assessment criteria will be used. To assess the capability of the NCM to analyse and engage in related legislation per case, an assignment will be given where the NCM has the opportunity to present a well-organised filing system. The system can be in hard copy using a ledger file with an appropriate and correct index. This would result in quick referencing and amendments of the twenty-one acts necessary for their daily practice. The filing system may also consist of computerised files that can be stored on a USB flash drive and/or a compact disc. The latter would be more suitable as a computerised reference system is more user-friendly and accessible as most of the nurses work in a computer-assisted paperless environment. A written assignment involving the use of and the integration of the legislation related to a specific high-risk case could be handed in for

marking if this outcome were part of a learning programme. The critical cross-field outcomes that apply to the legislative aspect of cases become visible when the NCM can identify problems due to non-compliance within the legislation, and when they are able to critically evaluate the situation and relay messages to relevant role players that are correct and have a positive effect on the outcomes of the case. The result of non-compliance to legislation has serious high risks for the members as patients and medico-legal implications for the scheme.

#### **4.3 EXIT-OUTCOME TWO: ETHICS**

Ethics, as a developed outcome from this study, integrates the nursing ethics within the distinctive professional role of Nurse Case Management.

NCMs are trained professionals and from their general training they are aware of the ethical issues within the daily practice irrespective of where they are practising. The health context in which NCMs are practising exposes them to ethical issues within the business, i.e. contracts, the clinical cases and in their communication with service providers.

To show their competence in managing ethical issues within their cases NCMs will need to identify the ethical values which influence the decisions made in their work life and will be able to develop protocols and policies that address ethical values. They should be able to integrate and apply the protocols and policies into their daily practice. Ethical behaviour needs to be an innate and integral part of the nurse as a person (Botes, 1999). To



complement what Botes (1999), states concerning ethics, it is something that becomes part of the nurse's values.

In her book *Nursing Dynamics*, Muller, 1998, gives a few guidelines on applying ethical behaviour within daily practice (Muller, 1998). The nurse's scope of practice influences ethical decision-making as does the principle of reason within common law.

#### **4.3.1 Ethical behaviour: A practical application**

An ethical issue can arise when the confidentiality aspect within a case is not respected. An example of this is when members, as patients, have the right to confidentiality concerning their disease or medical condition, and their right is violated. How this happens is when a member is admitted with an HIV (Human Immunodeficiency Virus) related condition and regards this as confidential. It would be unethical for the hospital NCM to inform anyone, but particularly in this case, the corporate NCM cannot inform relevant parties of the member's HIV status without obtaining written consent from the member.

Vice versa: The HIV NCM specialist, working in a corporate environment, may not disclose this information to the service provider. However, if the patient gave written consent for disclosure, then the diagnosis could be revealed.

Another example of how NCMs could behave in an unethical manner could be when they do not take their role of advocators seriously. Members are dependent and reliant on the NCM for guidance and information regarding the details of their cases. This information involves the clinical and financial

aspects of the case and is important for the member to know (Cesta *et al*, 1998:162).

A third example of how ethical behaviour comes under question is when incentive programmes are linked to the service delivery of service providers. By this I mean that payments of a kind may be given to NCMs to give service providers preference in contracts, thereby jeopardising appropriate and good care for members. This action is illegal and unethical (Cesta *et al*, 1998:162).

Action taken within MHC companies to prevent this type of liaison between NCMs and their service providers include the recording of telephone conversations and, more seriously, setting up forensic departments within the larger MHOs for investigation purposes if behaviour, in any situation, appears to be suspect (Qualsa, 2006).

#### **4.3.2 Assessment criteria**

In the learning situation the assessment criteria will require written assignments to show how the NCM has integrated the ethical values into managing high risks within each case. Policies, protocol and processes that are developed and applied within the daily practice will be included in the written assignment. The cases should reflect their innate value system from the manner in which they have managed their cases. The critical cross-field outcomes applied to ethics is the NCM's ability to identify problems, critically evaluate the situation, make an appropriate decision and communicate that decision to the team and other relevant role-players involved in cases.

#### 4.4 EXIT-OUTCOME THREE: MANAGERIAL COMPETENCE

Managerial competence, as a developed outcome from this study, is shown in the application of managerial skill and knowledge within the distinctive professional role.

The NCMs have the ability to apply their managerial knowledge and skill in their work environment by designing and creating managerial tools such as flow charts and procedure manuals to clarify complex processes. They take on the role as change agents within complex environments by developing new theories and modifying managerial concepts to suit specific situations within the workplace ensuring correct and appropriate transference of information.

This level of practice is not within the general training for nurses. The competencies are more at a level of a nursing manager (Greathead, 2003).

Management skills are taught, for example, on a course such as Nursing Administration (regulation R.1501) which is a post-basic specialised nursing management course (South Africa, 1978). The framework for this course has been developed and could be used as part of a learning programme for NCMs.

It is my belief that NCMs should be competent as managers. It is necessary for them to understand the bigger picture (macro environment) within their contextual fields of work. It is also my experience that NCMs need to be efficient and effective in managing administrative processes as an MHO per se is fundamentally administrative.

