Case management

The needs and expectations of healthcare professionals concerning case management in a university hospital: a qualitative study

Esther Hagemans

5506700

Master Thesis

30-06-2017

Master Clinical Health Sciences, Nursing Science

Utrecht University

Supervisors: Bianca Buurman (BB) & Anne Eskes (AE)

Course tutor: Thora Hafsteinsdottir

Institution: Academic Medics Centrum (AMC) in Amsterdam

Journal: International journal of nursing studies

Reference style: Vancouver

Words: 3781

Criteria transparent reportage: COREQ guidelines

Words English abstract: 284

Words Dutch abstract: 297

English abstract

Title: The needs and expectations of healthcare professionals concerning case management in a university hospital: a qualitative study.

Background: Gynaecological cancer is a life-threatening and complex disease. Patients are going through long-term pathways, and this situation requires well-coordinated care. Case management (CM) is a well-known strategy to improve care coordination. Despite its widespread application and popularity, CM is not consistently defined. Particularly in gynaecological cancer, there is insufficient information about the needs and expectations of healthcare professionals (HCPs) regarding CM. Insight into these needs and expectations would facilitate the development of a tailor-made CM intervention for this specific group and expedite the desired change.

Research question: What are the needs and expectations of HCPs working in a gynaecology department in a university hospital on CM?

Method: A generic qualitative design with an inductive approach was used. Semi-structured interviews were conducted between January and February 2017 with physicians, medical residents, (specialist) nurses and medical social workers. The recorded interviews were transcribed verbatim and analysed using thematic analysis.

Results: A total of 18 participants were interviewed. The majority of participants were working as nurses (n = 12). The needs and expectations reflect three major themes: (1) the importance of well-coordinated care; (2) transitions in professional roles; and (3) conditions for successful CM.

Conclusion: HCPs working in the department of gynaecology expect that in realising well-coordinated care, a case manager can have great value. HCPs are mainly focused on CM within hospitals, while the patients' complexity requires reliable hospital discharge planning.

Recommendations: The findings of this research can be used as a basis for the intervention of CM and to optimise the implementation of CM in a gynaecological setting.

Keywords: Case management, gynaecology, fragmented care, care coordination.

Nederlandse samenvatting

Titel: De behoeften en verwachtingen van zorgverleners met betrekking tot case management in een academisch ziekenhuis: een kwalitatieve studie.

Achtergrond: Gynaecologische kanker is een levensbedreigende en complexe ziekte. Patiënten doorgaan langdurige trajecten waarbij veel verschillende professionals betrokken zijn. Dit vraagt om goed gecoördineerde zorg. Een strategie om de zorg coördinatie voor deze patiënten te verbeteren is case management (CM). Ondanks zijn wijdverspreide toepassing en populariteit is CM niet eenduidig gedefinieerd. Vooral bij gynaecologische kanker is er onvoldoende informatie over de behoeften en verwachtingen van zorgverleners m.b.t. CM. Inzicht in deze behoeften en verwachtingen zou de ontwikkeling van een op maat gemaakte CM-interventie voor deze specifieke groep verbeteren en implementatie vereenvoudigen.

Onderzoeksvraag: Wat zijn de behoeften en verwachtingen van zorgverleners werkzaam op de afdeling gynaecologie in een academisch ziekenhuis omtrent CM.

Methode: Een generiek kwalitatief onderzoek met een inductieve benadering is uitgevoerd. Semigestructureerde interviews werden uitgevoerd tussen januari en februari 2017 met artsen, arts-assistenten, verpleegkundigen, verpleegkundig specialisten en maatschappelijk werkers. De opgenomen interviews werden getranscribeerd en geanalyseerd met behulp van thematische analyse.

Resultaten: In totaal werden 18 deelnemers geïnterviewd. De meerderheid van de deelnemers was verpleegkundige (n = 12). Drie hoofdthema's kwamen uit de resultaten: (1) het belang van goed gecoördineerde zorg; (2) verandering in rol; en (3) voorwaarden voor succesvol CM.

