How to use a case manager

A partnership approach

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There is great scope for general practitioners and case managers to work together. An agreement regarding roles and responsibilities negotiated between GPs and service providers assists in the resource efficient provision of care and can result in positive outcomes for patients. This article describes how a GP can effectively use a case manager in a partnership approach.

Case management has become increasingly complex in recent years. Numerous programs exist in the community to provide a variety of services. As a general practitioner, how can you navigate this system and how can you best use a case manager to help you and your patients?

The range of case management services in Australia is 'mind boggling', and they vary greatly in what they will and won't do. Current case management models include services that may:

- implement and coordinate the involvement of other services
- provide direct clinical care themselves
- be disease specific such as chronic obstructive pulmonary disease (COPD), diabetes, or heart failure
- cater for complex patients ('complex' having numerous definitions)
- only see people who have had a certain number of hospital admissions.

Services that offer case management include private providers, hospital/emergency department based services, postacute care, community health services, mental health services, and services offered through divisions of general practice. There are also a range of different services accessed through the aged care assessment service/teams (ACAS/ACAT).

Within each service, case managers can have different professional backgrounds such as nursing, social work, psychology, and occupational therapy. They may also have less formal qualifications. Case management programs may have specialist physicians attached to their programs. Case management duration can vary from a few hours to a few weeks or years.

What are the benefits?

The benefits of case management have been demonstrated through various studies, including most recently through a 2003 study of postacute care services in Victoria. The 'Post acute care' program led to greater improvement in overall quality of life at 1 month after discharge and a reduction in hospital bed day utilisation in the 6 months after discharge, with an apparent reduction in health care costs.[1]

How to use a case manager

There is no doubt that the world of case management can be confusing, not just for a GP, but also for patients and other service providers. Anecdotally, the best way to look at a case manager is as an extension of what you can provide as a GP. The right case manager can save you time and can help you to better manage your patient. The questions GPs want answered are:

'How can you help me and my patient?', or alternatively, 'What are you already doing for/to my patient that I may not know about?'

These questions can be answered through clear communication with the case manager. The relationship developed between individual professionals is invaluable and the ability

to share responsibility for the pathways of communication is vital. Five minutes of your time talking to a case manager today can potentially save you hours in the future trying to sort out a difficult or complex patient situation. It is important for the GP to let the case manager know if there are significant changes that occur to a patient's treatment. The involvement of additional agencies or health care providers can share, and thereby lessen the load historically placed with the GP. Literature and anecdotal evidence indicates this is most effective when roles and responsibilities are shared and defined.

'The chronic care model suggests that the structure of medical practice must be redesigned to ensure clearly defined roles, full use of nonmedical staff, and a division of labour within clinical teams. In particular, care must be planned with case management available for patients with complex problems'.[2]

Questions to ask a case manager

- What can you do to help?
- Will you be seeing my patient regularly or for a single session? (Some case managers only see a patient sporadically to assess their needs, and then put services in place. Others will have regular contact to monitor progress or provide a service)
- How long will you be seeing my patient?
- Do you have a care plan? Can I have a copy of the care plan? Can we develop the care plan together?
- What is your professional background?
- Can you keep me informed of any changes in my patient's care?
- Can you let me know if my patient is discharged from your service or any other services under your coordination?

Example of a case management service

In December 2003, 'Healthy at home,' a case management program run from the Whitehorse Division of General Practice, funded by the Victorian Department of Human Services as a 'hospital admission risk program' (HARP) commenced. The program employs registered nurses to case manage patients aged over 65 years who have had a minimum of two unplanned hospital admissions in the past 12 months. The vast majority of patients have multiple chronic conditions and complex needs. The program works by augmenting the GP's role, assisting in the creation of enhanced primary care style health assessments and care plans to identify needs. The nurse monitors medical conditions, coordinates services and takes action if a patient's condition is deteriorating. This is achieved through a combination of self management and chronic illness approaches to make best use of resources. Both patients and GPs have shown great satisfaction with the service. To date, a 50–60% reduction in overall hospital admissions has been achieved in comparison to the previous year's admissions.

The GP-case manager relationship

The following case studies illustrate a successful GP-case manager relationship.

Case 1 – Mabel

Mabel, is 72 years of age and suffers severe COPD and high levels of anxiety. She lives alone and has recently started home oxygen. She reports she is very lonely. Mabel has been to the local hospital emergency department 13 times in the past 2 months. She calls her GP at least twice a week requesting a home visit because she is 'not well'. When the GP visits she usually finds Mabel's condition has not changed.