#### **4.4.1 Managerial competence: a practical application**

I would like to take my personal experience as an example of how NCMs need to be competent in managerial skills. About a year ago, the company was looking to venture into Occupational Health and Employee Well-being. I was one of the few occupational-health nursing professionals in the company that had advanced experience in this field. I wrote a business plan for the company incorporating products and services into the new product of managing Occupational Health clinics throughout the country. The document was presented and used to develop a new product and a new department. Increased revenue and business growth was brought about as a result of the business plan (management tool) (Qualsa, 2005).

#### **4.4.2 Assessment criteria**

The NCMs will be expected to hand in written assignments structured scientifically and informing the examiner of how they apply managerial skills to their daily practice and how they manage the operational processes. The types of documentation needed to measure productivity of NCMs are quality control, project control templates and work assessment documents. The MHC firm usually has its own assessment criteria. Managerial competency will be measured by producing process flows, examples of templates for managing themselves, and policy and protocol documents. Training manuals will be considered as a measuring tool for new products that they feel their company should use. An assignment on how the NCM acted as a change agent and added value to the company by doing so will be handed in for marking. The critical cross-field outcomes applied to managerial competence are indicated in the manner in which the NCM communicates managerial

processes and protocols within the team and how well organisational skills are used to manage the projects. The NCM should have a sound understanding and good knowledge based on the technological aspects of the job, particularly information technology and computerised programmes.

#### **4.5 EXIT-OUTCOME FOUR: CLINICAL COMPETENCE**

Clinical competence, as a developed outcome of this study, is shown in the manner in which NCMs relate clinical knowledge and skill to the process of managing cases within their distinctive professional roles.

The specific competence that the candidate shows is the ability to demonstrate sound anatomical knowledge to enable clinically correct responses to cases (Viljoen, 1988).

The NCM has the ability to apply clinical knowledge in making the correct judgment calls when clinically managing assigned cases. The NCM has the ability to explain and demonstrate how to develop a nurse care plan per case, involving clinical concepts of nursing. The nurse care plan will be aligned to the general nursing process which is a five-step guide within a framework.

The steps are:

- *Identifying* the problem within the case;
- *Assessing* each case on its own merit;
- *Planning* according to the needs of the case;
- *Implementing* what has been planned and monitoring the process;
- *Evaluating* what has been done and how successfully it was implemented (SANC, 2006).

In the process of clinically managing the case, using the above-mentioned framework, the NCM has the ability to correctly advise, guide and inform the relevant parties involved as to what the expected clinical outcome would be. This is the role of an advocator and it is an important role in holistically managing a case. Clinical expertise underpins the ability to make correct decisions on appropriate medical services for the members and their families.

#### **4.5.1 Clinical competence: a practical application**

As part of their general training NCMs are exposed to a comprehensive clinical component. They have a sound understanding of conditions and diseases that affect the body. On the continuum of care of cases, the general nursing process is applied. See section 4.5.

The nurse has passed several scientific competency examinations relating to anatomy, nursing sciences and special nursing subjects in the basic nursing course. After a few years of practice, they are regarded as expert nurse practitioners. This combination of training and experience equips them to competently apply their clinical knowledge and make correct judgment decisions when managing assigned cases. The competency of understanding and managing the services and treatments, plus the cost of the members on schemes, is paramount to the success of managed healthcare, hence a care plan should be developed per case. The difference and challenge for NCMs in showing competence is that they are managing specialised cases in fields that they have not specialised in. The outcomes developed from this study used within a post-basic learning programme will equip them to competently manage all specialised cases. The critical cross-

field outcomes applicable to clinical competence relates to how well the NCM can apply clinical knowledge and skill to make appropriate decisions within the cases that are managed. The NCM needs to be able to critically evaluate and identify the problems within each case, particularly complicated cases, so as to make an appropriate decision on the care plan and medical services required by the member. Information is stored in clinical programmes on the computer, therefore technological skills need to be of a level that is conducive to competently storing information on cases. A report on the member's condition related to complications of the case need to be communicated to team members as part of a multidisciplinary system.

#### **4.5.2 Assessment criteria**

Competence will be demonstrated by combining regular theoretical testing together with an Objective Structured Clinical Examination (OSCE) until the student nurse case manager can demonstrate competency and ability.

A part-time course on clinical instruction will be part of the training followed by the OSCE. The tests will show the anatomical and clinical knowledge base of the NCM. Competence of clinical skill with applied knowledge is shown by presenting nurse care plans for cases as written assignments to ensure this knowledge has been embedded.

#### **4.6 EXIT-OUTCOME FIVE: ADMINISTRATIVE COMPETENCE**

Administration is a large component of corporate MHC environments. Policy and protocol development are tools to manage large organisations. This allows for standardisation of business processes with the intention of keeping

uniformity of operations. The policy and protocol within MHC provides clinical and administrative guidelines to ensure the service level agreements and cost-efficient strategies within each case are appropriately managed. NCMs are trained internally to manage cases with consideration to policies and procedures related to the business and the scheme in which they are working. Apart from the guidelines within the workplace, there are seven fundamental principles of good governance that the Council for Medical Schemes recommends to management and their teams who are contracting with and are managing schemes and funds. I have placed them here as they are relevant and act as a practical guideline for NCMs to consider when managing their cases:

- Discipline enhances the commitment to adhere to behaviour that is accepted to be correct and proper;
- Transparency encourages timely, accurate and meaningful information to be made available and to be well managed;
- Independence ensures that mechanisms minimise or avoid conflicts of interest;
- Accountability ensures the presence of mechanisms to allow for accountability;
- Responsibility ensures behaviour that allows for corrective action and penalises mismanagement;
- Fairness ensures that systems balance the rights and interests of all groups;
- Social responsibility ensures awareness and response to social issues with an emphasis on ethical standards.



