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Original article

Care managers' experiences of interprofessional collaborative practice with physicians in community-based integrated care: a qualitative study

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Abstract

Objective: Under Japan's Long-term Care Insurance system, care managers (CMs) are expected to function as coordinators in the community-based integrated care system. However, few studies have focused on inter-professional collaboration between medical and non-medical professionals. The aim of this study was to identify CMs' perspectives on enablers and barriers to successful collaboration between care managers and physicians within the community.

Patient/Materials and Methods: We targeted care managers with ample experience working as CMs in the community and recruited 12 CMs using snowball sampling. Online interviews were conducted from January to May 2023 using an open-ended questionnaire concerning participants' experiences of collaborating with physicians and integrating medical services into care management. Qualitative data were analyzed through inductive manual coding using a qualitative content analysis approach.

Results: Four main themes were identified as enablers and barriers to successful CM–physician collaboration in the community: medical knowledge, professional attitudes, communication skills, and the professional culture of medicine. Equipping CMs with practical medical knowledge is essential for effective communication. Professional attitudes among CMs are imperative to fostering collaborative relationships. Effective communication skills are another critical factor, emphasizing the need for clarity, specificity, and utilization of nurses as key mediators in physician–care manager dialogue. Recognizing and navigating the professional culture of medicine is essential to overcome barriers stemming from differences in norms, beliefs, and practices between CMs and medical professionals.

Conclusion: This study underscores the significance of interprofessional education focusing on cultural differences and the development of systematic learning approaches to enhance CMs' medical knowledge of CMs. Furthermore, the findings highlight the need for clarity in defining CMs' roles within healthcare teams and addressing physicians' misperceptions regarding their contributions and responsibilities.

Key words: care manager, interprofessional collaboration, non-medical professional, professional culture, communication

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Introduction

Care needs in many contemporary societies are increasingly complex due to aging populations[1]. The complexity often requires collaborative and integrative efforts among a multiplicity of providers and professionals[2, 3]. If poorly coordinated, older patients and their relatives risk facing fragmented healthcare systems that are difficult to navigate[4]. Japan's government advocated a community-based integrated care system, partnerships that bring together professionals and practitioners from across different health and care organizations in a particular local area, working together more closely and providing joined-up care 24/7 around the needs of older people, their families, and their communities[5]. Un-

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der Japan's Long-term Care Insurance (LTCI) system, care managers (CMs) have played a major role in providing psychosocial support (i.e. social talk, information giving and reassurance) for family caregivers via their monthly visits[6]. CMs are also expected to function as coordinators in the community-based integrated care system[7]: hosting regular multidisciplinary care management conferences aiming at coordinating formal and informal care resources for older people who require care.

However, barriers to interprofessional collaboration faced by care managers in the community have been reported[7]. Ohta *et al.*[7] identified relationships with physicians as one of the most prevalent barriers to successful multidisciplinary collaboration through a qualitative study targeting forty-six care managers. They also cited information sharing with medical professionals such as physicians and nurses as an issue in interprofessional collaboration. Other studies have implied that a care manager–physician communication gap exists in community settings due to hierarchical communication power relationships[8, 9]. Moreover, previous studies have identified enablers and barriers to successful interprofessional collaboration in the community, with the former including good face-to-face relationships among different healthcare professionals, the clarification of role boundaries, and the enrichment of team members' nontechnical skills[9–12].

Thus, some studies have focused on general interprofessional collaboration. However, few have focused on interprofessional collaboration between medical and nonmedical professionals, such as care manager–physician collaboration, which is a fundamental element of Japan's community-based integrated care system. Therefore, we aimed to identify care managers' perspectives on enablers and barriers to successful care manager/physician collaboration in the community.

Method

To deeply understand care managers' perceptions of enablers and barriers to good interdisciplinary collaboration with physicians, including integration of medical services into care management of older clients living in the community, the authors used a qualitative approach to carry out their study.