Conclusie: Zorgverleners die werkzaam zijn op de afdeling gynaecologie verwachten dat bij het realiseren van goed gecoördineerde zorg een case manager van toegevoegde waarde kan zijn. Zorgverleners zijn voornamelijk gericht op CM binnen de muren van de ziekenhuizen, terwijl de complexiteit van de patiënt om een goede nazorg vraagt.

Aanbevelingen: De bevindingen van dit onderzoek kunnen gebruikt worden voor het optimaliseren van de interventie van CM en als basis voor de implementatie van CM binnen een gynaecologische setting.

Keywords: Case management, gynaecologie, gefragmenteerde zorg, zorg coördinatie.

INTRODUCTION AND RATIONALE

Gynaecological cancer is a life-threatening disease, and it negatively affects the individual's quality of life before, during and after treatment[1]. Gynaecological cancer is one of the major causes of mortality and morbidity[2], and accounts for 19% of the estimated 5.1 million new cancer cases in the world[3]. The number of patients diagnosed with gynaecological malignancies is rising significantly due to increasing age[4]. The treatment plans of patients with gynaecological cancer differ widely, and can include medication, chemotherapy, radiotherapy, surgery or combinations of these treatments[5]. The treatment duration depends on several factors, such as age, size of tumour or treatment plan[6].

All these treatment options and factors make gynaecological cancer a demanding and complex disease. Patients are going through long-term pathways, with many transitions from one setting to another[3]. Within these pathways, many healthcare professionals (HCPs) are involved and they all deliver a part of care[2, 10,11]. As a result, healthcare can become fragmented and a patient can experience discontinuity of care. Consequently, providing medical treatment for these patients is often challenging, which raises the need for well-coordinated care[7]. In reality, the coordination of healthcare is often only focused within one setting (e.g. a hospital) [10]. Ideally, care should be coordinated by one professional, who will take the lead in the treatment process and serve as a bridge between the different settings and professionals[2]. Case management (CM) is a well-known strategy used to improve care coordination for these patients[2, 13].

CM is an expanding organisational approach used to optimise the quality of treatment and care for individuals with complex care needs[8]. The case manager, most often a nurse or social worker, is responsible for the coordination, planning, facilitation and evaluation of care[8, 9]. In addition, the case manager advocates for options and services to meet individual's and family's needs[8]. Previous research has shown that CM both improves the quality of the care process by reducing fragmentation of care, and that it is cost effective[2, 12].

Despite its widespread application and popularity, CM is not consistently defined, and its practice varies from place to place because of diverging objectives, distinct target populations, programme and system variables, and other local differences[10]. Due to its widespread application, there are many misconceptions and ambiguities regarding CM, which makes it difficult to implement[11, 12]. It has been recognised that the successful implementation of an intervention depends on several factors, such as support. To create this support, it is important to allow the department to consider the details of CM, to give more interpretation and prevent misconceptions[13].

Although there is evidence that CM is an effective intervention to improve the coordination of care, CM is mainly used for chronically ill patients[11, 14]. However, within university hospitals patients in the gynaecology department are becoming increasingly complex. HCPs have no experience with CM for patients with gynaecological cancers, and there is insufficient information about the needs and expectations of HCPs concerning CM[15]. Insight into these needs and expectations would facilitate the development of a tailor-made intervention for this specific group and facilitate the desired change[8, 11,15]. Therefore, the aim is to explore the needs and expectations of HCPs working in a gynaecology department in a Dutch university hospital regarding CM.

METHODS

This study is reported according to the consolidated criteria for reporting qualitative research (COREQ) [16].