(Council for Medical Schemes in South Africa. An International Perspective on Governance, 2002).

An area of good governance that applies to the practice of NCMs is in the authorisation of medical events that coincide with the correct details on the accounts submitted by service providers. The accounts and claims are to be paid on time. This enhances good relations between the administrator, the MHC company, the members and the schemes.

Suffice to say that the principles of value integrated into the concept of good governance, embrace the critical cross-field outcomes in their totality.

#### **4.6.1 Administrative competence: a practical application**

NCMs contribute to protocol and policy development within a team rather than on an individual level. However, they have individual commitments to ensure that service level agreements are met. They do this by ensuring turnaround times (commitments on authorisations given within a certain period of time, e.g. within seventy-two hours of admission) are met. Good communication between the service provider and the NCM will ensure that the claims for the services rendered have been authorised and submitted. It is beneficial to all the role-players that the NCM demonstrates competence in administrative processes. The NCM often communicates with the secretary or the accounts manager of medical specialists. Clinical staff in the MHC environment are not responsible for the payment of claims but their clinical decisions within the processes impact on the administration processes and are interdependent. A flow chart should be developed guiding the MHC team on operational processes which integrate administrative processes. As an essential level of

competence that the NCM should have is the ability to recognise the International Classification of Diseases and Related Health problems – called the Tenth Revision coding system, commonly known as the ICD 10 coding system. This is necessary to be able to identify body systems related to diseases and to be able to correlate and articulate the coding demands when auditing and managing accounts (Vorster, 2004).

A NCM is allocated, per team, to audit the accounts and claims for services rendered. In this role, NCMs are acting in the capacity of accounts auditors. These accounts and claims have been authorised by their colleagues.

There is a system of rotation of positions within the team and each team member needs to become competent in the job allocated to him/her. This is to make sure that service level agreements are always adhered to if a staff member goes on annual leave or are absent due to sick or study leave.

It was legislated by the Council for Medical Schemes that by July 2005, all service provider accounts and claims sent to administrators of funds must have ICD10 codes related to services rendered for payment. The cut-off time for this legislation to be applied was extended to July 2005. The ICD 10 set of codes translates the written description of a diagnosis into a coded format, e.g. acute tonsillitis = J03.9. This set of codes forms part of an international standard of diagnostic codes and is owned and maintained by the World Health Organization. Nurses in their general training are not taught this coding system. However, NCMs are expected to use them constantly (Qualsa, 2005). The critical cross-field outcome applicable to administrative

competence is the ability to critically evaluate a problem within a case, to make a wise decision to correct the problem, and to communicate the problem in a sensible manner to senior staff members who need to assist them. A further ability is applied in storing information on an administrative computer programme for referral when required and in working with a team as a significant amount of the financial administrative work is related to the work of colleagues.

#### **4.6.2 Assessment criteria**

Competence is demonstrated by the presentation of written assignments on cases. The NCM provides a document with fictitious names to ensure anonymity and confidentiality, according to the legislative and ethical expectation. The assignment relates to the claims and accounts submitted for services rendered. By presenting this assignment, competency and a good understanding of administrative management will be demonstrated. The assignment needs to demonstrate competency on coding of the ICD10 system legally required on accounts.

#### **4.7 EXIT-OUTCOME SIX: RESEARCH (DATA ANALYSIS) AND (BUSINESS) REPORTING**

Competence in research and reporting skills are demonstrated by the scientific approach, *i.e.* a research methodology that enables the NCM to identify and analyse the effects of the micro, meso and macro environment. This is an area that nurses in general and NCMs in particular are in need of training. Managers of MHOs often expect nurses to perform as researchers. However, NCM fall short of being competent in this area. Formal training would equip them to understand what the 'scientific approach' is about and

how to apply the knowledge and information gained from reports. This outcome has come as a request from the participants of the study for NCMs to develop competencies in research and analytical reporting.

#### **4.7.1 Research (data analysis) and (business) reporting: a practical application**

In the practical environment, the manner in which an analytical report is constructed is via a request sent to departments that specifically manage data related to MHCs and MHOs, and the effects on the business. The information analysed can range from medical to administrative and clinical. NCMs are usually not allocated this function. However, it has now become apparent for nurses to understand these aspects of the business, particularly in their role as NCMs. An example of how this outcome is applied is when the team of NCMs has an understanding of the financials of the scheme that they are employed to manage. In understanding this part of a report, they are able to assess themselves and their performance by viewing the savings they facilitate for the funds and the effect that they have on the way the fund is managed. In bigger MHOs the responsibility of managing analytical reports lies with those departments skilled to do so. When NCMs need to request specific statistics and/or information, they do this by sending an electronic mail to the relevant department which, in turn, sends back a report based on the criteria requested. The department will usually allocate a statistical analyst to respond to the request.