The authors targeted care managers with ample experience working as care managers in the community and recruited 12 care managers through snowball sampling from facilities with which we had a pre-established relationship. In the previous studies, two types of care managers have been identified: "welfare-related" and "medical-related". The "welfare-related" category includes professional caregivers and social workers, while the "medical-related" category includes nurses. Interprofessional collaboration between medical and nonmedical professionals in care management is challenging to care managers whose basic qualifications are "welfare related". Medical care managers were included in this study to gather opinions from an intermediate position between welfare-related care managers and physicians[13]. Participant details are listed in Table 1. The first author (YH), a geriatrician with ample qualitative research experience, individually conducted online interviews from January to May 2023, using an open-ended questionnaire concerning their experiences in collaborating with physicians and integrating medical services into care management. The topics of the interviews were the knowledge, attitudes, and skills of care managers in communicating with physicians, as well as the differences in professional culture between physicians and care managers. Each interview lasted approximately 60 minutes and was audio-recorded and transcribed verbatim.

The first author read the transcriptions repeatedly to be-

Table 1 Characteristics of participants

Code	Prefecture	Gender (M/F)	Age (years)	Workplace	Nurse's license (Y/N)	Clinical experiences as a care manager (years)
P1	Akita	F	49	Affiliation with hospital or clinic	N	18
P2	Akita	F	47	Stand alone	N	12
P3	Akita	F	31	Affiliation with hospital or clinic	N	6
P4	Aichi	M	50	Affiliation with hospital or clinic	N	18
P5	Aichi	M	48	Affiliation with hospital or clinic	N	23
P6	Aichi	F	60	Stand alone	Y	30
P7	Aichi	F	59	Affiliation with hospital or clinic	Y	29
P8	Aichi	F	58	Affiliation with hospital or clinic	N	25
P9	Aichi	F	57	Stand alone	N	22
P10	Aichi	F	56	Stand alone	N	27
P11	Aichi	F	55	Affiliation with hospital or clinic	N	23
P12	Aichi	F	52	Stand alone	N	15

M: male; F: female.

come acquainted with the data and performed data cleansing to ensure the clarity and readability of the transcripts, clarifying meaning where needed by adding additional words in brackets to enhance readability, converting fragments into full sentences, and fully spelling out abbreviations and acronyms. Qualitative data were then analyzed by inductive manual coding using a qualitative content analysis approach[14]. First, we performed line-by-line labeling wherein pieces of data were segmented and condensed into individual sentences. Then, the emergent labels were organized, and the grouping process involved reading and comparing individual labels to cluster similar labels into categories and inductively formulate themes. The rigor and generalizability of the qualitative data analysis results were maintained, as the international teams from Japan (YH) and Sweden (EE) thoroughly discussed the identified codes, categories, and themes until a full consensus was reached. Both teams comprised professionals with academic backgrounds in health care management.

Ethical approval

This study was reviewed and approved by the Bioethics Review Committee of the Nagoya University School of Medicine (approval number: 2020-0248). All participants were informed of the objectives of the study and were notified of their right to withdraw from the study at any time and skip questions or topics that they did not wish to discuss. Written informed consent was obtained from each participant prior to study participation.

Results

Four main themes were identified as enablers of and barriers to successful care manager–physician collaboration in the community: medical knowledge, professional attitude, communication skills, and the professional culture of medicine. The themes, categories, and representative codes identified are listed in Table 2.

Medical knowledge

Older people tend to have multimorbidity represented by multiple chronic diseases (i.e., hypertension, diabetes, dyslipidemia) or geriatric conditions (i.e., cognitive impairment, falls, incontinence, low body mass index, dizziness, vision impairment, hearing impairment) and dependency in activities of daily living (i.e., bathing, dressing, eating, transferring, toileting). Such conditions require a wide variety of medical management practices. Participants believed that care managers should be equipped with sufficient practical medical knowledge to communicate smoothly with physicians and make high-quality care plans for older clients.

