
CONFERENCE ABSTRACT**Care coordination in primary healthcare for patients with complex needs: A comparative case study**

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Introduction

In recent years, several projects and innovations have been carried out in primary healthcare level, in Quebec, to reduce fragmentation and improve healthcare delivery through better coordination of services for patients with complex needs. These projects were all based in family medicine clinics yet presented significant structural and content variations across clinics. Moreover, when several care coordination projects were conducted in one clinic, they included a different list of care coordination components, carried out by the same care coordinators. In this study we aim to examine similarities and divergences in terms of design, policy environment and components across care coordination projects and how these similarities or divergences are related to patients' complex needs.

Methods

A comparative case study was conducted using a purposive sampling of two projects, the VISAGES project (case management targeting frequent users of healthcare services), and the Quebec Alzheimer Plan (QAP). Data collection included a documentary analysis and five semi-structured interviews with key researchers involved in the implementation of the "cases". The Integrated Care Case Study Descriptive Template was used as a framework. Within and cross-case analysis were performed.

Results

In terms of design and policy environment, both projects include a shared governance model that facilitated innovations. Patients were involved in different phases of both projects. The PAQ is a more mature project. It was launched earlier, was intended to be scaled up at a national level, had more allocated funds and a solid change management support which also impacted the staffing model and training.

Common coordination activities include identifying eligible patients and assessing their needs jointly with the physician, interdisciplinary follow-up, communicating with other professionals and services and facilitating transitions. Indeed, the presence and use of referral processes varied between settings. VISAGES care coordination activities are more oriented towards linking patients and family with health and social care professionals while those of QAP focus on early diagnosis and follow up.

Discussions

Characteristics of patients' complex needs have a major impact on design, implementation and delivery of care coordination projects. Indeed, the homogeneity of PAQ target group population shaped the patient care trajectory as based on disease management and care while also considering social needs. In parallel, the heterogeneity of VISAGES target patient population required a case management approach where less emphasis is placed on disease and more on integrating health and social care services. A single care trajectory based on disease would not be relevant nor feasible.

This main difference had an impact on the clinical tools that were developed, staff training and care coordination activities.

Conclusions

Care coordination projects targeting patients with complex needs may vary in terms of design and components. However, they share a commonality in that they tend to adjust to the varying homogeneity of needs.

Lessons learned

The scale-up of every care coordination project necessitates an effective change management support.

Limitations

Data collection could have included observations or interviews with healthcare professionals; however, the pandemic impeded their availability.

Suggestions for future research

Future research should address patient's experience of care coordination.