Once information has been collaborated according to the request, it is sent via e-mail to the NCM. The information is compiled into a report, using templates

if required. Usually, the NCM will be looking at risk factors that are common to the majority of cases.

A strategic plan will be developed to counteract and combat risks. That plan becomes a process, which is documented for all relevant parties to view and put into practice. If training is necessary, training sessions with an instruction guide (often written by NCMs if that is their forte) will be set up. Monthly reports to monitor the effects of the strategy will be reviewed by the team.

This level of practice is not taught to nurses in their general training. Nurses who have been practising in the acute care environment are usually not competent in this area of practice. The critical cross-field outcomes applied to competence in research and reporting include the ability to communicate with other departments on what data is required for reports, and the ability to communicate findings and to find solutions for identified problems. Good organisational skills are needed to make relevant changes within the workplace.

#### **4.7.2 Assessment criteria**

Competence is demonstrated by a presentation of written assignments, clearly showing the research process, and how it was conducted, what the findings were and what effective changes to the company operations came as a result of the research. The NCM shows how the changes were applied. A report focused specifically on the research, the findings, the strategic changes applied and the outcomes of this process will be handed in as a written assignment.

#### **4.8 CONCLUSION**

The findings of the data collection process were discussed and six exit-level outcomes were developed from the responses from Round Three of the collection process. These outcomes had specific related outcomes and assessment criteria to measure the competence and capabilities of the student NCM. The practical applications of the six exit-level outcomes were discussed and included the critical cross-field outcomes required by SAQA for all learning programmes. I found that the research and reporting outcome is a new and challenging outcome expected of the NCM. This is certainly a skill worth acquiring. I recognised that what the participants want and expect from NCMs practising in South Africa was a high quality and advanced nursing level of performance.

The findings and the application thereof in the practices of NCMs gave me courage and a perspective of how I would like to see future developments taking place for NCMs practising in South Africa.

I now move on to Chapter Five, the final chapter of this study, where I will give my final remarks on the study.

# CHAPTER FIVE

## CONCLUDING REMARKS

### 5.1 INTRODUCTION

In this final chapter I will summarise the study and briefly discuss how the findings, being the outcomes developed and researched, could influence further investigation into the development of a curriculum for the formal training of NCMs practising in South Africa.

### 5.2 CONCLUDING SUMMARY

In my career as a NCM, through my own experience and through networking with other NCMs, I have seen the need for formal education and training within the specialised field of Nurse Case Management. I began this study with the aim of finding out what outcomes would be needed for the development of a qualification and learning programme for NCMs practising in South Africa.

I selected experts in the field of MHC to be participants in the study using a descriptive survey study design. The Delphi technique was chosen to ensure an accurate and unbiased data collection process. Consensus was reached on the third round of the Delphi method.

The findings showed that the outcomes developed in this study require competencies that go beyond the basic training of nurses. The outcomes researched relate to competence in the:

- Understanding of the legal implications of managing cases;
- Ethical decision-making to be considered when managing cases;

- Ability to manage complex clinical and administrative processes in relation to technical systems in MHC environments; and
- Ability to compile reports after studying trends and researching business needs related to the workplace environment.

The outcomes do provide a basis for the development of a curriculum but are not exhaustive or definitive and could be re-interpreted as guides to the selection of content for a learning programme. However, such reinterpretation could be usefully informed by the discussion in Chapter Four on how the exit-level and specific outcomes developed from the study apply to the daily practice of NCMs in South Africa.

### **5.3 THE FINDINGS OF THE STUDY IN RELATION TO FURTHER INVESTIGATION IN THE DEVELOPMENT OF A CURRICULUM FOR NCMs IN SOUTH AFRICA**

On completion of the research process I understood that the outcomes developed from this study are primarily useful for the assessment of students who are in a learning programme to specialise as NCMs. However, I would like to comment on some of the implications of my research for further investigation that could form part of the continuing development of a curriculum for NCMs in South Africa.

#### **5.3.1 The development of a learning programme for Nurse Case Management in South Africa**

Curriculum development in South African higher education currently comprises a two-phase process – first, the design of a qualification and its specifications for registration on the NQF, and secondly, the design of a learning programme leading to the qualification. My research findings could



prove most useful in the first phase, in which the identification and formulation of outcomes is the central aspect of qualification design.

Further research as a basis for qualification design should include consideration of 'learning assumed to be in place' upon entry into the qualification, as well as integrated assessment within the learning programme, with appropriate strategies to integrate theory and practice in the field of study.

In addition to the research that is needed for qualification design, there needs to be further research towards the development of a learning programme, which would lead to a full qualification for NCMs practising in South Africa.

It is suggested that accredited South African Higher Education Institutions, responsible for the training of nurses, take the opportunity to undertake such research in developing the formal learning programme.

A task team consisting of appropriate representation of nursing educators and NCMs should be formed to plan the development of the learning programme.

The learning programme needs to be designed within a framework of lifelong learning to ensure that students develop relevant knowledge and skills related to the world of work and to career path possibilities and opportunities.

