
CONFERENCE ABSTRACT

Case management as a tool for integrated care

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Introduction: Résinam and Chronicopôle are two pilot projects implemented in the Namur and Liège areas. They are part of a larger plan of 12 integrated care initiatives targeting chronically ill people. The “Case management” is a central action within the two pilot projects. Its main specificity is that it meets with a number of components of integrated care as well as needs arising from the field experience.

Policy Context And Objective: Each territory has its own specificities. For example, we can identify home nursing coordination, integrated home care services, P3 protocols... The “case manager” is not an additional initiative. He/She intervenes up when the missions of the different structures do not allow a sufficient offer of care to the patient. His/Her intervention is therefore ad hoc and characterized by a period of crisis. His/Her main objective is to stabilize patient care while offering a treatment path that corresponds with their needs. His/Her intervention requires acting in coherence with the operating mode of the network. He/She must be able to target his/her strengths and limits of action in order to adapt his/her missions.

Target population: Chronically ill people in a situation of polyfragility (mental health problem and/or social insecurity)

Highlights (innovation, impact, outcomes): The implementation of case management has been evolving (since 2018, 3 case managers have taken care of 171 patients in the Namur region) according to the specificities of the areas and to the projects that have developed the mission.

Netheless, we can identify a common process to facilitate the development of this action. It is necessary to co-construct the profile with the various stakeholders (in Namur, a working group with home care coordination and a Be-Hive researcher has been set up) in order to identify the existing processes and the unmet needs among patients.

On the other hand, we can mention an added value for the patient namely the reactivation of available services, the networking of the various stakeholders (which goes beyond simple multidisciplinary consultation). This approach invites social interventions (CPAS, humanitarian aid centers and the social and housing services) to interact, focusing on the patient and his health.

Conclusion: The implementation process as described is an added value in terms of change management. The action highlights the different processes of patient care and allows an improvement of the situations encountered in the most complex situations. This process requires flexibility from stakeholders and openness in terms of integrated care.

The process of network activation and patient support requires stakeholders to be open in the process and innovative in the segmentation of services to provide quality outpatient service.

The outpatient service also allows to work from the patient's perspective, using communication tools that allow case managers and protagonists to work on requests while respecting the person's choice.

This co-construction system allows the needs of each stakeholder (subsidizing power-service providers-patients) to be met and is therefore a reference as a methodology for implementing other integrated care initiatives.