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CANADA RESEARCH CHAIR IN
IMPLEMENTING INTEGRATED CARE
FOR PEOPLE WITH COMPLEX NEEDS

Integrated care for adults with complex needs

**Opportunities of case management in primary care
to improve equity**

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- 🌀 The authors declare no competing interests in this study
- 🌀 This study was recently published¹

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Opportunities of integrated care to improve equity for adults with complex needs: a qualitative study of case management in primary care

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Context

- 🕒 People living in precarious socio-economic conditions²⁻³ are at greater risk of:
 - ❖ Developing mental and physical health problems⁴
 - ❖ Having **complex health and social needs**⁵
 - ❖ Experiencing **health inequity**⁶
- 🕒 Addressing the **social determinants of health (SDH)** can reduce health inequity.⁷
- 🕒 **Integrated care** approaches such as **case management** can address SDH.⁸⁻¹⁰

Objective

To better understand how case management in primary care can address the SDH in people with complex health and social needs.

Methods

Design

Qualitative study

Setting

A case management program (CMP) for people with complex needs was implemented in four urban primary care clinics recruited from a non-probability sample of volunteers¹² between March 2022 and June 2023

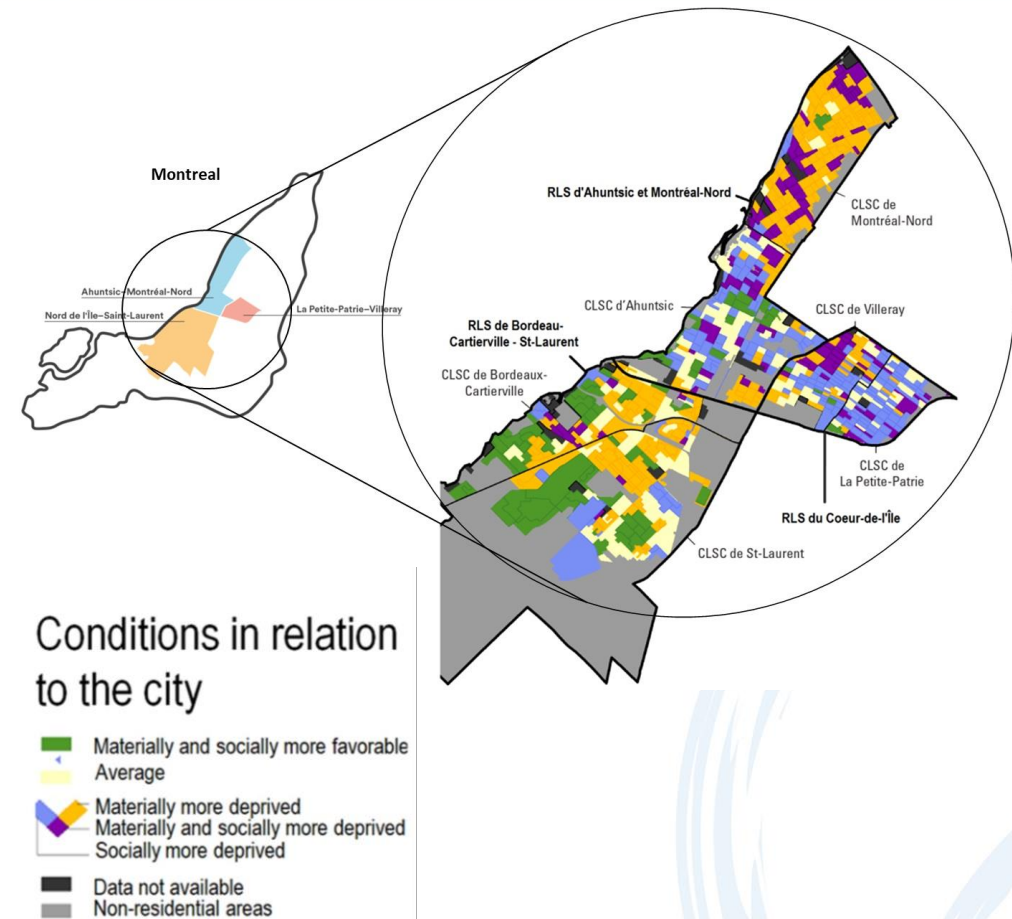
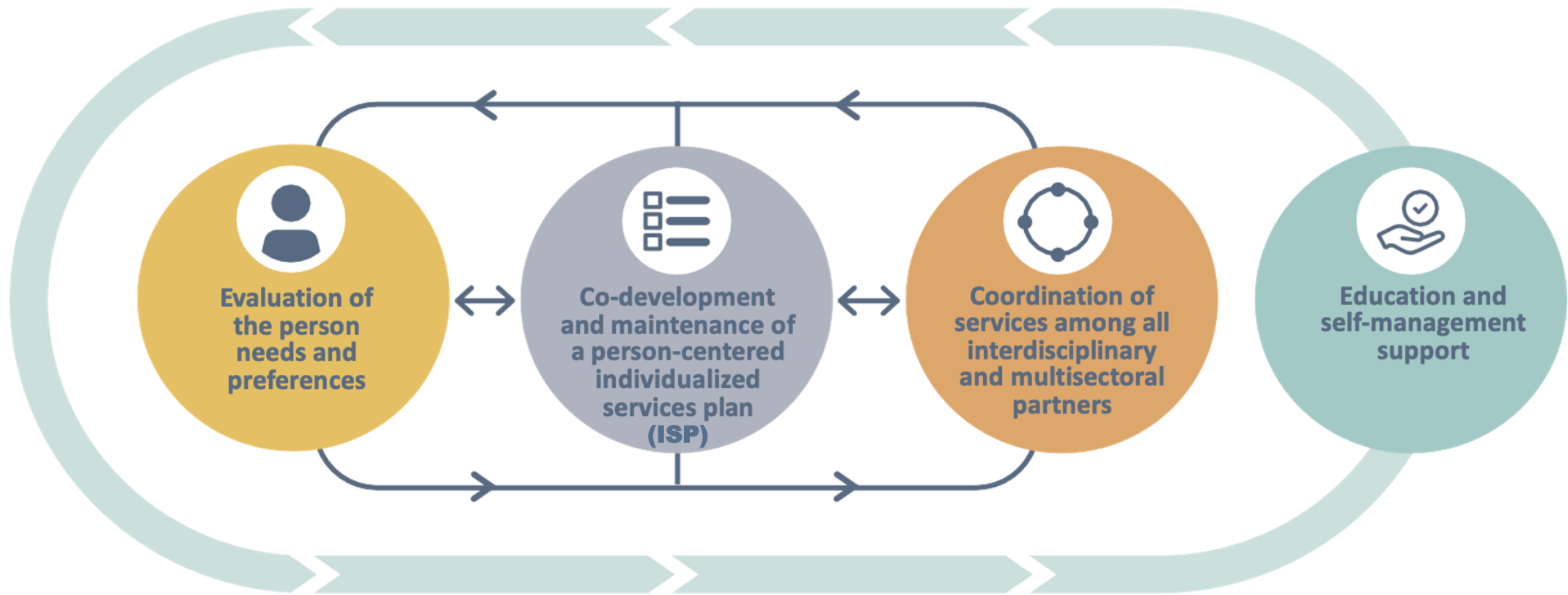


