Lessons in Case Management for the Physician

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The emergence and rapid proliferation of case management programmes, quality improvement projects, and continuous improvement plans is a prominent feature of the medical landscape in recent years. This is certainly the case in the public hospitals. The phenomenon is viewed by some doctors, depending on the context in which the measures have been introduced, with either suspicion, resistance, indifference, tacit agreement, or full and positive engagement. Whatever the case in our own institution, case management is beginning to take root in our hospital culture. We need to recognise this fact and to learn how best to cope with it in our everyday practice.

We can take a negative view of case management, regarding it as, at best, a form of misguided cookbook medicine or, at worst, a subtle cost-cutting Trojan horse used by administrators to bypass doctors' best judgment on patient care. This view may lead us doctors to conclude that it is best sidelined and left in the hands of some anonymous nurse or case manager, and that we can carry on as before. A negative response is a mistake, and the case management programmes will then fulfill our worse expectations.

The Division of Respiratory Medicine, National University Hospital, did the opposite and decided, from the very beginning, on full and proactive engagement in all care plans involving our patients. We were certainly not going to miss out on an opportunity to exploit a rare occasion when the hospital unilaterally offered additional resources relevant to patient care. We were also keen to ensure that all aspects of patient care were coherent with our own practice plans and philosophy. In the process, we transformed a vested interest into a virtue.

Firstly, patients actually benefited. They were released from the hospital faster, had to undergo fewer unnecessary tests, and incurred lower charges, and had perhaps fewer nosocomial complications. For example, from 2001 to 2004, in the National University Hospital, the average hospital stay for patients with chronic obstructive pulmonary disease (COPD) fell from 6.6 to 3.5 days, and for elderly patients with community-acquired pneumonia (CAP) and complications from 9 to 6 days. Patients also received more information regarding their illness than before, and some even learned new self-management skills, to cope better with the next exacerbation. There was also a knock-on effect of these initial positive outcomes, enabling us to justify a request for more funding, which really enhanced the quality of patient care beyond the usual levels of support. However, using positive results from a case management programme as a springboard to attract further funding successfully requires both some luck and the right timing.

The overall quality of patient care actually improves under a well-tended programme. The tools of a continuous review process, audit, and re-evaluation of outcomes and barriers can help to detect specific problems early. For example, in the area of over-investigation, the house staff are fond of ordering "routine" panel tests in all categories of acutely ill patients and, in particular, excessive blood cultures in patients with low-risk pneumonia. Conversely, under-testing may also occur. Delays and omissions in measuring arterial blood gases to detect respiratory acidosis in acute exacerbations of COPD, or to detect refractory hypoxaemia in severe CAP, may lead to the omission or late initiation of non-invasive ventilation. Rectifying these problems resulted in better patient care, on the one hand by reducing unnecessary testing, and on the other by triggering the start of urgent acute cardiorespiratory support at the points of critical need.

The house staff generally did not mind the case management programme too much. Of course, house staff will also appreciate the skillful case manager who negotiates an early discharge in a "difficult" patient. They have to fill in more forms; they need to follow simple rules and generally do less work, especially in carrying out investigations. However, this will only be true if the programme does not overload staff with documentation. Poor adherence to clinical pathways is a common complaint from case managers. However, the quality of data collected should be distinguished from the quality of

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patient care. Better patient outcomes should be the primary goal, not perfect documentation. This priority should be a fundamental feature in the design of these programmes.

The physician needs to learn how to work effectively with a larger team of doctors and non-doctors, and to get people from different social and professional backgrounds to cooperate. Active engagement and commitment will be engendered by ownership and the conviction that this process will improve patient outcomes meaningfully. The clinician can play a vital role in this regard by crafting care plans to incorporate key improvement steps, which are firmly evidence based and relevant to the local setting. Incorporating clinical evidence into management plans provides a firm scientific and medicolegal basis for new actions. It also enables the healthcare team to proceed with the conviction and confidence that they are doing the "right" thing.

During the outbreak of the severe acute respiratory syndrome in 2003, all clinical pathways, especially for CAP (for obvious reasons), were overridden by infection control procedures. However, we maintained the continuous evaluation of CAP outcomes under our care. This detected a marked increase in the number of admissions for CAP, specifically among older and sicker patients. This was associated with higher mortalities and longer hospitalisations. When infection control precautions were suspended after the Northern Hemisphere winter of 2003, we urgently re-implemented intervention steps in these older patients with CAP, to restore cost-effective care safely and successfully in this vulnerable group.

The deficiencies of managed care include a greater risk of treating the patient as a case, and failure to recognise and cope appropriately with differences between patients. Thus, we should be even more alert, and not lapse into a featureless, formulaic approach both in clinical practice and teaching. The overall shorter hospital stays also demand a higher standard of acuteness in clinical judgment, and faster turn around times for tests. There is also a greater need for communication with patients and families, both quantitatively and qualitatively, to minimise complaints of inappropriate early discharge from hospital. These programmes are also not attractive to the more ambitious clinical researchers. Case management usually does not employ novel treatment methods, and the data derived from these programmes are generally not supported by prospectively randomised controlled study populations.

In conclusion, our experience with case management programmes has been generally positive. However, these are complex interventions with unpredictable results. The physician needs to invest in long-term, sustained and insightful efforts to increase the likelihood of success. We will not err too much if improving the quality of patient care continues to be our primary objective.