Preparing for the scale up of a case management intervention: Creating tools that work

Schwarz, C., Rubenstein, D., Peeters, M., Bisson, M., Porter, J., Chouinard, M-C., Doucet, S., Luke, A., Aubrey-Bassler, K., Lambert, M., Maisonneuvre C., Wilhelm, L., Taylor, J., Lemay-Compagnat A., Cook, M., Pickard, P., Piccinini-Vallis, H., Hudon, C.



What is case management (CM)?

- A collaborative approach to care focused on meeting individual and family needs
- A promising intervention to improve integrated care for patients with chronic conditions and complex needs

4 components:

Assessment of patient's needs and preferences

Coordination among health and social service partners

Development of a patient-centred care plan

Education and self management support

Program background

Implemented and evaluated
 CM for individuals with
 complex health and social
 needs in 5 Canadian
 provinces

 Scaling up CM in Quebec and New Brunswick



Our research team:

- Researchers, patient
 partners, and healthcare
 providers
- Team members from
 Quebec, Newfoundland
 and Labrador, New
 Brunswick, Nova Scotia
 and Saskatchewan
- > 7 years of experience working together



Our toolkit

- Clinical tools developed in Quebec to assist with program implementation
- Tools added to assist with patient and provider engagement
- Working group formed to refine and develop the toolkit



Our toolkit

Clinical tools

- Virtual training modules for case managers
- Forms providing tips and processes
- Initial assessment form and a formalized care plan
- Implementation guides
- Screening questionnaire for complex needs

Recruitment and engagement tools

- Patient journey map
- Scripts for clinic staff
- Patient and provider leaflets
- Videos explaining the benefits of case management



Toolkit contents

This toolkit contains:



Pamphlet

 A description of what case management is



Videos

- This is Max
 Dationt testime
- Patient testimonial



Infographics

- What is
- Case Management
- Patient Journey Map

All tools are available at: soinsintegres.ca/en/research-tools/





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Case management is an intervention that aims to improve individual health outcomes for people living with chronic diseases and who have complex care needs, which may include physical, social, mental, emotional, spiritual and cultural needs. Case management may also help to improve outcomes for the health system as a whole.

Case Management

Case management typically has four main steps which are led by a case manager:

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

Participate in a PriCARE research project

If you agree to participate in the case management intervention, your case manager will ask your permission to send your contact details (name, telephone number and/or email) to the research team.

A research assistant will contact you to give you more information about the study and to ask if you agree to take part.

If you agree to take part in the research project, you will be asked to:

- Complete a questionnaire at the start of your participation in the study (30-45 minutes)
- Complete a questionnaire 12 months after the start of your participation in the study (15-30 minutes)
- Take part in an interview 12 to 15 months after the start of your participation in the study (60-90 minutes)

My Case Manager's Name:

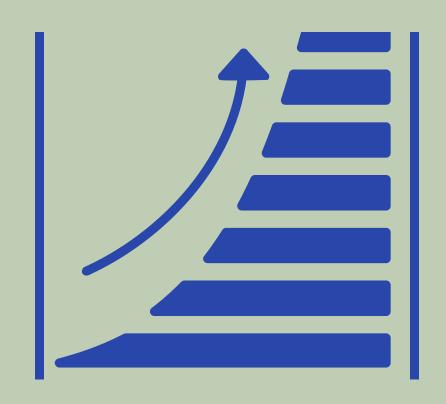
During Case Management Prior to Case Management I'm feeling better both going to do It's hard to Manager is really emotionally and juggle multiple things helping me manage physically. differently my health plan and chronic illnesses. Case Manager with Patient assess needs and preferences Meet or call to explore challenges and Family Appointments are made. Case Manager / Practice is main complete/discuss questionnaire. Case Manager checks in, Team discusses source of Interview with Case Manager. answers questions, helps with goal information and progress & My health plan with goals, priorities, options setting, monitors and coaches me support feedback with and a schedule is created. with problem solving. patient. Occassional research check ins done. Health Team is kept Participants are encouraged to bring a friend or family member PriCARE informed to meetings with your Case Manager and/or team member.

Notes:

PriCARE - Patient Journey Map

Preparing for scale-up

- Meetings with government, health authority, and clinic representatives
- Presenting tools and resources to local teams
- Adapting forms and resources to fit local contexts and settings





Key adaptations

Setting



- Hospital and primary care setting
- Adaptations to training, standard of care, etc.

Provincial differences



- Accounting for current practices and documentation methods
- Provincial dynamics impact inclusion criteria (rural vs. urban environments)

Access and information sharing

- Access to information varied by province and setting
- Different methods of information sharing in place



Time and resources

 Staff or healthcare team time available for the intervention impacts caseload and eligibility

Co-building for adoption and sustainability

- Building partnerships
- Learning from diverse partners at the national, provincial, and clinic levels
- Flexibility and receptiveness to adaptations





Thank you! QUESTIONS?

Contact:

Charlotte Schwarz <u>cschwarz@unb.ca</u>
Donna Rubenstein <u>donnaruben@gmail.com</u>