

# Community case managers' challenges collaborating with primary care when managing complex patients in the community: A qualitative study in Singapore

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## Abstract

Community case managers (CCMs) play a crucial role in the continuity of care for complex patients in the community. However, they are often considered as non-members of the healthcare team and not actively engaged by the primary care team because of the unique landscape of social services in Singapore. Given that these two distinct professional groups had minimal collaboration previously, integrating CCMs as partners of patient care within the primary care team may pose many challenges. The objective of this qualitative study was to understand the challenges encountered by CCMs when collaborating with primary care services. This exploratory qualitative descriptive study used individual in-depth interviews. CCMs were selected using convenience and snowball sampling. The interviews were semi-structured, guided by a topic guide. Fourteen CCMs were interviewed within a period of 12 weeks (October–December 2018). Thematic analysis was used to analyse the transcripts. Two researchers coded each transcript independently, and a coding framework was agreed upon. Potential themes were then independently developed based on the coding framework. Fourteen individual in-depth interviews were conducted. Six themes emerged from the data, i.e., self-identity, patient factor, inter-professional factor, collaborative culture, confidentiality and organisational structure. Challenges that resonated with previous studies were self-identity, inter-professional factors and confidentiality, whereas other challenges such as patient factors, collaborative culture and organisational structure were unique to Singapore's healthcare landscape. Significant challenges were encountered by CCMs when collaborating with primary care services. Understanding these challenges is key to refining intervention in current models of comprehensive community care between medical and non-medical professionals.

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## KEYWORDS

challenges, collaboration, collaborative care, community care, community case managers, complex patients, primary care services, Singapore

## 1 | INTRODUCTION

Primary care frequently acts as the hub for coordinating care of patients with multiple chronic conditions and also those confronted with complex psychosocial problems intertwined with medical problems. Early definitions of complex patients focused on factors such as the number of chronic diseases or medications (Valderas et al., 2009). More recent definitions of complex patients incorporate mental health, social influences and economic factors that substantially affect chronic disease outcomes (Grembowski et al., 2014; Zulman et al., 2014). The Agency for Integrated Care of Singapore defines complex patients as those fulfilling at least two of three domains: complex medical issues ( $\geq$ three chronic conditions or advanced disease), functional impairment (requiring assistance in  $\geq$ one activities of daily living or cognitive impairment) or psychosocial impairment (caregiver, family, financial, social isolation or psychological issues) (Community Case Management Service, 2019).

In Singapore, the primary care services are provided by 20 polyclinics, under the purview of the Ministry of Health with around 400 doctors, and about 1,700 private General Practitioner clinics for a population of 5.8 million. The proportion of attendances attributed to chronic disease has increased from 18% in 2010 to 27% in 2014, with care for elderly patients increasing from 10% in 2010 to 15% in 2014 (Primary Care Survey, 2014). Though the primary care services are nestled in the community, they are still confined within the environment of a consultation room. Primary healthcare providers do not usually have the resources to follow up on complex patients in their place of residence in the community. This, however, could be achieved by tapping on the resources and expertise of social work services through case management. The terms social workers and community case managers (CCMs) have been used interchangeably, depending on the place of practice (Netting & Williams, 1996); indeed, case management is an integral part of social workers' role (Geron et al., 2000). For many years in Singapore, the community social support for health services was managed independently by non-profit social service organisations with grants from the Ministry of Social and Family Development.

Integrating CCMs into the primary care setting has the potential to address shortfalls of patient care in the community. There are ample empirical studies supporting the key roles and benefits of case management (Claiborne, 2006; Nikolaus et al., 1999; Rizzo & Rowe, 2006; Sommers et al., 2000; Williams et al., 1987), but studies understanding the challenges of inter-professional collaboration between medical professions and social workers are lacking in the medical literature.

Previous study by Abramson and Mizrahi (2003) developed a typology of collaborators from a qualitative study that addressed professional behaviour between social workers and physicians

### What is known about this topic

- There are multiple known challenges in case management collaboration between social workers and physicians in acute hospitals.
- There is a lack of studies understanding the challenges between CCMs and primary care physicians.
- There are findings on primary care physicians' and nurses' perspectives on CCMs but minimal vice versa.

