Case management and self-management support in primary care for individuals with chronic diseases who are frequent users of health services: A pre-implementation evaluation

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INTRODUCTION

- A number of people with chronic diseases require more health services due to characteristics that increase their vulnerability.
- Case management and self-management strategies in primary care have been proposed as promising interventions to address the special needs of this vulnerable population and to encourage them to play a greater role in the management of their health.
- The implementation of such an intervention needs to be informed by primary care practitioners' perspectives about the situation of the target patients as well as the pre-implementation contextual factors.

OBJECTIVES

- To present results of the pre-implementation evaluation phase of a pragmatic intervention [1] combining case management by a primary care nurse [2] and self-management support based on the Stanford Program [3] for individuals with chronic diseases (diabetes, cardiovascular diseases, respiratory diseases, musculoskeletal diseases and/or chronic pain) who are frequent users of health services, considered as vulnerable patients.

- The pre-implementation evaluation aimed to describe:
  1) The characteristics of the four primary care practice settings (Family Medicine Groups – FMG) in which the intervention will be implemented;
  2) The current processes used by these FMG with this vulnerable population and integration of services;
  3) Issues related to the implementation.

METHODS

- Realistic evaluation approach [4]
- Descriptive qualitative methods
- Data were obtained through:
  - Four focus groups with family physicians in participating FMG (n=25)
  - Interviews and focus groups with primary care nurses (n=10)
- Thematic analysis

RESULTS

Characteristics of the four Family Medicine Groups (FMG)

FMG	Patients (N)	Vulnerable patients (N)	Primary care providers	Characteristics
Urban #1	9,594	3,409	16 family physicians 22 family medicine residents 3 primary care nurses 1 psychologist	▪ Medical training environment ▪ FMG accreditation in 2004
Urban #2	4,090	2,003	5 family physicians 1 primary care nurse	▪ FMG accreditation in 2011
Semi-urban	17,441	5,678	12 family physicians 1 specialized nurse practitioner 4 primary care nurses 1 social worker 1 nutritionist	▪ FMG accreditation in 2004 ▪ Network-clinic accreditation in 2010
Rural	4,928	2,126	5 family physicians 1 primary care nurse 1 social worker	▪ FMG accreditation in 2008

Contextual factors to consider in the implementation of the intervention

- Complexity of the task for case management nurses
- Hiring of a nurse who has the right personal and professional skills for case management
- Nurse turnover and consequences on the trust bond established with patients
- Considerable changes in professional practice, especially for physicians
- Ability to establish flexible collaboration and information exchange between practitioners and organizations involved in a case
- Team capacity to resolve logistical challenges during the implementation
- Sustainability of changes brought on by a short-term project
- Centralization of information around the nurse and physician capacity to stay informed about patients' health condition

« We are dealing with different people every 15 minutes. We always have to adjust our objectives to each patient. We have to adjust to him. »

« As a barrier, I would add that it is often disadvantaged patients with limited financial resources who will buy noodles and bread because they don't have money to buy fruit, they don't have any resources. This kind of situation sounds typical. »

« And the first thing about it [vulnerable patient] is that the patient who went to the emergency room six times for his asthma attacks, in general I don't know that he really went (…) six times to the emergency room (ER). No one [at the emergency room] told me (…) he [the patient] does not wait to schedule an appointment at the clinic and no one told me that he went six times to the ER. »

« I think that we are not that well equipped to deal with these people [vulnerable patients] and we just get discouraged and we don't know what to do for them because we are at the end of our capacities. »

« Does anyone [in the V1SAGES project] have an overall view of this case to ensure (…) that it seems to be OKAY, then it seems to get better [for the patient]? (…) I manage that by myself, recognizing there are some aspects that I don't take care of because I don't have the time. I had no connection [with other professionals or organizations], no specific [service] corridor. I know that it exists, but I … we are losing some of it. »

FACTORS FACILITATING THE FOLLOW-UP OF VULNERABLE PATIENTS WITH CHRONIC DISEASES

Professional factors

Health interventions that are centered on patient objectives and life situations

Time dedicated to patients and development of a trust bond over the years

Organisational factors

Two-way communication between FMG professionals and those in other health organizations

Presence and good level of collaboration among diverse types of health professionals inside the FMG

Identification of a central practitioner who consolidates information on patients

MAIN INDIVIDUAL FACTORS THAT INCREASE VULNERABILITY…

- Socioeconomic deprivation
- Mild to severe intellectual impairment
- Multimorbidity
- Accumulation of all of the above in the same case

…AMONG PATIENTS WITH CHRONIC DISEASE

- Mental health problems, especially anxiety and borderline personality disorder
- Inadequate social network or social isolation
- Unhealthy lifestyle habits

MAIN BARRIERS IN THE FOLLOW-UP OF VULNERABLE PATIENTS WITH CHRONIC DISEASES

- Tendency to work in silos and lack of sensitive information sharing between health organizations and/or health practitioners
- Limited access to transportation to attend medical appointments
- Helplessness felt by professionals when confronted to their limited impact on patient health and will
- Limited access to specialized health services
- High cost of medication for some patients
- Patient lack of comprehension about issues related to their diseases
- Patient reluctance to engage in treatment
- Lack of linkage between FMG and community organizations

LIMITATIONS

- Did not consider perceptions of other primary care providers in FMG (social worker, psychologist, nutritionist, etc.).
- Did not discuss perceptions of case management and self-management support with primary care nurses who are not participating in the project.

CONCLUSIONS

- The context and current processes identified in the follow-up of individuals with chronic diseases who are frequent users of health services will inform the research team and stakeholders in primary care and the healthcare network, guide the implementation process and contribute to the understanding of their influence on the implementation within FMG.
- The pre-implementation evaluation was pursued by interviews with primary care manager, vulnerable patients and their careers, community pharmacists, health center professionals and managers, and community partners.

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