Design and setting

A generic qualitative design with an inductive approach was used to obtain insight into the needs and expectations of HCPs concerning CM for patients with gynaecological cancers. This research design can be effective in clarifying expectations and needs, and allows the researchers to flexibly and pragmatically collect and analyse the exploration topics[17]. The study was conducted at a gynaecology department in a Dutch university teaching hospital. This study is part of a larger project focusing on the development of the intervention of CM. A qualitative approach was employed to give more scope for interpretation and to optimise the development of the intervention of CM.

Role of the researchers

Two researchers (EH and MA) were involved in the process of data collection. EH has a bachelor's degree and professional background in social work and is currently a master's student in nursing sciences. MA is a registered nurse (RN) and she combines clinical practice with academic work. Furthermore, at the time of the study, she was near to finishing her MSc in evidence-based practice. The researchers were supported by AE, a registered nurse with a post-academic degree, and BB, a professor with longstanding experience in nursing, qualitative research and care transitions. The researchers had no relationship with the participants prior to or outside of the research situation.

Participants

In order to gain a broad perspective on the subject, purposive sampling with the use of maximum variation was used to ensure maximum variation in the function of HCPs[18]. The following inclusion criteria were used: the participant should work as physician, medical resident, (specialist) nurse or medical social worker on the clinical gynaecology ward or in the outpatient clinic. Furthermore, he or she must have at least one year of experience within the field of gynaecology and give written permission to be interviewed. The head of the department informed the eligible participants by email and asked if they would be interested in participating in the study. In total, 24 HCPs were eligible to participate. The participants were recruited and data were collected until data saturation was reached.

Data collection

Recruitment and data collection were carried out between January and February 2017. Data were collected through semi-structured qualitative interviews. The two researchers (EH, MA) conducted twelve and six interviews respectively. The interview guide has been prepared based on the core concepts of the definition of CM (e.g. planning, process of assessment, care coordination, communication, advocacy for options, and services to meet individual's and family's needs) [8] (Appendix 1), and supported by the pathway of a patient with ovarian cancer. This pathway gives a clear example of a complex patient with gynaecological cancer and enables the participants to keep one specific patient in mind with regard to CM. The interview guide was tested in a pilot interview. The researchers received feedback from a gynaecological nurse practitioner on the interview guide. No major changes were made to the interview guide after the pilot interview.

Each interview took 30–45 minutes. The interviews took place in private rooms in the participant's department. All interviews were audio-recorded with interviewee consent. Field notes were made during and after each interview. The field notes were used to reflect on and improve the interview skills of the researchers and to write down initial ideas. After 14 interviews, no new information was obtained and data saturation was achieved[19]. To ensure maximum variation and data saturation, 18 semi-structured interviews in total were performed.

Analysis

The researchers (EH, MA) transcribed the interviews directly after completing them. A member check was conducted by providing a written summary to the participants. A thematic analysis was used, which involved searching for repeated patterns across the data sets[18, 20]. First, the researchers (EH, MA) re-read the interviews and independently coded and reviewed the transcripts. In the next step, the researchers discussed each of the first five separately-coded transcripts until consensus was reached on the coding. This process was repeated for up to 14 interviews. From this point on, one researcher (EH) took responsibility for ongoing data coding and categorisation. The researcher (EH) analysed the codes and created initial themes. Finally, a thematic map was created to provide insight into the relationships between codes and themes.

To ensure the reliability of the coding process, codes and categories were reviewed on a weekly basis with researcher (MA) to ensure accuracy of interpretation and the internal consistency of codes[18, 20]. As the coding process progressed, family codes and categories of data were identified, as well as thematic relationships. Transcripts were analysed using MAXQD12 software to systematically evaluate and interpret qualitative texts[21].

Ethical considerations

This study is conducted in accordance with the standards of Good Clinical Practice, in agreement with the Declaration of Helsinki, Dutch law in general and with the Medical Research Involving Human Subjects Acts (WMO) in particular[26, 27]. The Medical Ethics Committee (METC) confirmed that WMO permission was not necessary (METC number: W17-071). Participants were guaranteed anonymity and confidentiality through the informed consent process and were notified of their right to withdraw from participation at any time.

