Implementing a Case Management Program in Primary Care Settings for Patients with Complex Health and Social Needs: Learnings from Newfoundland and Labrador

Objective

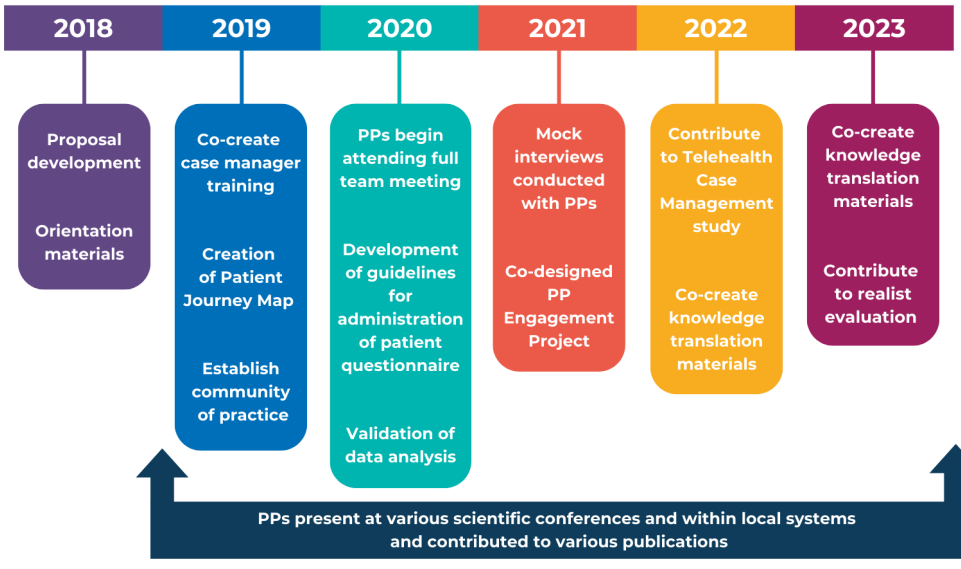
This project implemented a one-year case management program for patients with complex care needs in 14 primary care clinics across Canada, including one in Newfoundland and Labrador (NL), to examine the intervention's potential in Canadian primary care settings and to gain understanding of how, why, when and for whom the intervention worked.

Practice Points

1. Case management is increasingly recognized as an effective intervention to improve the integration of care for patients with complex needs.
2. Patients often require a variety of services from the health and social systems and other community networks.
3. Accessing multiple services often leads to challenges due to lack of care integration, and consequently patients with complex needs are at greater risk for disability, reduced quality of life and increased mortality.
4. Providing better coordination between existing care providers can improve patients' health outcomes and the efficiency of the health care they use.
5. Some identified limitations to case management's effectiveness include limited availability of appropriate services and patient circumstances that impede their readiness to participate.

Methods (K. Aubrey-Bassler, D. Howse, M. Lambert, M. Warren, C. Hudon on behalf of the national PriCARE team)

1. The PriCARE team, comprised of researchers, research staff and patient partners, implemented a one-year case management program in a small, rural, multi-disciplinary family practice in NL.
2. Patient partners were heavily involved in the study from the beginning and contributed to all aspects of research design, data collection and analysis, and knowledge translation (see Figure 1).
3. Patients enrolled in the study were ≥18 years old, had at least one chronic condition (including mental health), complex health care needs, heavy use of health care services (according to professional judgment), and were deemed to benefit from the intervention.
4. Patients completed a health questionnaire at recruitment and follow up with a research assistant occurred six months later.
5. Interviews were conducted with eight patients, two case managers, one clinic manager and three family physicians.



Graphic created by Judy Porter, patient partner.

Figure 1. Start to Finish: Patient Partners (PPs) Add Value to PriCARE

Results

- Case management is a collaborative approach whereby the case manager and patient work together to identify and meet the patient's and family's needs through four main steps:

  1. Assessment of the patient's needs and preferences;
  2. Development and maintenance of an "individualized services plan" (ISP), i.e. a personalized care plan adapted to patient needs, in partnership with the patient;
  3. Coordination of services among health and social services partners;
  4. Provision of education and self-management support for patients and families.

- The intervention was successfully implemented in NL with 27 patients enrolled as participants.
- Key messages were identified for three target audiences: the general public, providers, and decision-makers (see Table 1).

Table 1. Key Message for Target Audiences

Audience	Key message
Public/ patients	Case management can help improve patient's quality of life through goal setting, planning and coordination of health care.
	Patients and families feel supported by a system that includes services from within and outside the traditional health care system, as well as coordination of community supports and other services.
Providers	There is a necessity for health care professionals to work together and reduce their workload as well as to provide better services for patients and families.
	Outcomes are improved when nurse case manager "is on the case."
Decision-makers	Case management reduces emergency department use and is associated with health care services efficiency.
	Integrated care is a step for case management.

Conclusions

1. Five positive outcomes of case management were identified through research interviews with patients, providers, managers and other health care professionals:

   - Decreased health care use (e.g. fewer emergency department visits)
   - Improved patient health and well-being (e.g., improved physical and mental health and health management)
   - Enhanced professional collaboration (e.g., communication between nurse case manager and providers)
   - Expanded professional practice (e.g., increased nurse case manager knowledge and networks)
   - Greater satisfaction for all stakeholders

2. The study has now ended, but the participating NL clinic opted to continue the case management program for already enrolled and new patients, and to expand the program to patients at other clinics in the region.
3. A new Chronic Disease Registered Nurse role has been created for new Family Care Teams in NL and includes a significant intensive case management component, which was informed by the case management study.
4. Several follow-up studies are underway.
5. For more information on the PriCARE program, please visit: https://v1sages.recherche.usherbrooke.ca/en/pricare-program/.