### What this paper adds

- CCMs attributed many challenges because of the nature of their job, one that is multifaceted and undefined in primary care.
- The challenges faced by CCMs include self-identity, patient characteristics, inter-professional issues, collaborative culture, confidentiality and organisational structure.
- CCMs emphasised the need for their continuing involvement and the need to develop meaningful and sustained relationships with primary care instead of episodic collaborations.

to understand the complexities of interdisciplinary relationships. Understanding the perspectives of social workers and physicians can be summarised into three continuum models of collaboration, namely, traditional, transitional and transformational, each with its own challenges and strengths. Unfortunately, the study findings have limited applicability in primary care because the study was conducted in acute hospitals. A systematic review by Gabrielova and Veleminsky (2014), also involving hospitals, revealed four main challenges experienced by social workers, namely, theoretical differences, various professional perspectives, lack of knowledge and weak communication. Keefe et al., (2009) identified two themes concerning community social workers with focus group discussions involving primary care physicians and nurses. The first theme was the perceived role of the social worker with care coordination, placement and community-based services as subthemes. The second theme reported the challenges of having a social worker in the primary care team, including additional time burden and pressures on office space. However, this study focused on doctors and nurses and did not include the CCMs' perspectives. Another paper regarding the challenges of primary care case manager-physician collaboration by Netting and Williams (1996) included perspectives from both sides. The authors described three themes, namely, relationships, differing role perspectives and professional identity.

In order to understand the complexities of collaborative care between members of these two groups, this study draws on the lens of social identity theory (SIT) expounded by Tajfel and Turner (1986). This widely accepted theory has contributed to the understanding of identity and intergroup relationships. According to SIT, identity is formed through three processes, namely, social categorisation, social identification and social comparison. In social categorisation, CCMs and primary care providers categorised themselves by referring to the groups they belong to, the former being members of a non-healthcare group, whereas the latter being members of a healthcare group. In the second stage, social identification, both groups adopt the identity of the group they have categorised themselves by conforming to the norms of the group with significant emotional and self-esteem ascribed to that membership. Finally in social comparison, once CCMs and primary healthcare providers have identified with their group, they tend to compare with each other to establish distinctiveness for their respective groups. This is a critical juncture where prejudice and challenges may arise because of differing identities.

In Singapore, CCMs are often considered as non-members of the healthcare group because of the unique landscape of social services here. CCMs are not directly involved with the care planning of complex patients with the primary care team. This reinforced the notion that CCMs are indeed members of an out-group in the care of complex patients. In recognising the importance of integrating healthcare and social services, in April 2018, the Ministry of Health took oversight of healthcare-related social services (Ministry of Health Singapore, 2018). There is now greater potential to engage and integrate CCMs into the primary care team. Given that these two distinct professional groups had minimal opportunity to work closely previously, there are bound to be challenges. The initial step to a successful integration is to identify these challenges, and this study aimed to understand the challenges encountered by CCMs when collaborating with primary care services.

## 2 | METHODS

### 2.1 | Participant sampling and ethics

Qualitative descriptive research involving individual in-depth interviews was adopted for this study. Ethics approval for this study was obtained from the National Healthcare Group Domain Specific Review Board (NHG DSRB) (Ref: 2018/00801), and methods were performed in accordance with the relevant guidelines and regulations laid by NHG DSRB. Recruitment and data were collected within a 12-week period (October–December 2018). CCMs were sampled using two strategies: convenience sampling and snowball sampling. The first four CCMs were conveniently sampled based on their location of practice, through their organisation directory. The next 10 CCMs were sampled based on recommendation from prior CCMs. This was done to ensure information-rich sample that was of interest. CCMs were invited through invitation e-mails followed by

telephone calls to confirm that they met the inclusion criteria prior to their participation. The inclusion criteria were (a) CCMs involved in managing complex patients in the community and had experience working with primary care services, (b) has at least 1 year of experience working as a CCM and (c) had prior training in case management. All 14 CCMs that were sampled met the criteria and participated in the study. Participation was voluntary.