RESULTS

A total of 18 participants – two men and 16 women, with an average of 7,22 years of experience (median = 7 years) in the field of gynaecology – were interviewed. The majority of participants were working as nurses (n = 12). Table 1 provides an overview of sample characteristics.
All participants expressed the expectation that a case manager could be of great value in realising well-coordinated care. Three major themes emerged from the data by searching for the needs and expectations with regards to CM; (1) the importance of well-coordinated care; (2) transitions in professional roles; and (3) conditions for successful CM.

The importance of well-coordinated care

The majority of the participants mentioned that they are convinced of the value of well-coordinated care to improve patient satisfaction. Furthermore, they noticed that a case manager could be beneficial to achieve this target. However, only one participant expressed that CM is not of added-value because from his or her perspective the physician is the primary treatment provider and thereby functions as a case manager. The participants noted that, in the current situation, many patients feel insecure, do not always know where to go, and questions remain often unanswered. In addition, the participants stated that patients have to deal with a great amount of information, and that healthcare is becoming fragmented due to the involvement of many care providers (see table 2; Q1).

Patient in control

All participants noted that, during healthcare provision, care should be more patient-oriented. The patient should be central to the process. For this reason, they expect a case manager to function as a regular contact point for the patient, his or her environment and the care providers (Q2). It is expected that this will simplify the communication and will lead to more clarity and transparency for the patient in his or her care provision. Nearly all participants communicated that

they expect a case manager to be present at the multidisciplinary consultation. This is perceived as added value for representing patients' interests (Q3).

Improving care coordination

Results show that the participants expect a case manager to be able to coordinate with the patient in all sorts of situations and to be able to answer the patient's questions. Because the case manager coordinates the care and functions as a contact point, participants think that this in the long term will lead to short lines of communication, prevent double diagnoses and save patients from having to repeat themselves to care providers. The participants expect of a case manager that he/she would improve care coordination, closing the gap between the different departments and maintain an overview of the process and the patient's treatment. Collaboration is an essential factor to close the gap (Q4).

Transitions in professional roles

Fear of changing roles

Primarily, the nurses working in the clinics and outpatient department indicated that they expect their roles will change once CM is implemented. They fear that tasks will be overlooked or that tasks will overlap with existing roles. They are primarily worried about other tasks rather than their own. The participants assume that they will fill the role of case manager and thus foresee that tasks will be taken over by other care providers (Q5). At the same time, the role of case manager is seen as a challenging position with opportunities for professional development (Q6).

Potential candidates for case manager

The participants indicated that they foresee nurses from both the clinical ward and outpatients' clinic as suitable care actors for fulfilling the role of case manager (Q7). Social workers and physicians were also named as potential role candidates, although a clear distinction was made between the tasks of the physicians and nurses. The physician is the primary treatment provider

and the case manager coordinates the care. The participants indicated very clearly that the responsibility for the treatment and the medical trajectory rests with the physician, and that the case manager is not the primary treatment provider (Q8).

Education

The participants reported that the role cannot be filled by any person. The participants indicated a number of conditions that the case manager should meet. First, the case manager is expected to possess sufficient knowledge of issues in order to answer medical questions. The participants also expect the case manager to be easily approachable, both by other care providers and by the patients themselves. Additionally, they expect the case manager to be up to date with the status of the patient. The case manager should also have sufficient knowledge and insight into different treatment theories and methods, and the course of disease processes. For this reason, an oncological background is seen as a great advantage.

The role of the case manager

Beside the necessary education and experience, the participants indicated that a case manager must have certain qualities. There was a high degree of consensus about these competencies. For example, a case manager must be able to maintain an overview of the whole care process. The participants stated that a case manager is not, by definition, responsible for things such as scheduling, and that he or she only needs to monitor the process. The participants also noted that a sense of responsibility and a capacity for empathy are important qualities in carrying out these tasks. Finally, the participants expect a case manager to be flexible and able to set limits.

