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Poster Abstract

## The efficiency of health an social care service integration and the importance of the caregivers.

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## Abstract

**Introduction:** The advance on medicine together with aging of population generates an increasing number of complex chronic illness patients. This situation implies new challenges in society and the health community, whose goal is to achieve a better quality of life for patients. On the other hand, the current economic situation creates the need to manage the resources more efficiently. The article presents a consolidation of some results, which were already presented in the 14th International Conference for Integrated Care, of a developed experience in a semi-rural area of 22.400 inhabitants. From March 2013 to December 2014, 128 patients (mainly complex and frail) are assigned to an integrated community platform of primary care and social services ("Virtual Ward"). 41% of these patients come from hospital continuity structures, while 59% comes from the primary care and social care services professionals.

**Virtual community ward:** A community virtual ward is a new point of view on the multidisciplinary case management, for the citizenship who are susceptible to unplanned hospital admission Complex Chronic Patient (PCC) or Advanced Chronic Diseases (MACA). The patients are assessed in their homes by the virtual community ward nurse joining with the social worker. The working team is made up by virtual community ward nurse, a social worker, a GP and the primary nurse, a occupational therapist and the patient and his/her caregiver decide an intervention plan together in coordination. The patients are then visited and reviewed by the whole team daily, weekly, monthly depending on the patient conditions. The basic information about the patient is shared by all the health care services (primary care, hospital and emergency services). The virtual community ward offers a proactive attention and preventive home visits and after a period of time,

the work team can decide if the patient can be discharged back to her local primary care and the social care service.

**Goals:** The aim of the project is to improve the quality and the effectiveness of the social and health services throughout coordinated work team in collaboration with patients and their social networks. Other objectives are lighten the caregiver's overburden and improve the patient's experience of care services. And also to evaluate the impact of the project on the ratio of unplanned hospitalization.

**Results:** The total number of patients treated was 128 (53% of them with social needs. Only the 35% of patients required hospital or emergency admissions. The ratio of admissions per patient and year was reduced from the 2.2 to a 0.67. The 18,7% of these patients were attended by the occupational therapist, her activities included: training for caregivers, technical aids and home adaptations.

**Conclusions:** The integrated attention by the social and health services which achieved a specific home attention for every patient and so reduced the number of hospital admissions also help to reduce public spending on health services. Something is indispensable to this results is due to the support and attention that caregivers need. And finally it is essential for professionals to share the information of patients and so prevent duplication and errors.

**Discussion:** The integrated work between primary and secondary care and social services offer efficient and cost-effective benefits on the health system. It is therefore going to be very important to have a good platform to share information. Up to now being difficult to share the information in the same informatics platform between social and care systems. It is for that reason that is needed to establish a data protection law that permits to overcome this problem. The chronicity care must emphasize the supports to the caregivers, as so they take an important part on the good evolution of the patients.

**Lessons learned:** As a result of the interventions we required the need to create a support guide (removable files) for patients and caregivers but more personalized and adapted to the real situation of its. Nowadays we are at the end of the editing process. This guide is intended to guide people involved in the healing and self-healing towards: an awareness of the sickness, a knowledge of the daily activities and life habits, some stress and behavior management techniques, free time, community resources, technological support material, elimination of the architectural and moral barriers and, above all, the accompaniment to bereavement and death. The main goal of this guide is to give a new vision of the illness, caregiver's role and functional routines.

## **Keywords**

**avoidable admissions; case management; integrated care; occupational therapist**

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## **PowerPoint presentation**

<http://integratedcarefoundation.org/resource/icic15-presentations>