

Introducing case management into the outpatient dialysis center

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Introduction

In no human endeavor is the concept of teamwork more central than in the practice of health care. Teamwork is evident, for example, in the operating room, where the players not only are referred to as the "OR team," but even wear scrub suits in the same style and color. Similarly, we talk of "team nursing" or the "cardiac resuscitation team" and cannot help but recognize the prevalence of collaborative effort. Indeed, the merging of highly specialized skill and individual egos into a functioning group is absolutely necessary for complex patient care to occur.¹

When discussing outpatient medical organizations, it is therefore essential to keep in mind the importance of teamwork. The management of the enormous number of patients treated in outpatient settings is the most significant element in maintaining and restoring health in the nation's population. Combining all the involved skills and technologies in a smooth, effective, and continuing effort is not an easy task.¹

Defining case management

The definition of nursing case management varies depending on the discipline employed, the personnel and staff mix used, and the setting in which the model is implemented. Primarily borrowing principles from managed care systems, nursing case management is an approach that focuses on the coordination, integration, and direct delivery of patient services. It places internal controls on the resources used for care. Such management emphasizes early assessment and intervention, comprehensive care planning, and inclusive service system referrals.⁴

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Specific roles for the RN as case manager emerge within the case management concept: assessor, planner, coordinator, collaborator, advocate, counselor, educator, and evaluator. In addition to these management and professional roles, the RN must possess clinical expertise in the care of patients targeted for case management.¹

The case management process

Case management models serve as the hub for the delivery of multi-levels of patient care within the ambulatory setting. For example, if a patient experiences a health crisis at his residence or during a visit to the health care provider, he is placed in one of the following categories.

- Level I:** Defined treatment on a short-term basis
- Level II:** Intensive care via visits, followed by telephone management until discharge
- Level III:** Continuous long-term care management via coordination with other services and monthly visits
- Level IV:** Home health services with minimal dependence on external services
- Level V:** Coordination of care, which provides a linkage between the healthcare facility and client's residence

The process of case management begins with the referral of a patient. The need for referral is usually determined by a screening process. The screening considers factors in the patient's situation that are indicators for continued health care. These indicators may include prescribed intake of four or more medications, living arrangements with environmental hazards, absence of social

support systems, cognitive disorders, multiple illness, hospital readmissions, and difficulty accomplishing activities of daily living. Major components of the assessment process include:

- ▶ Demographics
- ▶ Functional status
- ▶ Legal issues
- ▶ Financial issues
- ▶ Cognitive status
- ▶ Assessor's impressions
- ▶ Medical history
- ▶ Living arrangements
- ▶ Support systems
- ▶ Medication profile

Historical background

On Oct. 30, 1972, Congress passed Public Law 92-603 as an amendment to the Medicare Act with only a single dissenting vote. After only 30 minutes' debate, the Senate followed with a 52-3 vote, and President Richard Nixon signed the bill into law. This gave all American citizens the right to treatment for end-stage renal failure, regardless of age. ESRD is the only medical condition, before or since, to be given this status.

Contemporary estimates on how many patients would eventually need treatment in the United States varied from 16,000 (a figure actually achieved as early 1974) to 55,000 patients a year. By 1999, the patient population approached a quarter of a million. The annual Medicare budget for the ESRD Program was expected to be \$250 million; by 2000, it was more than \$15 billion.³

Making the case

Presently, more than 340,000 patients are in the Medicare ESRD program, the vast majority undergoing regular dialysis treatment. Although representing less than 1% of all Medicare patients, the care for this vulnerable population con-

sumes 6% of all Medicare expenditures. Hospitalizations are also common in patients with ESRD, averaging more than 12 to 15 days per patient per year.⁶

Caring for ESRD patients is a challenge because of their comorbid conditions; in many cases, issues cannot be adequately handled through current diabetes or congestive heart failure programs. Caring for a typical diabetic patient is not the same as providing care for a diabetic patient with renal disease. Therefore, a disease management program, using renal case managers, must focus on the overall management needs of this highly complicated patient, rather than those of the kidney disease itself.

The most effective means of managing this population is a field-based program using nurses to coordinate the care of the patients among the various medical providers they use. Although it is possible to have an impact on these very ill patients with a telephonic program, to achieve optimal results, there must be an onsite presence. An onsite presence makes it easier to assess patient needs and integrate with health plans and providers to streamline the delivery system for these patients. Improved patient and provider education and compliance leads to the elimination of unnecessary or inappropriate utilization of services.²

A field-based disease management care program in Vernon Hills, Ill., in which nurses meet face to face with Kaiser members suffering from chronic kidney disease and ESRD, has resulted in dramatic decreases in emergency department visits and hospital bed days.³ The members are risk-stratified according to comorbidities and utilization of services. The coordinators and the members jointly identify issues that need to be managed and develop a plan of care. The plan is delivered to the member and the entire care management team, which may include a nephrologist, multiple specialists, a primary care physician, and dialysis care team. Risk stratification drives the frequency of the contacts the coordinator makes with the member. The nurses regularly see the patient face

to face, and may also telephone them between visits.³

Conclusion

Data show that it is possible for ESRD patients enrolled in managed health plans to have excellent clinical outcomes. The coordinated care in the form of disease-state management leads to improved clinical outcomes. Such collaborative care approaches could be developed by nephrology practices or other provider groups.⁶

Expanded use of coordinated care for patients with ESRD, whether based in managed health plans or the current fee-for-service Medicare system, may provide the possibility of improved outcomes for this vulnerable patient population.⁶ ♦

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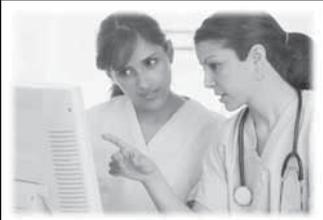


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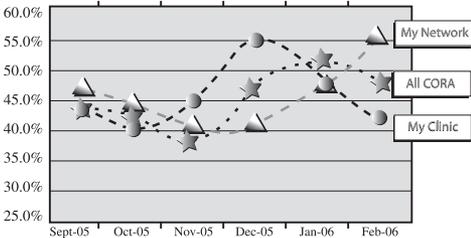
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