Conditions for successful CM

Concerning the conditions of successful CM, each participant stated time as the largest barrier. They see many advantages to CM, but noted that it can only be successful if sufficient funds are available to create more time.

Tasks of a case manager

The participants also listed a number of important conditions to successful CM, such as a transparent task description. The data show that participants are not very aware of the work of other healthcare providers thereby they do not know what they can expect from each other. Such a task description would give insight into the distribution of responsibility. As a result, patients and care providers will know what they can expect of a case manager (Q9). It requires a strong collaboration, and common goals are essential, as one of the participants stated in Q10.

The accessibility of the case manager

Most participants indicated that the accessibility of the case manager is essential. In order to make the case manager accessible smooth communication between the department, the clinic and the other HCPs is critical. There must be a low threshold for approaching the case manager, for both patients and care providers. This will cause patients and care providers feel free to discuss issues with the case manager.

Building a bond of trust

There was a high degree of consensus concerning the role and tasks of the case manager for patients with gynaecological cancer. The participants made it clear that building up a bond of trust, based on mutual respect and honesty, is essential to fulfilling the function. This relationship is necessary for developing a complete, honest and holistic picture of the patient in order to make the patient central to the process. The participants reported that a face-to-face meeting is valuable in building this bond of trust, as it allows the patient to personally meet the case manager.

DISCUSSION

This study shows that participants expect that a case manager can be of great value in realising well-coordinated care. Participants identified different essential elements to make CM successful for patients with gynaecological cancer. We identified three major themes: (1) the importance of well-coordinated care; (2) transitions in professional roles; and (3) conditions for successful CM. The participants expect that patients will be more satisfied when these elements are incorporated in case management provided to patient with gynaecological cancer.

The importance of patient-centered care was an essential value linking the three defined themes. The results of our study show that all HCPs agreed that patients should have a central position in the health care process, and that care should be patient oriented. This is in line with previous research. A fundamental competency of a case manager is to be advocate about the care of their patient population; in this regard patients' goals must be leading factor[22, 23]. However, considering present-day reality, participants also mentioned that there is room for improvement; one way to facilitate improvement could be a case manager. The patient is a priority for the HCPs and they are all willing to improve care coordination. In addition, HCPs expect that a case manager should be able to answer medical questions, and they consider a professional background in the field of oncology to be a great advantage.

Although we did not give a clear definition of CM before the start of the study, almost all of the participants mentioned the five basic principles of CM as formulated by the Case Management Society of America (CMSA) [8]. Notably, although CM should stimulate transitions in care, including a complete transfer to the next care-provider's setting in an effective, safe, timely and complete manner[8], all participants focused exclusively on the care delivered within the hospital. Participants indicated that reintegration is not easy for patients, but they did not consider it part of

the case manager's duties. Because participants already see social work and home care playing a major role here. However, research shows that from a patient perspective there a need is for additional support with regard to reintegration[10, 22].

The participants noted several barriers that could prevent CM's success. First, they predicted that distribution of money and transitions in position would be the largest barrier. Minkman et al[24] described inadequate or absent structural funding as one of the failure factors of CM. Structural funding is needed to implement CM effectively, but in the long term CM has already been proven to be cost effective[11, 25]. Furthermore, aspects such as clear task description were discussed extensively in each interview. Participants fear that tasks will be overlooked or will overlap with existing roles. It is notable that this does not coincide with the patient's interests but relates to those of the participants. At the same time, the participants feel that it is their responsibility to achieve what is in the patient's best interests and they regard shared decision making as an important part of this task. These results are also in line with the literature's description of CM in a clinical system; whenever possible, case managers facilitate self-determination and self-care through the tenets of advocacy, shared decision making and education[8]. Research shows that it is important that HCPs and practitioners come together to reach a consensus regarding the guiding principles and fundamental spirit of the practice of CM[11, 13].