Within the framework of lifelong learning, the Recognition of Prior Learning should be taken into account, particularly when practising NCMs enter the

programme. Furthermore, nurses who have studied in other fields of nursing may have duplicated subjects in previous courses, such as nursing management. They should, where appropriate, receive credits for such subjects and not have to repeat them. However, to ensure that all theoretical study has practical relevance, all students in a learning programme for NCMs in South Africa should show, by practical assignments such as case studies, that they are competent and have an understanding of and insight into managing cases effectively.

With regard to learning assumed to be in place at the outset of the programme, entry level criteria, possibly in addition to those specified in the qualification, need to be established for use prior to the registration of students. The criteria should include a qualification of schooling up to grade 12 (matriculation) and one year of Nurse Case Management experience plus computer literacy (intermediate level). This is important as the quality and level of education to be developed for the NCM in South Africa warrants a basic understanding of Nurse Case Management. If this entry level is not met, students could be doomed to fail or struggle to complete assignments expected of them within the programme.

### **5.3.2 Workplaces and Higher Education Institutions**

To be able to take the suggested road forward in section 5.3, Higher Education Institutions need to form partnerships and affiliate themselves with the employers of NCMs, *i.e.* MHOs. The practical and experiential abilities that the student develops during the learning programme will at times need to be on site in the workplace. This will be particularly challenging to arrange

with the MHOs, as presently the roles and functions of NCMs within the corporate environment and hospitals are considered to be business strategies and 'trade secrets'. The suggestion that I would like to make here is that the initiative should come from the Higher Education Institution to appeal to MHOs to open up an avenue of communication and interaction in a 'sharing' capacity to the benefit of the process of developing a learning programme for NCMs in South Africa.

In addition, I would suggest that learning programmes developed for NCMs include training on how the two types of NCMs can overcome the differences within the context of work (see section 1.6.5).

In terms of the MHOs' business processes it needs to be noted that workplace technology changes continuously and rapidly. The ability to be and remain competent and perform effectively within the operational environment of a MHO, is a skill that cannot be learned and taught without actual engagement in the workplace environment.

I recommend that the student NCM be given the opportunity to complete the practical training aspect of a learning programme at the work site (experiential training). The amount of time spent at the workplace for this type of course needs to be investigated. However, suffice it to say, that enough time should be allocated for practical exposure as part of assignments. The opportunity of practically seeing various MHC and hospital environments allows the NCM trainee a fair opportunity to absorb the surroundings, document relevant information and experience dynamics within MHC environments. The

process of practical exposure should contribute to the proficiency of trainee NCMs, not only in completing assignments and examinations but also in their practice as NCMs.

In addition to the outcomes identified in this study being used for formal education, they could be used for the development of in-house learning programmes within the workplace. This would entail further research and investigation to develop learning programmes for in-house training for NCMs practising in South Africa.

### **5.3.3 Meeting Higher Education Quality Committee criteria**

Programme developers of Higher Education Institutions should take note of the criteria for programme accreditation required by the Higher Education Quality Committee (HEQC) of the Council for Higher Education (CHE). An example of this is appropriate qualifications of staff teaching on the programme.

This study is the first of its kind in South Africa and due to the limited expertise of NCMs in the country, further investigation should establish whether there are available resources for tutorship of student NCMs registering on the developed learning programme. I would like to suggest that because NCMs practice as specialists within specific fields of nursing, that the experts of those nursing fields be approached to tutor particular modules that are designed for the learning programme, e.g. specialist lecturers in intensive care training or surgical theatre training. This training could focus on the clinical management of cases. Further research on how to train the NCM in

other areas mentioned in this study, *e.g.* analytical reporting, needs to take place.

#### **5.3.4 SANC approval**

In addition to meeting the criteria of SAQA and the HEQC (Higher Education Qualification Committee), programme developers need to ensure that the requirements of SANC, the relevant statutory professional body, are met.

SANC, being the statutory body governing all nursing training and practice, accredits all training developed for nurses in South Africa. The learning programme to be developed will need to be assessed and accredited by SANC. SANC focuses on specific relevant aspects of training and training programmes for nurses, such as the definition of the course, the Higher Education Institution to present the course, admission requirements (assessment criteria prior to registration), the course duration, and the curriculum and the compliance thereof to the minimum requirements for the registration of the additional qualification. These criteria of investigation are stipulated in regulation R.118 of the South African Nursing Act, No 50 of 1978 (SA, 1978). On completion of the learning programme and with a successful pass, the NCM should receive an additional qualification in Nursing Case Management, approved and accredited by SANC.

I would suggest that the developed learning programme for NCMs in South Africa be presented to SANC for approval and accreditation as an additional post-basic qualification for NCMs pitched at a level 7 on the NQF of South Africa. As an example, the exit level outcome of Legislation with aligning

descriptors, such as; scope of practice; service provider practice; an understanding of health services; and contracts of schemes, could be presented as part of the learning programme and the value of empowerment to the NCM in his/her daily practice could be shown.

#### **5.4 CLOSING REMARKS**

This study has achieved consensus on the outcomes needed as a basis for skills development of the South African NCM, as a professional, in a specialised field of nursing. The qualification that the NCM would acquire once successfully passing the learning programme to be developed, could be the basis for ongoing Continuing Professional Development and a valuable complement to in-house MHO training.