### 2.2 | Data collection

Prior to conducting data collection, a topic guide was formulated to guide the semi-structured interviews (Table 1). The topic guide was developed based on the findings from previous literature reviews and looking through the lens of SIT. The study objectives and confidentiality of data were explained to all potential participants, and a minimum of 2 days were provided for them to ask questions and consider participating in the study. All individual in-depth interviews were conducted after the written informed consent forms were signed. The interviews were conducted in English in the privacy of the CCMs' administration offices by a researcher (GTSY). Socio-demographic information and a brief anonymous self-introduction were obtained before commencing the interview. The individual in-depth interviews were recorded digitally.

### 2.3 | Data analysis

Each CCM was provided with a pseudonym. The audio-recorded interviews were transcribed verbatim. Inductive thematic analysis of the data was conducted according to the method described by Braun and Clarke (2006). Data were analysed alongside ongoing data collection. Coding was performed manually, and data was managed using Excel software. Codes were identified after every two individual in-depth interviews. We began with familiarisation of transcripts, followed by systematic line-by-line coding of transcripts. Initial codes were identified inductively and developed independently by two researchers (GTSY and PK) in an iterative process. We independently coded each transcript before clarifying and agreeing on the coding framework. Potential themes were then independently developed based on the coding framework. Any disagreements that arise during coding and theme development were discussed between both researchers to reach a consensus (Clarke & Braun, 2018). We did not apply numerical measurement such as percentage agreement nor Krippendorff's  $\alpha$  to ensure intercoder reliability (O'Connor & Joffe, 2020). Nevertheless, this was guided by our approach from a realist paradigm and coding at the semantic level (Braun & Clarke, 2006). Conscious attempts were made by us so as to be open to unexpected findings. Both researchers concurred that there was no new emergence of data by the 10th interview and the point of data saturation (Saunders et al., 2018) had been reached. Subsequent interviews did not contribute to the development of new data.

**TABLE 1** Topic guide

Study information		
1. Study title	Community case managers' challenges collaborating with primary care when managing complex patients within the community: A qualitative study in Singapore	
2. Date of interview	___(DD) / ___(MM)/20___(YYYY)	
3. Study site		
4. Interviewer		
5. Interviewee serial number		
6. Sex	Male / Female	
7. Ethnicity	Chinese / Malay / Indian / Others	
8. Year of birth		
9. Years of practice experience		
10. Location of practice		
Section A: Introduction (10 min)		
Discussion item	Prompt	Concepts
11. Briefly describe the study	We are interested in CCMs' opinion on the challenges they faced in primary care when managing complex patients. Please also share with us your suggestions to improve the system and ways to integrate CCMs' involvement in the primary care services.	Calibrate definition of primary care services according to Ministry of Health definition Calibrate definition of complex patients according to AIC definition
Section B: Discussion (40 min)		
Discussion item	Prompt	Concepts
12. Can you tell me what you do in case management of complex patients in the community?	What is your role? Typical day like?	Social categorization Social identification
13. What is your background qualification/experience before doing case management?		Social categorization Social identification
14. Who do you work with in primary care services?		Social identification Social comparison
15. What are your experiences with different professionals in primary care services	Polyclinic doctors? GPs?  Nurses? MSW in polyclinics? Operation staffs? Allied health staffs? Laboratory staffs?  Elaborate on who is easier to work with and communicate?	Social identification Social comparison
16. In your practice, what are the challenges in primary care services that prevent you from managing complex patients effectively?	System? People? Financing? Patients' understanding? Resources? Do your colleagues face similar issues?	Social identification Social comparison
Section C: Conclusion (10 min)		
17. Are there any other points that you would like to bring up?	Most important point to improve primary care services with involvement of CCMs	

Note: AIC: Agency for Integrated Care; CCM: community case manager.

### 3 | FINDINGS

Fourteen individual in-depth interviews were conducted. The length for each individual in-depth interview was between 45 and 60 min. The mean age of the CCMs was 36 years (range:

24–50 years), and the majority of them were female ( $n = 12$ ). The average number of years of practice as CCMs was 5 years (range: 2–12 years). As for the location of practice, four CCMs served island wide, eight served the central and northeast regions, whereas one served the western and eastern regions, respectively. They all

had formal postgraduate training in social work, although they had diverse undergraduate training, for example, in nursing, psychology and finance (Table 2).