"I would like to know basic medical knowledge about principles for the prevention and control of non-communicable diseases" (P9)

"Individual clients' medical histories are too specialized and difficult for care managers to integrate into concrete care plans" (P11)

Professional attitude

Care managers play a crucial role in community-based integrated care systems by comprehensively coordinating home long-term care services. The participants suggested the importance of care managers' professional attitudes toward their own roles and that they should actively and directly contact physicians. The participants also implied that care managers should be passionate about their coordination practices to better collaborate with physicians. Specifically, participants emphasized that care managers should actively provide expert opinions on their clients' socioeconomic status when discussing their clients' care plans.

Table 2 Content analysis group organization: themes, categories and representative codes

Theme	Category	Representative code
Medical knowledge		Care managers can improve the quality of their care plans by increasing their medical knowledge.
		Care managers tend to focus on non-medical needs due to lack of medical knowledge.
Professional attitude	Positive attitude toward communication with physicians	Care managers should actively give expert opinions on their clients' socioeconomical status to physicians.
	Passion for care coordination	It is important for care managers to reconcile the differences of opinion among different professions, including physicians.
Communication skills	Clear communication	Care managers have to clearly and specifically communicate with physicians.
	Nurses as a liaison with physicians	Care managers have to use nurses as a key medical mediator to communication with physicians.
Professional culture of medicine	Hospital's lack of understanding of care plans made by care managers	Care managers' plans are often rejected by hospitals.
	Lack of understanding professional culture of medicine	There are customs that exist only among medical professionals.

"Whenever I talk to a physician, I am afraid that the way I talk would drive him or her crazy for no special reason" (P8)

"Some care managers often leave communication with physicians to nurses, while others take full responsibility in it" (P6)

"I am always thinking of making care plans considering both maintenance of good health and family budget" (P8)

"Person-centered care plans I made often annoyed physicians who emphasized physical aspects of patients" (P2)

Communication skills

Effective communication between care managers and physicians is crucial for building good relationships and ensuring the quality of care for older adults. The participants suggested two communication strategies to enhance care manager-physician conversations: (1) being clear and specific and (2) using nurses as key medical mediators to communicate with physicians.

"Physicians' instructions with a specific number are helpful for care managers to understand what they are expected to do" (P3)

"I am often told by physicians that I should put it simply" (P1)

"I consult nurses more often than physicians (when I have questions about medical conditions of my clients)" (P7)

Professional culture of medicine

The professional culture of medicine refers to the collective attitudes, norms, beliefs, and practices that shape everyday behavior and interactions within medical settings. As care managers are non-medical professionals and unfamiliar with the professional culture of medicine, they can hardly understand the culture of medical professionals or organizations. The lack of understanding of the professional culture of medicine prevents care managers from sharing information and collaborating with medical organizations or professions.

"Some hospitals reject care managers' proposals of care plan with no further discussion" (P4)

"There are many invisible conventional practices peculiar to medical facilities" (P11)

Discussion

The results suggested four key elements for successful collaboration between care managers and physicians from the care managers' perspective: Knowledge, Attitude, Skills, and Culture. The KSA framework, which represents knowledge (K), skills (S), and attitude (A) and is a valuable concept when designing educational programs or analyzing competencies, could be applied to the results[15, 16]. Knowing the differences in professional cultures among different professionals is also a fundamental element in interprofessional education[17]. The results imply the importance of interprofessional education focusing on cultural differences between care managers and physicians.

These results imply that there is a lack of systematic learning approaches to medical knowledge required for care managers. Most Japanese care managers have no license for medical professionals, such as nurses, and are not equipped with sufficient medical knowledge to collaborate with medical professionals[9, 18]. The aims of an officially required training program for care managers include the acquisition of medical knowledge; however, the program is focused only on case-based learning of the management of chronic diseases[19]. While using clinical cases is expected to aid in learning how interdisciplinary collaboration works with actual or simulated cases[20], it does not suit systematic learning. Few studies have reported on the practices of systematic learning approaches to fundamental medical knowledge designed for Japanese care managers.

Care managers did not recognize their role as professionals in the healthcare team that helped with completing care management with older clients as part of the clinical team; they were not good at defining their professional roles or playing a leading role in care management. There are two possible reasons for this. First, as has been widely discussed, building face-to-face relationships among healthcare professionals in a community remains challenging. Successful multidisciplinary collaboration in a community requires casual acquaintance. A lack of recognition of physicians' faces could prevent care managers from talking frankly with each other.