Figure 1: Material and social conditions on the surrounding territory. ¹¹

Description of the CMP



Description of the CMP

Inclusion criteria

- ⌚ Adults (18+ years old) with six or more ED visits in the previous year
- ⌚ Positive score on the CONECT-6 complex needs screening tool¹³
- ⌚ Complex needs confirmed by the primary care case manager or the GP

Implementation

- ⌚ Supported by an implementation committee based in a health and social services organization
- ⌚ Led by primary care case managers (nurses and social workers) trained by experts
- ⌚ Support from a hospital case manager
- ⌚ Clinical and training materials
- ⌚ Community of practice and other clinical meetings

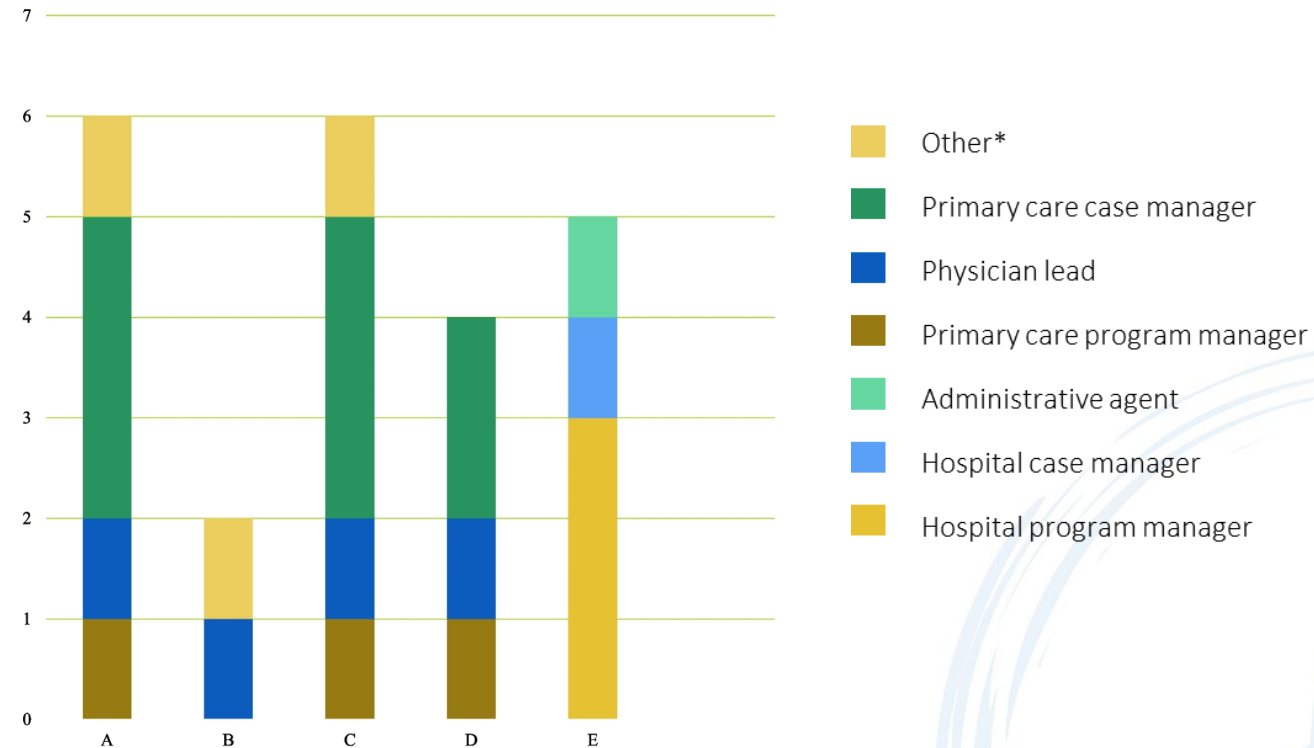
Methods

Data collection

Semi-structured interviews and a focus group with key informants (n=24)

Analysis

Inductive thematic analysis to identify emerging themes, and pattern coding¹⁴



*Other healthcare providers were two clinical nurse assistants and one clinical coordinator for social workers affiliated to the participating clinics.
The other participant was the project manager who worked with the research team.

Source: Hudon et al. 2024¹

Results

Case managers can understand the person's whole situation, build trust with them, and act as their advocate

- 🌀 A trustful 'anchor' within the health system providing increased and better adapted access
- 🌀 Stimulating a culture of patient-centred care within the health system
- 🌀 Overcoming prejudices and negative perceptions among clinicians
- 🌀 Accountability and advocacy based on trust



Results

Case managers promote inter-professional and inter-sectoral collaboration

- 🌀 Complementary and broaden skillsets
- 🌀 Less medicalized services
- 🌀 Partnerships with community resources
 - ❖ better understanding of person's environment and overall situation
 - ❖ help to build trust with new arrivals
 - ❖ a **challenge** due to unequal decision-making power, different organizational cultures, bureaucracies and priorities, unidirectional communication

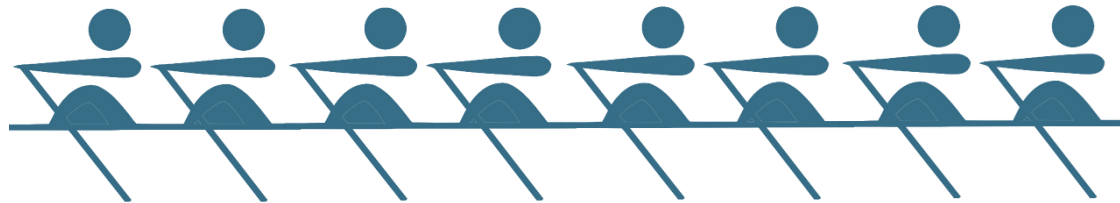
Organizational development and change management needed!



Results

Case managers may improve social support

- ⌚ Benefits of involving family, friends, or significant relatives in the ISP development, with the person's consent
- ⌚ If no family or social network: case manager is reassuring
- ⌚ Involving cultural communities to promote health and social services among the new arrivals





Strengths and limitations

Strengths

- 🕒 Close partnership between the research team and the implementation committee
- 🕒 Level of involvement, skills and support of the hospital case manager

Limitations

- 🕒 Recruitment of patients for the interviews
- 🕒 Short duration of the project
- 🕒 Transferability limited to urban areas

Key messages

Case managers can address SDH and improve health equity

- ④ Improving **continuity** of care and **navigation** across health and social services
- ④ Raising **awareness** of social needs and improve healthcare professionals' **skills in SDH**
- ④ Providing socially **accountable** care and **advocate** for structural changes
- ④ Promoting **intersectoral** collaboration and **equitable** distribution of resources

Further research is needed

- ④ Intersectoral collaboration between case managers in primary care clinics and community resources
- ④ Experiences of people with complex needs



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