We identified six overarching themes that described the challenges faced by CCMs. The categories that emerged from discussions included self-identity, patient factor, inter-professional factor, collaborative culture, confidentiality and organisational structure. Each of these themes was further elaborated by the subthemes to better understand these challenges (Table 3). The illustrative quotations included in the rest of this section were from the interview transcripts.

### 3.1 | Self-identity

#### 3.1.1 | An undefined and multifaceted role

Community case managers attributed many challenges arose because of the nature of their job, one which is multifaceted and undefined. They manage not only issues of patients but also family members, combined with many administrative tasks. Some even

verbalised that they had difficulty describing their job to patients. As one CCM described it succinctly:

I think it's our role. Our role is quite [tsk], I think not very clearly defined, because we really help them with a range of things. Sometimes, even introducing them what we do is tough, y'know. (CCM 5)

#### 3.1.2 | Under-recognised

Community case managers felt frustrated when they compared their esteem as a CCM to other healthcare professionals. They were unanimous that the role of CCMs in the community is under-recognised. They also lamented the lack of resource support despite the multifaceted role they played.

I think people don't recognize that we are the owners [pause] of the clients. They think that y'know, because we, we don't have the resource, or y'know, we're-we're like, just in the community... (CCM 10)

**TABLE 2** Participants demographic

Participant	Sex	Ethnicity	Age (years)	Years of experience	Location of practice	Background qualification
01	Male	Malay	41	8	East	Diploma in Clinical Supervision Bachelor in Social Work Master in Social Work
02	Female	Malay	24	2	North	Bachelor in Social Work
03	Female	Chinese	41	2	Island wide	Diploma in Nursing Advanced Diploma in Gerontology
04	Female	Chinese	32	8	Island wide	Bachelor in Pharmaceutical Science Postgraduate Diploma in Social Work
05	Female	Chinese	35	3	Island wide	Postgraduate Diploma in Social Work
06	Female	Chinese	41	6	Island wide	Bachelor in Psychology Postgraduate Diploma in Social Work
07	Male	Chinese	37	4	Central	Bachelor in Finance Master of Social Work
08	Female	Chinese	50	3.5	Central	Bachelor in Social Work
09	Female	Malay	34	3	Central, North East	Bachelor in Social Work
10	Female	Chinese	30	5	Central, North East	Bachelor in Nursing Postgraduate Diploma in Social Work
11	Female	Chinese	46	12	West	Bachelor in Social Work Master in Counseling
12	Female	Chinese	31	7	Central, North East	Diploma in Nursing Bachelor in Social Work Master in Gerontology
13	Female	Chinese	38	3.5	Central, North East	Bachelor in Social Work
14	Female	Chinese	27	5	Central, North East	Bachelor in Social Work

**TABLE 3** Themes and subthemes

Theme	Subthemes
Self-identity	An undefined and multifaceted role Under-recognised
Patient factor	Disabled patients Financial obstacles
Inter-professional factor	Inaccessibility to doctors Mismatched expectations Power dynamics Interaction with medical social worker (MSW)
Collaborative culture	Continuity of care Care plan
Confidentiality	Limited access to medical information Balancing role as a patient advocate
Organizational structure	Different services and inflexible workflows

You talk about community care, shift care, whatever, but first of all, this title, is it recognized? It's not! (CCM 11)

### 3.2 | Patient factors

#### 3.2.1 | Disabled patients

Community case managers are often challenged when addressing the problems of those with intellectual and physical disability. These patients have difficulty accessing primary care, and yet, they get neither priority nor adequate medical support, for example, transport escort services or medical house calls.

Ya, and I think a lot of doctors not really trained in ID (Intellectual Disability) sector. I mean, not only the polyclinic doctor but even some speci-, hospital doctor, they're not really trained in this sector so it's a lot of stumbling block for this sector. (CCM 4)

But, er... I think one... thing that we always overlook is that sometimes client, they don't... they're not able to get primary care because they're not able to get there physically, ya. Transport escort is always an issue, and we do not have the manpower... (CCM 9)

#### 3.2.2 | Financial obstacles

Community case managers associated the care of disabled patients with higher costs of care for non-residents and permanent residents (Singapore citizens and permanent residents receive subsidies of 75% and 37.5%, respectively, for fees at the polyclinics, whereas non-residents do not receive any subsidy). Often disabled patients had a lack of access to certain medico-social services because of

their residency status and were frequently referred for case management for continuity of care.