To appreciate the findings of this study, some aspects require further consideration. The current study has some limitations. First, the findings may have limited transferability to other departments within the hospital. The results primarily provide a view of a specific department of a university hospital, although the participants do differ in terms of gender, occupation and work experience. To facilitate transferability, the selection and characteristics of participants, data collection and the process of analysis are described in both the text (p.7-9) and in Table 1. Second, in this study, we have consciously chosen to ask HCPs with varied disciplines who they think is most suitable for the role of case manager in a local setting. This is debatable, but in

general, nurses are seen as the case managers who fulfil this duty. Thus, other professionals are deliberating about tasks, which they most probably are not going to do themselves. On the other hand, support of other professional groups for CM is essential, and a strong provider network and good collaboration are necessary to implement CM successfully[11, 24]. Third, we chose a pragmatic approach and provided a possible solution, namely CM, to improve the care experienced by HCPs and patients. As a result, it must be recognized that this approach could create bias in the responses, because there may have been less attention paid to uncovering issues pertaining to the underlying problem under study. On the other hand, CM will be implemented in our university hospital, and the information generated by our study will be helpful in making a tailor-made intervention, which fits the needs of the HCPs.

The strengths of the present study are its different perspectives, member check and investigator triangulation, which helped to increase trustworthiness. To meet the requirements of credibility and dependability, consensus about analysis and interpretation was continuously striven for and reached among the co-authors. Direct quotes from the interviews are presented in this paper, further strengthening the credibility of our findings. Another asset is that this research is distinguished from other investigations by highlighting a vision of CM from a qualitative point of view. Evidence shows that there is a need to conduct qualitative inductive research to collect and analyse representations of the case manager's role, as these representations have an influence on the implementation process[11, 24]. The current literature focuses mainly on costs and effects, but does not take the perspective of the field of work into account.

The findings of this research can be used to optimise the intervention of CM, and as a basis for the implementation of CM. Evidence shows when one shares ideas and considers details with co-workers, they feel a sense of ownership and loyalty[11, 13]. Interviews with HCPs help to encourage participation and can ensure a strong start of an implementation process. Incorporating these results in the intervention can lead to early detection and identification of

problems. Creating a shared understanding in multidisciplinary teams of what constitutes CM, reaching a consensus about the content of CM, and the division of tasks are important factors when addressing the implementation process[11]. The results pertaining to the functional description of CM may be a starting point for future research. In future, it would be useful to conduct research in other professions and organisations and to achieve a broader, more generalised view of CM as an intervention.

CONCLUSION

HCPs working in the gynaecology department expect that in realising well-coordinated care, a case manager can be a great value, and expect that when CM is successful patient satisfaction will improve. HCPS are primarily focused on CM within the hospital setting, while complex patients also require reliable hospital discharge planning and follow up. The role of the case manager concerning the aftercare of patients with gynaecological cancer remains unclear.

APPENDIX

Interview guide

1. Can you describe how well coordinated care for an ovarian cancer patient looks likes?

   (What do you need to achieve this?)

2. What could better? Why? How?

   (Communication, planning, care coordination, process of assessment, patient satisfaction)

3. What does this means for your job? Expect you that tasks will change with a case manager?

   (Example, own role, roles of others)

4. What should be the position and tasks of a case manager in an ideal world without barriers?

   (Characteristics, timing, intensity, type of contact (start, end), skills, background)