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## **ADDENDUM I**

### **THE LEGAL FRAMEWORK APPLICABLE TO NURSE CASE MANAGERS PRACTISING IN SOUTH AFRICA**

The larger extent of legislation needed for proficiency in the practice of *Nurse Case Management*.

In general, these legislative structures do not always affect the Nurse Case Manager directly in his/her daily duties, but can have repercussions on decisions concerning denials, limitations and exclusions while working within the parameters of the medical schemes. Denials, limitations and exclusions are part of the medical insurance contract. Please note that the pieces of legislation have been listed with the most recent dates at the top of the list.

#### **The various Acts are:**

The Public Finances Management Act No.1 of 1999 as amended.

The Competitions Act No. 89. of 1998 as amended.

The Sterilization Act No.44 of 1998 as amended.

The S.A. Medicines and Medical Devices Regulatory Authority Act No. 132 of 1998 as amended.

The Skills Development Act No. 97 of 1998 as amended.

The Medical Schemes Act No. 131 of 1998 as amended.

The *Employment Equity Act* No. 56 of 1998 as amended.

The Basic conditions of Employment Act No. 75 of 1997 as amended.

The Compensation of Occupational Injuries and Diseases Act No. 61 of 1997 as amended.

The Health Act No. 63 of 1997 as amended.

The Medicines and Related Substances Control Act No. 90 of 1997 as mended.

The Choice of Termination of Pregnancy Act of 1996 as amended.

The Constitution of the Republic of S.A. No. 108 of 1996 as amended.

The Labour Act No. 66 of 1995 as amended.

The Public Service Act No. 103 of 1994 as amended.

The Occupational Health and Safety Act No. 85 of 1993 as amended.

The Human Tissue Act No. 65 of 1993 as amended.

The Nursing Act No. 50 of 1978 as amended.

The Pharmacy Act No. 53 of 1974 as amended.

The Health Professionals Act No. 56 of 1974 as amended.

The Mental Health Act No.18 of 1973 as amended.

The Children's Act No. 33 of 1960 as amended.

## ADDENDUM II

### LICKERT SCALE QUESTIONNAIRE FOR ROUND TWO

Researcher contact details with an explanation of how to fill in the questionnaire, plus the meaning of the descriptors and related sub descriptors, were sent. The attached questionnaire was sent via electronic email to the participants of the study.

#### *LICKERT SCALE QUESTIONNAIRE SENT OUT AT ROUND TWO*

Descriptors	Options				
	Most Definitely	Definitely	Occasionally	Not at all	Comments
<b>1. LEGISLATION</b>					
Scope of practice					
Services provider practice					
Health services					
Contracts					
<b>2. ETHICAL ASPECTS</b>					
Ethical aspects					
<b>3. MANAGEMENT</b>					
Leadership					
Communication					
Negotiate/bargaining					
Innovation and creativity					
Coordination					
Problem solving					
Evaluation					
Assessment					
Planning					
Organizing					



## LICKERT SCALE QUESTIONNAIRE SENT OUT AT ROUND TWO

Descriptors	Options				
	Most Definitely	Definitely	Occasionally	Not at all	Comments
<b>3. MANAGEMENT (continued)</b>					
Decision-making					
Time management					
Financial planning and control					
Manage partnerships					
Self management					
<b>4. ADMINISTRATIVE</b>					
Contract management					
Managing internal administrative changes					
Re-admissions					
Case and contract/ record keeping					
Computer literacy					
Pre-authorization consultation					
<b>5. ADMINISTRATIVE</b>					
Concurrent Case reviews					
Update flowcharts electronically					
Coding and claims review					
Product development					
<b>6. CLINICAL TRAINING</b>					
SA context specific					
Holistic care					
Develop care plans					
Identify and manage case complications					
Knowledge and application of new technologies					

LICKERT SCALE QUESTIONNAIRE SENT OUT AT ROUND TWO  
 (continued)

Descriptors	Options				
7. EXPERIENTIAL TRAINING	Most Definitely	Definitely	Occasionally	Not at all	Comments
Apply case management indifferent contexts					
Understand unique environments					
Apply change management strategies					
8. PROFESSIONL DEVELOPMENT					
Participate in life long learning					
9. OTHERS					

## ADDENDUM III

### LEARNING OUTCOMES FOR NURSE CASE MANAGEMENT IN PRACTICE IN SOUTH AFRICA

Researcher contact details with a request from the participants to indicate if they agree that the exit-level outcomes, the specific outcomes and the assessment criteria is what they (participants), agree, should be part of a Learning Programme for tertiary education for NCM in South Africa. The attached questionnaire was sent via electronic email to the participants of the study.

#### QUESTIONNAIRE FOR ROUND THREE

EXIT-LEVEL OUTCOMES	SPECIFIC OUTCOMES	ASSESSMENT CRITERIA
<b>1. Legislation</b>  Relates the work of the NCM to relevant legislation.	Ability to compile a database of relevant legislative documents for referencing purposes.	Competence is demonstrated when relevant legislation is compiled and updated so as to ensure easy referencing and sourcing during the daily practice of NCMs.
	Ability to analyze the legislative context in which the NCM works.	Competence is demonstrated when a presentation of a number of high risk case studies shows how legislation may impact on the process of case management.
	Engages with relevant legislation in the process of managing cases.	Competence is demonstrated when a number of case studies will show how the NCM manages the effect of the applied legislation on the process of case management.

