International Journal of Integrated Care

Guinovart, Carme et al 2016 The case conference as a tool to improve shared care and to focus on personalized care. *International Journal of Integrated Care*, 16(6):A252, pp. 1-8, DOI: http://doi.org/10.5334/ijic.2800

CONFERENCE ABSTRACT

The case conference as a tool to improve shared care and to focus on personalized care

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

Carme Guinovart Garriga[1], Jordi Roca Casas[1], Anna Rufí Vilà[2], Marta Serrarols Soldevila[3], Carles Blay Pueyo[4], Montserrat Riera Corominas[5], Joan Espaulella Panicot[1,6]

1: Hospital Universitari de la Santa Creu – Vic, Barcelona, Spain;
2: Consell Comarcal Osona – Vic, Barcelona, Spain;
3: Equip d'Assistència Primària Vic S.L.P. – Vic, Barcelona, Spain;
4: Operation Manager PPAC (Programa Atenció i Prevenció Cronicitat) - Generalitat de Catalunya, Spain;
5: ICS (Institut Català de la Salut) - EAP Osona – Vic, Spain;
6: Consorci Hospitalari de Vic – Vic, Barcelona, Spain.

Context: Osona is a Catalonian county with almost 157.000 inhabitants, of which 2.9% are 85 years old or over, and it behaves like a micro health system in the Catalan territory. Local health providers made a strategic alliance more than ten years ago (virtual integration), and launched a range of tools and strategies that seek to create a more integrated and person-centred care of patients with complex health care needs, based government guidelines for Programs of Prevention and Care of Chronic Patients (PPAC) and Social and Health Interaction (PIAISS). One of the main strategies was the development of complex care pathways and the involvement of the social system in its development.

Often patients with complex health care needs require the intervention of multiple suppliers and each design their own action plan, therefore the challenge is to achieve shared care for this group. We propose a tool to address the difficulties this entails, called the case conference. That aims for each patient to have a single treatment plan co-designed with the patient and all the suppliers involved now or in the future.

The aim of the communication is to describe the process of the implementation of the case conference in our environment.

Development of the project

- Phase 1: The first step was a trial in two Primary care centres, which showed the need for joint training of the professionals involved and created a rigorous methodology to facilitate the management of the duration of the session. The assessments of the patients were very extensive but superficial and fragmented without an overall view of the situation. The need for a common language and organizational culture were also detected, and everyone agreed that there should be learning processes to work this way and that high level of readiness is

required. It confirms the relevance of specialized care in method and content. The level of professional satisfaction was very high and we were asked not to stop the trial.

- Phase 2 includes the development of a regional consensus document for the case conference to be extended throughout the county taking advantage of previous experience and with the support of PPAC, which proposes a target of 50 territorial cases.

- The Third phase entails using case conference with different primary care centres and creating a framework for its evaluation, and planning how to scale up the experience for a number of patients.

Case conference methodology:

1. Teams involved:

- The nurse, the doctor and the reference social worker of the primary care team. In some cases also the nurse case manager. Their contributions give a longitudinal understanding of the situation. The ability for decision-making is assessed whenever possible.

- The doctor and the nurse of the specialized geriatric care team, who bring expertise in the diagnosis of the situation and forward planning.

2. Criteria for selecting patients.

Candidates have to meet the following criteria:

- Patients with complex health care needs according to the PPAC criteria of complexity.

- High probability of different service providers acting simultaneously.

- When a shared plan will provide value for the patient because the process of decision-making raises different options

3. Development of the case conference.

It consists of building a virtual team that put together their evaluations to make a single shared plan for the patient so it requires a process of preparation by the teams involved. The geriatric assessment is used as a reference and the role of the coordinator of the case conference is key because they moderate the interventions and guarantee the method. The professionals who make the validation process of the proposals with the patient and his family are chosen at the end of the session and also the information to record on the shared information system.

At the beginning the case conference will be done in person and in the future possibly by means of communication technology.

Evaluation framework: There is a descriptive part that includes patient characteristics, changes in personalized plans and proposals regarding advanced care planning. The experience of professionals will be assessed qualitatively.

Conclusions: Initial results are very encouraging in the sense that it is a very powerful tool to promote integrated care. The preparation time and duration of the sessions are the main difficulties to make it scalable to a large number of patients.

Guinovart; The case conference as a tool to improve shared care and to focus on personalized care.

Keywords: case conference; integrated care; complex patients