5. Is there anything more you would like to add or share?

REFERENCES

1. Toril Rannestad, Ole-Johan Eikeland, Harald Helland and UQ. Quality of Life, Pain, and Psychological Well-Being in Women Suffering from Gynecological Disorders. J Womens Health Gend Based Med. 9(8):897–903.
2. Hickam DH, Weiss JW, Guise JM, Buckley D, Motu'apuaka M, Graham E, et al. Outpatient case management for adults with medical illness and complex care needs. 2013;(99):-. Available from: http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1378
3. Sankaranarayanan R, Ferlay J. Worldwide burden of gynaecological cancer: The size of the problem. Best Pract Res Clin Obstet Gynaecol. 2006;20(2):207–25.
4. Dumas L, Ring A, Butler J, Kalsi T, Harari D, Banerjee S. Improving outcomes for older women with gynaecological malignancies. Cancer Treat Rev [Internet]. 2016;50:99–108. Available from: http://dx.doi.org/10.1016/j.ctrv.2016.08.007
5. Penson RT, Wenzel LB, Vergrote I, Cella D. Quality of Life Considerations in Gynecologic Cancer. Int J Gynecol Obstet. 2006;95(SUPPL. 1):247–57.
6. Jones GL, Jacques RM, Thompson J, Wood HJ, Hughes J, Ledger W, et al. The impact of surgery for vulval cancer upon health-related quality of life and pelvic floor outcomes during the first year of treatment: a longitudinal, mixed methods study. Psychooncology. 2016;662(September 2015):656–62.
7. Aktaş D, Terzioğlu F. Effect of Home Care Service on the Sexual Satisfaction of Patients with Gynecologic Cancer. Sex Disabil [Internet]. 2015;33(2):243–52. Available from: http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L53256670\nhttp://dx.doi.org/10.1007/s11195-014-9370-8
8. America CMS of. Standards of Practice for Case Management. Case Manager [Internet]. 2010;12:5. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21986967
9. Mahler M, Rühl A, Cuijpers M. Casemanagement. 2013;1–21.

10. Chow SKY, Wong FKY. A randomized controlled trial of a nurse-led case management programme for hospital-discharged older adults with co-morbidities. J Adv Nurs. 2014;70(10):2257–71.
11. Bamford C, Poole M, Brittain K, Chew-Graham C, Fox C, Iliffe S, et al. Understanding the challenges to implementing case management for people with dementia in primary care in England: a qualitative study using Normalization Process Theory. BMC Health Serv Res [Internet]. 2014;14:549–60. Available from: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4232624&tool=pmcentrez&rendertype=abstract
12. Man C, Nunes S, Casarin A, Isabel R, Gonzáles C, Freitas MC De, et al. A gement : evolution of the concept in the 80's and 90's management. 2002;10(4):472–7.
13. Grol R, Wensing M. What drives change ? Barriers to and incentives for achieving evidence-based practice. 2004;180(March):57–60.
14. Ross S, Curry N, Goodwin N. Case management. The King's Fund. 2011.
15. Grol R, Wensing M. Implementatie effectieve verbetering van de patientenzorg. Fourth. Reed Business; 2011. 592 p.
16. Tong A, Sainsbury P, Craig J. Consolidated criterio for reporting qualitative research (COREQ): a 32- item checklist for interviews and focus group. Int J Qual Heal Care. 2007;19(6):349–57.
17. Cooper S, Endacott R. Generic qualitative research: a design for qualitative research in emergency care? Emerg Med J [Internet]. 2007;24(12):816–9. Available from: http://emj.bmj.com/content/24/12/816.abstract
18. Boeije H. Analysis in Qualitative Research. 2010. 179 p.
19. Mason J. Qualitative researching. Second Edi. SAGE publications; 2002. 234 p.
20. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
21. Creswell J. Qualitative inquiry & research design: choosing among five approaches. third.

SAGE; 2007.

22. Lead RN, Nurse C. Women ’ s experiences of nurse case management on a gynaecological oncology unit in a Swiss tertiary hospital . A thematic analysis. 2017;(2).

23. Lee DTF, Hce PRD, Rn RM. Case management : a review of the definitions and practices. 1998;933–9.

24. Minkman MMN, Ligthart SA, Huijsman R. Integrated dementia care in The Netherlands : a multiple case study of case management programmes. 2009;1–10.