Um, recently I have a case um, of um, a Japanese boy with autism - he's not a Singaporean, so that, that complicates a bit of the funding issues for some of the services. (CCM 5)

### 3.3 | Inter-professional factor

#### 3.3.1 | Inaccessibility to doctors

Community case managers spoke about their frustration of the inability to contact the primary doctors directly for urgent matters. By default, they communicated via emails, but such asynchronous communication was inappropriate when urgent needs arose, especially for patients who do not have a primary doctor.

It's just that sometimes for urgent cases if we cannot find y'know, the particular person um, it makes it difficult for us, we don't know who else we can contact... Ya, who can link us up with the doctors. Because we know, we don't know which doctor will be seeing the patient, so sometimes we don't know who to talk to, ya. (CCM 5)

#### 3.3.2 | Mismatched expectations

In relation to mismatched expectations, CCMs were unanimous when they described doctors' lack of understanding about medical reports as a requirement for social services application. The majority of doctors seemed unaware of CCMs' crucial need for a medical report to move services within the community. In addition, this reticence to prepare a medical report was reinforced by doctors' time constraints and concern of medical liability.

We can write the social report, but I just want someone to fill up the medical report! ... Ya, so we need one doctor to write that. But I think there's a bit of liability issue, so-so some doctor is not, and not all polyclinic doctor will write the nursing home (medical) report. (CCM 4)

### 3.3.3 | Power dynamics

Power dynamics emerged during the discussion with CCMs. CCMs perceived that they were of little value as reflected by the physicians' attitudes and communication with them. Some doctors were not interested in their inputs. Though this subtheme was relatively muted, CCMs described it succinctly:

Er... If we see that they are don't really care, we'll just make it short. We're not going to bother you with too much... 30% don't listen. (CCM 6)

So sometime we want to go with them, but it's not every time the doctors will want to discuss cases with us. That's my experience. (CCM 11)

### 3.3.4 | Interaction with medical social worker (MSW)

Apart from doctors, CCMs described their interactions with MSWs as being cordial, and they were seen mostly dealing with financial issues within the organisation. Often MSWs were unavailable to bridge CCMs to primary care services.

... because social worker not stationed there every time. So we have issue like, getting them, then we need something urgent, so we will try to get our own link. (CCM 3)

So far okay, but mostly it's just financial, they don't really deal with a lot of case management thing. (CCM 7)

## 3.4 | Collaborative culture

### 3.4.1 | Continuity of care

Community case managers highlighted that lack of continuity of care was an issue they encountered, with a different doctor assessing the patients on each visit, making it difficult to establish professional relationship. The lack of relationship was also associated with the subtheme of inaccessibility to doctors. Fragmentation of care was also pointed out when multiple partners were involved in the care

of patients. These partners failed to work together in consolidating a harmonised patient care plan.

... because polyclinic you don't know which doctor will be seeing that patient on that day, so it's hard for us to even y'know, find someone... Because right now, I don't know they, when they go back to see polyclinic, it's always different doctors, you see so... (CCM 5)

Er... nurses and us, er, sometimes - now that community nurse is coming in - it could be overlapping, and... could be confusing to... the patients, er, even among our own... [tsk] sector itself. (CCM 14)

### 3.4.2 | Care plan

Community case managers expressed the challenge of not having a care plan for patients. Rarely, there will be a comprehensive care plan that included all the stakeholders (e.g., multiple doctors caring for a patient with multiple conditions) in the care of complex patients. In addition, there was no ownership of the care plan and lack of precise handover information to the CCMs.

