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CONFERENCE ABSTRACT

Towards a Collaborative Integrated Healthcare Model in Tona

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The Tona Model is one of the 8 projects chosen by the Programme of Prevention and Care of Chronicity of the Department of Health and the Department of Welfare and Family, to implement a collaborative model that creates the ideal conditions to provide integrated care to the public through the interaction between the social and healthcare services as well as other actors from the community.

It began in 2012, promoted by the Social Services Department of Tona Town Council and the La Plana District, along with the Primary Healthcare Centre of Tona, and defined the operative and functional guidelines for social welfare and healthcare cooperation to improve continuing care, especially those who find themselves in a complex situation.

Based on a strategic analysis of the conditions of the setting, the needs of the community, and the characteristics of the local and county social and healthcare services, the functional plan was drawn up. In the implementation stage this is periodically evaluated and re-planned with the changes required for a continuous improvement of the model.

Strategic analysis–Functional plan - Implementation - Evaluation– Re-planning– Plan of Action

In order to achieve our goals, we have the involvement of the local social services of Tona and the county, primary healthcare, specialised healthcare, the 3 elderly cares homes in the district and other agents from the community that have made a commitment to act in a coordinated and integrated way, optimising the local and regional resources available.

La Plana District - Mental Health - Hospital –Adapted Transport -

The main aspects that make up the Tona Model are:

1. Integrated, personalised and coordinated care of people: in order to be able to improve the care defining common responses despite the diversity of accesses, a local dependency committee has been created, made up of professionals from the social and healthcare services.

This committee defines procedures, criteria, protocols and circuits of action, as well as individualised plans directed at the users of the service.

2. Care where and when people need it and strengthening primary healthcare and in the community. The model is aimed at optimising the potential of the homecare services, avoiding

duplicities in evaluation, assessment and orientation of people and making this homecare the main device for covering the needs of people in a complex situation.

The main actions are:

o Creation of conditions for greater coverage and/or intensity in homecare services, telecare services and the technical support bank.

o Improvements in safety and planning in transitions between services.

o Optimisation of the preventive capacity of the telecare service.

3 Integrated and quality care of people living in old age people's homes.

o The medical services of the Primary Healthcare Centre have been incorporated into the old age people's homes, establishing agreements with the three homes in the district, with computerised medical records points, and working with the same protocols, clinical practice guides and recommendations as the rest of the public.

4 Promotion of autonomy and active ageing.

o The Active Ageing Committee has been created made up of professionals from local social services active ageing services, the primary healthcare area and professionals from the old age people's homes, who move outside the purely residential aspect in order to offer their services to the community. All together they have produced a plan of active ageing activities, of prevention and health promotion, placing emphasis on healthy lifestyles, physical exercise, leisure and socialisation to also avoid the impoverishment of the relational and/or health network.

5 Boosting training and skills activities jointly among the professionals from the different services.

Results 2012-2014;

• There have been 6 plenary meetings for implementing the model.

• 11 meetings of the dependency committee

• 6 meetings of the active ageing committee

• Identification of a potential joint population of 629people (in situation of fragility / dependency / complex chronic patient or with advanced chronic illness) of which:

36 are complex chronic patients or with advanced chronic illness, and users of basic social services

263 homes, of which 99 are in the residential sphere

183 have telecare service / 19 have homecare services

• 51 intervention plans adopted jointly

• 31 new dependence care solicitudes.

• 36 PIA (plans for individual/oneself autonomy)

• 85 intervention of technical support services

• 11pre-admittance activations of the homecare services (only in 2013)

• Computer access to the dependency management system by the health social work team

• 333 participants in several promotional activities of health and active ageing.

• Signing of 3 collaborative agreements with the residential services of the municipal district.

• Reduction from 31% (2011) to 17% (2013)of users who have been hospitalised during the year and from 724 to 187days of hospitalisation

• Reduction of exitus to the hospital or residential nursing home from 54% (2011) to 25% (2013)

• 29,37% Reduction of pharmacy costs from the 3 elderly care homes in the area.

Keywords: social; community; integrate; care; health