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CONFERENCE ABSTRACT

A new model of integrated health and social care ibased on collaborative work in vilanova i la geltrú

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Introduction: In the new model of Integrated Care it has been signed a new Government Agreement between the Department of Health and the Department of Welfare and (PIAISS) Vilanova i la Geltrú was one of the cities where was implemented one of the pilot territories for developing this project. Now in the city of Vilanova i la Geltrú two models of care are implemented at the same time, one implemented in a Primary Care centre where health and social workers are working under the same roof for 5 years ago and the second comprising 2 Primary care centres where health and social care are working collaboratively for 2 years ago.

A progressive growing of the aging population and an increasing number of people with chronic conditions jointly with a limited public resources encourages the need of transforming the model of provision toward a new Integrated Care approach. It is important this action could be approved by all the organizations, providers and health and social care professionals working with the same population.

Objectives: General objective: To guarantee a collaborative model of care between the health and social care, to share information between them and to establish a new joint outcome framework

To improve quality of care and satisfaction of the people who are living in the town.

Specific objectives: To improve the coordination between the professionals of primary health care and social care areas in order to offer a joint care management approach for the people living in the town.

To improve the outcomes in the identification and case intervention as a result of the joint work in a individual intervention plan related to home care, 24/7 guarantee, home help services, complex care management programs, etc.

To elaborate an Strategic Integrated Plan at local level.

To facilitate easy and quick access to people who requiring care from both health and social care services with an high response capacity in case of crisis .

To avoid duplication of resources and optimise utilization of available resources.

Action plan:

1. An internal taskforce group was organised to promote the new project: it has been planned 6 meeting among partners starting April 2013 till now

2. It has been agreed a realistic basis to involve and engage professionals during the second half of 2013

3. It has been captured the opinion of professional related to need of collaboration and priorities during second half of 2013

4. There has been identified barriers and also the benefits perceived by the professionals for the development of the project also in second half of 2013.

5. Mutual knowledgement among professionals of reference has been promoted in order to facilitate the direct contact without “liaison” professionals, creating a easy and accessible directory of professionals at the end of 2013.

6. There has been facilitated information to professionals of the potfolio of services of the both sides (health and social) to make them more understandable during second semester 2013.

7. A target population has been identified and priorised to be jointly care managed as vulnerable population , especially population with complex health and social care needs: disabled, childhood at risk; mental health, drug addictions, during first half of 2014

8. There has been introduced in each individual organization the “collaborative model” project inviting and calling all the professionals of the different areas: social care, health professionals, health and social educators, mental health professionals, pediatricians and midwives at May 2014

9. There has been created 5 areas of special interest: dependant people included in home care, mental health, drug addiction, women at risk and children at risk. Pathways have been simplified avoiding unnecessary visits or contacts , giving maximum competence and authonomy to front-line professionals involved completed at June 2014

10. After working internally, conclusions and internal agreements within simplified pathways elaborated by work groups are communicated to all professionals in internal conference at March 2015

11. There has been created a person consent to facilitate to share data between health and social care professionals working with the same person

12. There has been agreed to identify people with complex health and social care needs with an consented ICD-10 code (Z75.4) in order to register the cases.

13. There has been elaborated and launched a "miniguide" of good practice and directory with contact information completed at May 2015 (May 2015).

Preliminary outcomes: Sessions carried out:

- Working parties: 4 meetings for each group. Total: 20 meetings.

- Taskforce group: 1 monthly meeting of follow-up.

Number of person contacts (in May 2015): 30

Number complex patients with health and social care needs identified (f May 2015):30

Discussion / lessons learned: before implementing the model

• 1 social worker covering r 2 primary care centers (45.000h).

• Little knowledge among partners. No awareness about services which could be provided

• Little coordination among health and social care working for the the same population, also at managerial level.

• Duplicity in the follow-up of the cases. Professionals were working in silos

After implementing collaborative model:

• Creation of a taskforce group involving health and social care organizations.

• More joint work between health and social care work within the same twon.

• The professionals have more aware about the available professionals and resources in the social area, promoting joint training activities, integrated care pathways, an Strategic Plan and a well known directory.

• Joint work and communication among the professionals. Creation of new reinforced joint working dynamic focusing on an agreed joint targeted population : mental health, disabled people recruited in home care, families, women and children at risk, etc..

• It should be recognised it has been generated a new trust and respect environment which is required to build a new scenario, providing space and time to meet together .

• New indicators are being incorporated in the new joint outcome framework.

• A joint strategy is being implemented to identify people with complex needs difficult to identify separately.

Brief summary of the experience: (Describe your experience in 2 sentences so that the rest of users know what it is about).

We have started a process of relationship and communication among health and social care partners as we are convinced it is not an easy work but necessary to improve care for people with complex health and social care needs .

It is a process of professional enrichment for all organizations and professionals, building a model of care to give appropriate response for people who need care from different perspectives.

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Keywords: new model; integrated health and social care; collaborative work; satisfaction of the people; coordination between the professionals