**QUESTIONNAIRE FOR ROUND THREE (continued)**

EXIT-LEVEL OUTCOMES	SPECIFIC OUTCOMES	ASSESSMENT CRITERIA
<p><b>2. Ethics</b></p> <p>Integrates nursing ethics within the distinctive professional roles of NCMS</p>	<p>Ability to identify the ethical values which influence the decisions made in the work life of the NCM.</p>	<p>Competence is demonstrated through the presentation of written assignments of case studies which clearly show the integration of ethical values within the process of case management.</p>
	<p>Ability to develop protocols and policies that address ethical values within the daily practice of the NCM.</p>	<p>Competence is demonstrated through written assignments which indicate that the NCM has an in-depth understanding and the ability to develop protocols and policies applicable to ethics and their daily practice.</p>
	<p>Ability to integrate the protocols and policies into the daily practice of the NCM.</p>	<p>Competence is demonstrated through written assignments which indicate that the candidate has the ability to integrate the protocols and policies applicable to the professional practice of NCM.</p>
	<p>Ability to apply the developed protocols and policies related to ethics within the daily practice of the NCM.</p>	<p>Competence is demonstrated through written assignments which indicate that the NCM has the ability to apply the developed protocols and policies to the professional daily practice.</p>

**QUESTIONNAIRE FOR ROUND THREE (continued)**

EXIT-LEVEL OUTCOMES	SPECIFIC OUTCOMES	ASSESSMENT CRITERIA
<p><b>3. Management competence</b></p> <p>Apply competent managerial skill and knowledge within the distinctive professional roles of a NCM.</p>	<p>Ability to apply their managerial knowledge and skill to their work environment.</p>	<p>Competence is demonstrated by means of a written assignment indicating the manner in which the NCM applies managerial knowledge and skill.</p>
	<p>Ability to design and create managerial tools such as flow charts and procedure manuals to clarify and manage complex processes.</p>	<p>Competence is demonstrated when; the manuals and charts are designed in such a manner that change is accommodated. This is shown by presenting written assignments.</p>
	<p>Ability to take on the role as change agent within complex environment/s by developing new theories and ensuring correct and appropriate transference of information.</p>	<p>Competence is demonstrated when all relevant information concerning change has been correctly disseminated to all relevant parties/departments. A written assignment, indicating clearly how this is done will be presented.</p>
	<p>Ability to modify managerial concepts to suit specific situations within the workplace.</p>	<p>Competence is demonstrated by showing the modifications made and the effect that it had on the environment in a written assignment.</p>
	<p>Ability to apply competence in managing complex overt responses as in quick accurate computer usage.</p>	<p>Competence and skill is demonstrated by a practical computer examination.</p>

**QUESTIONNAIRE FOR ROUND THREE (continued)**

<b>EXIT-LEVEL OUTCOMES</b>	<b>SPECIFIC OUTCOMES</b>	<b>ASSESSMENT CRITERIA</b>
<p><b>4. Clinical competence</b></p> <p>Relates clinical knowledge/skill to the processes of managing cases within their distinctive professional role as NCM.</p>	<p>Ability to demonstrate sound anatomical knowledge to enable clinically correct response to cases.</p>	<p>Competence will be demonstrated by weekly written tests and an OSCE examination after attending lectures. These tests will clearly show the knowledge base of the NCM</p>
	<p>Ability to describe how clinical knowledge assists the NCM in making the correct judgment calls when clinically managing assigned cases.</p>	<p>Competence of clinical knowledge applied to practice is shown by presenting cases as written assignments.</p>
	<p>Ability to explain and demonstrate how the NCM develops a care plan per case, involving clinical concepts of nursing.</p>	<p>Competence in developing care plans per case is demonstrated by presenting cases as written assignments.</p>
<p><b>5. Administrative competence</b></p> <p>Administers contracts with good governance.</p>	<p>Ability to develop policy and protocol to enhance and ensure good governance of contracts.</p>	<p>Competence is demonstrated by the presentation of written assignments clearly showing how the policy and protocol that has been developed ensures good governance within the contracts that the NCM is assigned to work with.</p>
	<p>Ability to create a sequence of steps to ensure that policies and protocols are integrated into managing the contract/s from an administrative perspective.</p>	<p>Competence is demonstrated by the presentation of written assignments clearly showing what steps are taken and how they are managed, to ensure that policy and protocols are integrated into the process of managing contracts.</p>
	<p>Ability to correlate and articulate coding demands when auditing and managing accounts.</p>	