Because Mabel has been to hospital frequently she has been referred to a Victorian HARP program that specialises in people who have had frequent hospital admissions, specifically looking at how these can be reduced. A case manager is assigned to provide long term case management. The case manager contacts the GP who explains that she has become 'fed up' with this patient and can no longer provide the level of care she is looking for.

An agreement is developed where the GP and the case manager (who is a nurse) visit Mabel on alternate weeks. Mabel is told that if she has a problem, instead of calling the GP, she should contact her case manager. The case manager will assess the problem and visit her at home if necessary and will decide if it is necessary for the GP to become involved. The case manager also arranges services through the council, where Mabel is linked in with personal care, Meals on Wheels and someone to take her shopping once a week. The case manager also arranges for Mabel to attend an activity group once a week when she is able.

Of course Mabel still becomes unwell at times; it would be wrong to say that all her problems have been solved just through case management. She still has exacerbations of her COPD which require treatment, however, her reliance on her GP has been reduced to the times when it is appropriate. Mabel has developed a good relationship with her case manager, whom she now sees regularly. Regular frequent visits from the council and improved social networks through volunteer services have helped to reduce her loneliness, which in turn has helped to reduce her anxiety. The GP and case manager talk regularly about Mabel. The GP is able to provide the level of support Mabel needs and is grateful to have someone else who knows what is happening with her patient.

Case 2 – Simone

Simone, 15 years of age, presented frequently to emergency departments with reports of low grade gastrointestinal complaints that have been assessed as not organic in nature. Previously a solid academic achiever, Simone had irregularly attended school over the past 2 months. She did not have a regular GP and recently became involved with an adolescent community counselling service specialising in the cognitive behavioural treatment of anxiety disorders. This service placed a referral to a local GP and identified they were willing to case manage Simone's care.

The community counselling service places a detailed referral to a local GP indicating Simone's recent presentations to hospital and the outcome of assessments that occurred with each presentation. The referral also indicates that Simone's parents are aware and supportive of the referral. The case manager (a social worker), indicated a willingness to initiate a meeting of professionals involved in Simone's care in order to generate a care plan. Professionals invited to the meeting include the GP, case manager, and the school welfare coordinator.

The case conference results in the clarification of clear roles for each professional. The case manager coordinates meeting the needs of Simone through identifying an individual therapist within their community service to address anxiety issues and implement a therapeutic intervention. The school welfare coordinator will monitor Simone's school attendance and academic progress. The GP offered to monitor Simone's reports of gastrointestinal complaints, and be available for general medical appointments. The GP will also assess the appropriateness of prescription medication to assist in the reduction of anxiety symptoms should Simone's functioning deteriorate. The care plan also includes clear guidelines for the joint review of shared care and frequency with which this review will occur. A 'crisis plan' was clearly documented outlining potential situations in which Simone's symptoms may escalate and the responsibility and expected timelines of responses of each professional. The case manager agrees to discuss the proposed care plan with Simone and her parents.

The outcome of the case management involvement included the implementation of strategies to support Simone as she began to attend school more regularly. The school welfare coordinator identified stressors contributing to Simone's irregular attendance and worked to address these within the school setting. Concurrently, Simone commenced individual sessions with a therapist who introduced cognitive behavioural strategies to assist Simone in the management of her anxiety symptoms. The GP offered psychoeducation and monitoring of somatic symptoms that reassured Simone and assisted her parents in responding to Simone in a way that reduced the reactivity surrounding her distress.

The coordination of roles and the regular dissemination of information between all professionals involved was the key component in the success of case management shown by the reduced frequency of Simone's presentation to health care facilities.

How do I find a case manager?

The commonwealth 'Aged and community care information line' is a good place to start (1800 500 853). Your local ACAS or ACAT can also be a great source of information. Both of these services should have information on the case management services in your area, how to access them, waiting lists, and what each service can provide.

Conclusion

As the trend toward community based services continues, it is vital GPs remain informed on how to best access and utilise these services. Community services offer a range of models of case management. The factors underlying the success of various case management models include clear communication, identification of the needs of the patient, identification of the roles of professionals, regular review of the progress of shared care, and the involvement of patients in the planning of their care. A partnership approach to case management can result in great results for patients and decreased workload for GPs.

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References

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