I think common issue really is about the... the care plan. Because it's like, somehow, if let's say, you have cases where, you have chronic disease then, um, multiple, then it's like, not taking good care, then, who are the healthcare... providers that we can work with (CCM 11)

## 3.5 | Confidentiality

### 3.5.1 | Balancing role as a patient advocate

Patients often normalised their concerns when they were in a clinical consultation, leaving physicians unaware of the reality of the actual situation. CCMs described that it was difficult being a patient's advocate when patients did not share pertinent information with their healthcare providers. Respecting patient's autonomy and confidentiality limits CCMs' ability to share with the clinicians the information they have about patients.

I do have some referrals from doctor who somehow thought that they've made the assessments. The problem is, when you see patients right, it's really the tip of the ice, of the iceberg. (CCM 1)

... elderly tend to normalize, norm, normalize a lot of thing. When the doctor asks them, they will say, "Ho4 ("Good/I'm fine" in Chinese dialect). Then, when they



at home right, they will tell us, "Aiya, here pain, there pain. (CCM 4)

### 3.5.2 | Limited access to medical information

Community case managers also spoke of their limited access to medical information due to the Personal Data Protection Act, thus posing a challenge to obtain a proper diagnosis for medical and social care application.

... For nursing home daycare right, you want to go a dementia one, you need a diagnosis. If you have no diagnosis right, you cannot go to, dementia daycare; you cannot go to dementia nursing home, which is very important for us as well. (CCM 4)

## 3.6 | Organisational structure

### 3.6.1 | Different services and inflexibility of workflows

Community case managers elaborated on the confusion they experienced navigating different workflows and service variation in each polyclinic cluster. Different workflows also resulted in confusion of staffs' job role and contact person. In addition, workflow resulted in inflexibility to access personalised care especially in the time of need for complex patients. Examples are illustrated below.

I forgot what is their role. There's so many, I also don't know who are they... So the patient has to make a special trip just to apply for maybe a day care service. But maybe on Tuesday he's already went, gone down to, the polyclinic to y'know, follow up on chronic conditions... it makes it tough on the patient, especially if they have problems even going down to see the doctor. (CCM 5)

... because polyclinic I need to go for blood test, I need to see doctor, I need to, one week later, a lot of things, then social worker need to see you on another day, blah blah blah, so that one a bit messy, ya. (CCM 6)

## 4 | DISCUSSION

The challenges faced by CCMs in collaborating with primary care services stem from various factors, including self-identity, patient characteristics, inter-professional issues, collaborative culture, confidentiality and organisational structure. Nonetheless, all

interviewees were committed to the concept of collaboration despite the multiple challenges. CCMs want to be understood and to be involved in the care of patients. The satisfaction of journeying with patients outweighed the lack of their current professional recognition. CCMs emphasised the need for their continuing involvement and a shared care plan for complex patient that involves social and medical input.

Unfortunately, CCMs perceived that they were of little value in the primary care arena reflected by the physicians' attitudes and communication with them. They perceived physicians retaining a very dominant role in the planning of healthcare, whereby CCMs provide information as and when requested but without any collaborative partnership in the ongoing care of patients in the community. Though both professionals focused on patients at the centre of their care, much has to be worked on together in aligning their paradigm. More can be done to focus on collegial interaction skills on top of clinical encounter skills.

This study's findings resonate with previous studies of Netting and Williams (1996) and Keefe et al., (2009) on the challenges of case managers' struggles with professional relationships, roles and identity. This reinforced that the role and self-identity of CCM issues are generic and not institution specific. In addition, the themes on confidentiality and organisational structure were in line with the discussion of Gabrielova and Veleminsky (2014). Confidentiality and organisational issues transcend all aspects of medical care, and CCMs are not spared either.

Albeit these similarities, this study contributes a new perspective of CCMs' challenges with primary care services, notably the inaccessibility to doctors, mismatched expectations and their interaction with the MSWs. CCMs also spoke at length about the challenges with regard to patients of intellectual and physical disability seeking primary care services. Collaborative culture that was discussed in the Ambrose-Miller and Ashcroft (2016) study differs to this study. In this study, CCMs were concerned of continuity of care and care plan of patients. Paradoxically, the easy accessibility to primary care does not necessarily translate to better continuity of care with a regular doctor because of time, manpower and financial constraints. Inter-professional communication was a major theme in studies of Ambrose-Miller and Ashcroft (2016) and Abramson and Mizrahi (1996); however, in this study, inter-professional communication did arise, albeit in a more muted response and was explored under the subthemes of power dynamics among professionals.