Second, physicians often misunderstand care managers' roles within the healthcare team and the Japanese long-term care insurance system on which they are based. Differences in insurance systems may cause miscommunication between care managers and physicians.

The results provide hints for educational program development to allow care managers to communicate better with physicians. A lack of clarity in care managers' conversations could lead physicians to misunderstand the needs of older clients, resulting in delayed or missed opportunities to collaborate. The link between interdisciplinary miscommunication and poor patient outcomes has been well-documented[21]. When care managers are clear about their conversations with physicians and other healthcare professionals, they are expected to work efficiently with physicians and meet their clients. A review[21] suggested that nurses and physicians are trained differently and exhibit differences in communication styles. The review also suggested that the nurses' lack of confidence and professional hierarchy hindered their relationships and communication with physicians. The results imply that the communication gap between care managers and physicians is weaker than that be-

tween nurses and physicians.

This study suggests that differences in professional culture between physicians and care managers matter in interprofessional collaboration. Clinicians tend to argue strongly for clear role boundaries and to defend their perceived control over healthcare from other professions[22, 23]. Making care plans for older clients may produce conflicting perceptions from diverse healthcare professionals; conflicts may arise through professions being unwilling to accept plurality over roles, which may hinder progress in meeting the needs of older clients.

These conflicts can arise among professionals from different disciplines and cultures. Previous research has suggested that understanding interprofessional similarities and differences in culture can enhance conflict management training and that interprofessional case conferences are effective educational tactics for understanding such conflicts, where interprofessional participants may discuss various strategies to manage these conflicts through team dynamics[9, 20, 24].

This study had several limitations. First, social desirability bias[25], a type of response bias leading to over-reporting of ideal behavior or under-reporting of undesirable behavior, might have occurred because the topic of the interviews was a sensitive one in which the participants discussed issues related to collaboration with physicians, the interviewer's professional. Second, the disadvantages of snowball sampling should be considered when interpreting the results. The author (YH) might have only been able to reach a small group of care managers and might not have been able to reach data saturation. Third, while it is crucial to clarify the differences in awareness between welfare and medical care managers, only two participants in this study had medical backgrounds, making it difficult to assert that their opinions alone accurately represented the population. Elucidating these differences requires increasing the number of medical-related participants and incorporating questions such as "How do you perceive the difference in communication with physicians between welfare-related and medical-related care managers?" in the interview guidelines.

Fourth, to avoid COVID-19, we used online interviews as a data collection method rather than triangulation[26] and data collection from different methods, investigators, people, or theories. Triangulation helps qualitative researchers avoid the research bias that arises from using a single perspective. Finally, because long-term care systems, including financing systems, differ between countries, the results of this study should be generalized with caution.

Conclusion

The findings of this study emphasize the factors that influence successful collaboration between care managers and physicians within community-based integrated care systems in the context of Japan's Long-term Care Insurance (LTCI) system. The identified enablers and barriers highlight the importance of knowledge, attitudes, skills, and understanding of professional culture in fostering expedient interprofessional teamwork. Equipping care managers with practical medical knowledge is essential for effective communication with physicians and developing care plans for older clients with complex care needs. Moreover, professional attitudes among care managers, characterized by engagement with physicians and the provision of information on clients' socioeconomic status, are paramount for fostering collaborative relationships.

Effective communication skills are another critical factor, emphasizing the need for clarity, specificity, and utilization of nurses as key mediators in physician–care manager dialogue. Finally, recognizing and navigating the professional culture of medicine is essential for overcoming barriers stemming from differences in norms, beliefs, and practices between care managers and medical professionals. This study underscores the significance of interprofessional education that focuses on cultural differences and the development of systematic learning approaches to enhance care managers' medical knowledge. Furthermore, it highlights the need for clarity in defining care managers' roles within healthcare teams and in addressing physicians' misperceptions of their contributions and responsibilities.

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