**QUESTIONNAIRE FOR ROUND THREE (continued)**

EXIT-LEVEL OUTCOMES	SPECIFIC OUTCOMES	ASSESSMENT CRITERIA
<p><b>6. Statistics (data analysis) and Specific Reporting (Business)</b></p> <p>Research, with the intention to identify trends and changes that affect MHC and MHO environments.</p>	<p>Ability to research, analyze and recognize the effects of the micro, meso and macro environment.</p>	<p>Competence is demonstrated by a presentation of written assignments. Clarity, as to how the research was conducted and how valuable the findings were, will be shown in the assignments.</p>
	<p>Ability to demonstrate how to manage the variables within each level of research.</p>	<p>Competence will be shown through written assignments. Assignments will indicate how findings were managed and how changes were effectively made.</p>
	<p>Ability to develop programmes with the purpose of training and informing other relevant parties.</p>	<p>Competence is demonstrated by the presentation of written assignments clearly showing how the NCM will use the lines of communication and design specific training and/or informative session to transfer relevant information.</p>
	<p>Adapts and composes specific reports related to MHC organizations and their business expectations.</p>	<p>Competence will be shown through written assignments as to the correct outlay and structuring of reports plus the mechanisms used to do so.</p>

## ADDENDUM IV

### THE RESPONSES FROM ROUND TWO

The responses from round two using the questionnaire sent out for round two, with adjustments explained in chapter three.

#### **ILLUSTRATED RESPONSES FROM ROUND TWO**

Descriptors	Options			
	Definitely n (%)	Occasionally n (%)	Not at all n (%)	Total N (%)
<b>LEGISLATION</b>				<b>15 (100%)</b>
Scope of practice	15 (100%)	0	0	15 (100%)
Services provider practice	14 (93%)	1 (7%)	0	15 (100%)
Health services	13 (87%)	2 (13%)	0	15 (100%)
Contracts	11 (73%)	4 (20.4%)	1 (6.6%)	15 (100%)
<b>ETHICAL ASPECTS</b>				<b>15 (100%)</b>
Ethical aspects	15 (100%)			15 (100%)
<b>MANAGERIAL</b>				<b>15 (100%)</b>
Leadership	12 (80%)	2 (13.4%)	1 (6.6%)	15 (100%)
Communication	15 (100%)	0	0	15 (100%)
Negotiation/bargaining	13 (86.6%)	2 (13.4%)	0	15 (100%)
Innovation and creativity	11 (73.4%)	4 (26.6%)	0	15 (100%)
Coordination	13 (86.6%)	2 (13.4%)	0	15 (100%)
Problem solving	13 (86.6%)	1 (6.8%)	1 (6.6%)	15 (100%)
Evaluation	9 (60%)	5 (33.4%)	1 (6.6%)	15 (100%)
Assessment	14 (93.4%)	0	1 (6.6%)	15 (100%)
Planning	14 (93.4%)	0	1 (6.6%)	15 (100%)
Organizing	13 (86.6%)	0	2 (13.4%)	15 (100%)
Decision-making	14 (93.4%)	0	1 (6.6%)	15 (100%)
Time management	14 (93.4%)	0	1 (6.6%)	15 (100%)
Financial planning and control	7 (46.7%)	7 (46.7%)	1 (6.6%)	15 (100%)
Manage partnerships	10 (66.6%)	5 (33.4%)	0	15 (100%)
Self management	14 (93.4%)	0	1 (6.6%)	15 (100%)



**ILLUSTRATED RESPONSES FROM ROUND TWO (continued)**

Descriptors	Options			
	Definitely n (%)	Occasionally n (%)	Not at all n (%)	Total N (%)
<b>ADMINISTRATIVE</b>				<b>15 (100%)</b>
Contract management	10 (66.6%)	5 (33.4%)	0	15 (100%)
Internal administrative changes	8 (53.4%)	7 (46.6%)	0	15 (100%)
Re-admissions	13 (86.6%)	2 (13.4%)	0	15 (100%)
Case and contract/ record keeping	15 (100%)	0	0	15 (100%)
Computer literacy	14 (93.4%)	1 (6.6%)	0	15 (100%)
Pre-authorization consultation	15 (100%)	0	0	15 (100%)
Concurrent Case reviews	15 (100%)	0	0	15 (100%)
Update flowcharts electronically	13 (86.6%)	2 (13.4%)	0	15 (100%)
Coding and claims review	14 (93.4%)	1 (6.6%)	0	15 (100%)
Product development	5 (33.4%)	9 (60%)	1 (6.6%)	15 (100%)
<b>CLINICAL TRAINING</b>				<b>15 (100%)</b>
SA context specific	11 (73.4%)	4 (26.6%)	0	15 (100%)
Holistic care	11 (73.4%)	3 (20%)	1 (6.6%)	15 (100%)
Develop care plans	14 (93.4%)	1 (6.6%)	0	15 (100%)
Identify and manage case complications	15 (100%)	0	0	15 (100%)
Knowledge and application of new technologies	10 (66.7%)	5 (33.3%)	0	15 (100%)
<b>EXPERIENTIAL TRAINING</b>				<b>15 (100%)</b>
Apply case management indifferent contexts	12 (80%)	2 (13.4%)	1 (6.6%)	15 (100%)
Understand unique environments	12 (80%)	1 (6.6%)	2 (13.4%)	15 (100%)
Apply change management strategies	13 (86.7%)	0	2 (13.3%)	15 (100%)
<b>PROFESSIONAL DEVELOPMENT</b>				<b>15 (100%)</b>
Participate in life long learning	7 (46.7%)	7 (46.7%)	1 (6.6%)	15 (100%)
<b>OTHERS</b>				<b>15 (100%)</b>
Data analysis	1 (100%)	0	0	15 (100%)
Business reporting	1 (100%)	0	0	15 (100%)