25. Kim Y-J, Soeken KL. A meta-analysis of the effect of hospital-based case management on hospital length-of-stay and readmission. Nurs Res [Internet]. 2005;54(4):255–64. Available from: http://www.ncbi.nlm.nih.gov/pubmed/16027568

26. Association WM. WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. Asoc Médica Mund [Internet]. 2013;(June 1964):1–8. Available from: http://www.wma.net/es/30publications/10policies/b3/

27. Nederlandse Overheid. Wet medisch-wetenschappelijk onderzoek met mensen [Internet]. 2016. Available from: http://wetten.overheid.nl/BWBR0009408/2016-08-01

FIGURES AND TABLES

Table 1. Baseline characteristics

Characteristics		N=18	
Gender, N (%)	Male	2	11.1
	Female	16	88.9
Occupation, N (%)	Physician	3	16.7
	Medical resident	1	5.6
	Nurse	11	61.1
	Medical social worker	2	11.1
	Physician assistant	1	5.6
Gynecology department, N (%)	Outpatients clinic	4	22.2
	Clinical ward	8	44.4
	Both	6	33.3
Years' work experience at gynecology department (Median, mean)		7 ± 7.22	

***N = number of participants**

Table 2. Quotes

	Function	Quote
Q1	Nurse	At the moment people are quite confused about the different physicians operating or helping them. I don't know.. They feel like there is a split and I think to guide those patients it's better to have one contact person serving as a coordinator. I personally think this is an idealistic opportunity. This would almost be some kind of form of case management. This is how I would have done it. (…) Knowing what they can expect from this hospital and how we operate. Guiding the patients by offering structure and clarity.
Q2	Social worker	I think it would lead to more clarity in a big chaos. I think they would gain confidence. (…) This could mean the lack of trust would reduce. They get their control back. In this way they will know what to expect from their contact point. (…) They see way too many people. Also in terms of nurses and physicians.
Q3	Nurse	I think it's relevant to be a part of multidisciplinary consultation meetings and being able to represent the patient and to act on patient's interest.
Q4	Social worker	I think it is very important for a patient to have one contact point who has a clear overview. Someone who will be looking after the patient and keeping an eye out. Someone who knows which physician would be involved, who the nurses are. Someone who coordinates everything and has an overview.
Q5	Nurse	Yes, but I think that would lead to elimination. Imagine if you let nurses work at the clinical ward at the start of a treatment, how far would it be extended? Because… I am not sure of how to see the split in this manner. I am not saying I don't think this could not work… But I would not know how it would… I cannot visualize it… It could work, but I don't see how… I am confident that working together would be useful, but only when well organized. But to get the outpatient nurse to do the first part of the treatment? It would be possible, but I don't see it working in this case.

Q6	Physician	Well, I think it is beneficial and nice for a nurse to be responsible for a patient during the whole treatment (…) I also think that it is an added value for people who find pleasure in helping the patients during the whole treatment. The added value of being integrated and being actively involved in the treatment.
Q7	Physician	I am convinced that a nurse is capable enough to do this. I think it is important that all nurses are substantively aware of all diseases. All of the nurses of the clinical ward are aware of the patients' conditions but I think we have to extend it. I imagine possessing a pool of people from the clinical ward and outpatient clinic. The outpatient clinic should have more knowledge about the clinical ward and the clinical ward should have more knowledge about the outpatient clinic. In this way you will have a group of people being capable to do it.
Q8	Physician	The case manager is not the therapist. The physician is the one who substantively decides the process and the case manager is the one coordinating the process.
Q9	Nurse	Back and fourth- communication. Are they missing or lacking something? What are we doing double? What is needed? It would be remarkable if we were able to properly connect care. That it is clear to everyone what their tasks are, that they know what information to give. And also that we are informed about what they do.
Q10	Nurse	This cooperation is very important. At the moment no-one is aware of what the others are doing on their 'islands'…