There is a need for community case management to play a greater role in Singapore's changing healthcare landscape of 'Beyond Hospital to Community'. The idea is to let patients receive appropriate care at home or in the community so they can stay well and avoid hospital admissions; but issues of confidentiality, collaborative culture and inter-professional factor currently deter the integration of primary care and social care. Formal recognition of CCMs through a statutory board to govern registered CCMs would be a step in the right direction to alleviate many of these obstacles arising from lack of recognition.



In addition, as the healthcare system moves toward greater emphasis on primary care settings, workflows and medical information technology need to be revised to cater for non-medical professionals who are directly involved with patient care. Gone are the days when physicians worked alone and without inter-professional collaboration. Complex patients need a common care plan with constant input from CCMs; thus, an overarching medical record comprising social, financial and medical elements is a sine qua non for successful care integration.

Community case managers and primary care services need to develop meaningful and sustained relationships instead of episodic collaborations. Mismatched expectations between CCMs and primary care physicians do arise accordingly as in this study; nevertheless, success in collaborative practice requires stakeholders to understand these barriers and strategise to minimise them. Emphasising uniqueness and differences may separate the professionals at a time when it is more imperative to focus on the patient.

A change from current practice through continuous dialogue and appreciation of each other's professional role will take time. Parallel change needs to take place during the early formation of CCMs and medical professionals. Thus, educators need to be innovative with the current undergraduate curriculum. Schools of medicine and schools of social work should collaborate to ensure students understand each other's domain and challenges through attachments or joint projects. Consequently, both will learn to speak each other's language for the benefit of patients.

#### 4.1 | Strengths and limitations

The major strength of our work is the novelty of this study in Singapore exploring CCMs' role and their challenges being partners of patient care within the primary care services. We have identified three novel subthemes, i.e., inaccessibility to doctors, mismatched expectations and their interaction with the MSWs that would supplement the understanding of inter-professional challenges of CCMs.

Nevertheless, there are limitations of this study that need highlighting. Given that a primary care physician carried out the interviews, this may have subconsciously impelled the CCMs to trivialise the negative impact of difficult professional communications with doctors. However, the interviewer did remind all participants at the beginning of the interview and consciously throughout the interview of his role as a researcher rather than as a physician. Our prior experience and knowledge of working with CCMs may have inadvertently influenced our lenses of interpretation that may differ, if it was interpreted by CCMs themselves. The accounts from CCMs are within the unique context of Singapore's healthcare system, and thus, we caution about generalising and transferring our findings to other healthcare systems. Nonetheless, these findings serve as a contribution to the international literature in understanding the dynamics of collaborative care between CCMs and primary care services.

Future studies are now needed to evaluate medical professionals' perspective on CCMs and their impact on primary care. This

dyad will ensure patient-centred outcomes to be the focus in community care.

## 5 | CONCLUSION

This study has identified several challenges that CCMs faced with primary care services in Singapore. Understanding these challenges is key to refining the current models of comprehensive community care between medical and non-medical profession to address biopsychosocial aspect of care. Dissemination of the findings will play an important stimulus in ensuring continuing engagement and building a stronger collaboration to meet the needs of complex patients.

#### Ethics approval and consent to participate

Ethics approval for this exploratory qualitative descriptive study was obtained from the National Healthcare Group Domain Specific Review Board (NHG DSRB) (Ref: 2018/00801), and methods were performed in accordance with the relevant guidelines and regulations laid by NHG DSRB.

#### Consent for publication

Not applicable; manuscript does not contain data from any individual person.

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#### CONFLICT OF INTEREST

The authors declare that they have no competing interests.

#### AUTHOR CONTRIBUTIONS

GTS Yeo and PK performed the interviews, data collection and data analysis. ES Lee and HE Smith verified the analytical methods and supervised the findings of this work. GTS Yeo wrote the main manuscript text. All authors reviewed the manuscript.

#### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available because of privacy or ethical restrictions.

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