Consorci de Salut i Social de Catalunya

Persons with complex needs

CARE MODEL

COMPLEX CARE MODEL

Catalan and Social Care Consortium
September 2018

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Contents

1.- Introduction

Increasing life expectancy and social changes (family structure, inclusion of women in the workplace, economic crisis, etc.) have led to the emergence of an growing number of people who suffer from multiple pathologies, also known as multimorbidity (NICE guideline, 2016), namely the presence of several chronic illnesses or health problems with multiple and interrelated, even inseparable, health and social care needs.

Living in depressed areas can increase the presence of chronic illnesses (Barnett, 2012) and reduce life expectancy while poverty and loneliness have been shown to increase the risk of death (Stringhini, Carmeli, & Jokela, 2017), (Holt-Lunstadt, B., Baker, Harris, & Stephenson, 2015). The increase in both health and social care needs is closely correlated to age and increased life expectancy, but is not accompanied by more years of healthy life.

Moreover, the system has not adapted to respond to people's needs and continues to provide separate health and social care services, with excellence in care mainly focused on the illness and lacking an all-round view of the person's values and their functional loss. This all means that patients themselves have to seek out the services, with a reactive response by the system which is segmented by activity rather than coordinated amongst professionals, and with little or no involvement by the person/caregiver in decision-making.

This group of people requires significant resources and, with a population predicted to grow significantly, presents a sustainability issue of the first order. Providers focused on sustainability will not be able to cope with these increases with their current organisational model and areas of activity.

Health and social services continue to be paid for separately, and payment is segmented by by activity, levels and institution. The system doesn't incentivise or encourage collective coordinated action. This requires a change in the organisational model in order to provide an efficient response to the needs of the group.

There is no simple or agreed definition in the literature for 'people with complex needs'. The definition adopted, however, is that made by Rankin J (2004) that states that they are people who have multiple, interrelated, interconnected and profound needs and require intensive assistance in different (health, social and emotional) areas. Proposals on how to respond to this challenge in the literature and international experience do agree, however: the response is **COORDINATION** (Goodwin Nick, 2013). This response is recognised in the Catalan Health Plan (*Generalitat de Catalunya*, 2016) and in the Interdepartmental Plan for Care and Social and Health Interaction (Ledesma A, 2015) as well as expressed in the Catalan Parliament's resolution on the public

healthcare system that urges the government to coordinate social and health care (*Parlament de Catalunya*, 2015;610).

2.- Objectives

The aim of the project is to implement a person-centred service in the different territories in order to meet all the health and social care needs detected. The service should be staffed by professionals with decision-making power, be located in the most cost-effective locations, and should have overall responsibility together with the bodies involved in the provision of the care.

The intention of the approach is to meet the *Triple Aim* set out in Berwick D (2008; 27 (3)) from the *Institute for Healthcare Improvement*: to improve the experience of care, to increase the health of populations, and to reduce per capita costs. There is therefore a clear focus on the territory and the management of the population.

Persons/caregivers have hitherto received a reactive response to their needs, with multiple journeys needed to access services, lack of coordinated care, and constant changes in professionals based on the services needed. Once the project is implemented person/caregivers should receive a proactive and planned response to their needs and be involved in deciding their own service plan. They will have home care whenever possible with continuity of social and health services, with a professional to coordinate the service and a team with decision-making powers.

3.- Care model

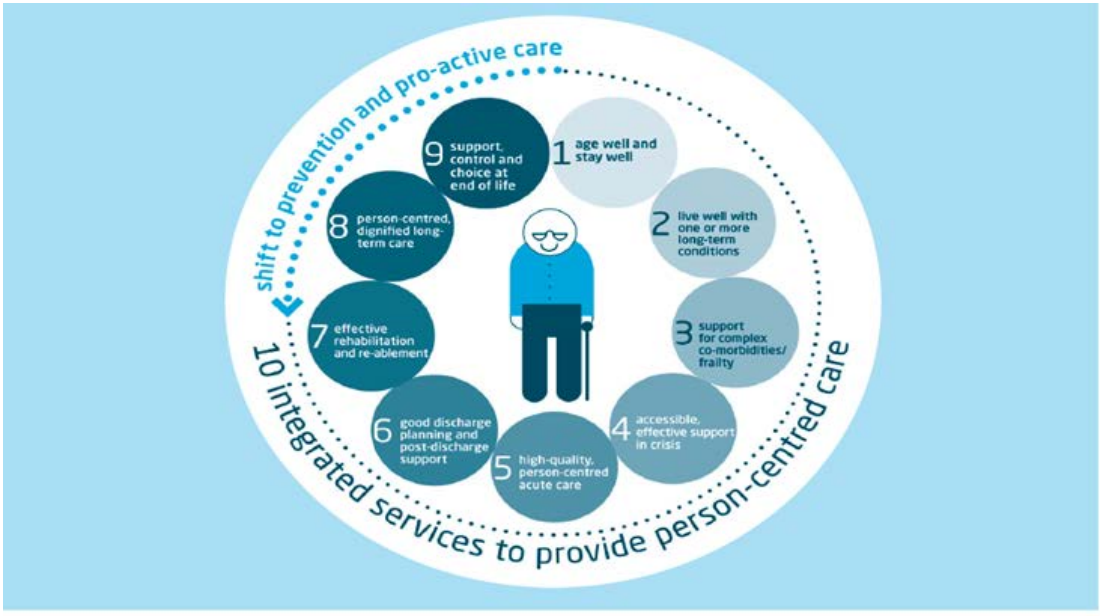
The care model is designed for a group defined as ‘persons with complex needs’. This term, rather than defining the characteristics of an individual, describes the response framework needed. There are no generic cases as every individual with complex needs has a unique set of interconnected health and social care needs which require a custom-made service response.

Persons with complex needs are believed to make up some 5% of the population. The group has been observed to be heterogeneous, however, and can be segmented according to needs. It is closely associated with age and thus entails more intense coordination and intervention. Care models need to be designed which resemble each other but which vary according to the risk involved.

Recent studies have identified the features involved in the successful management and functioning of care programmes for persons with complex needs (Hong CS, 2014): **'Effective programs customize their approach to their local contexts and caseloads; use a combination of qualitative and quantitative methods to identify patients; consider care coordination one of their key roles; focus on building trusting relationships with patients as well as their primary care providers; match team composition and interventions to patient needs; offer specialized training for team members; and use technology to bolster their efforts'.**

We have based the design of our care model on a study focusing on older people (Oliver, Foot, & Humphries, 2014) but which is perfectly compatible for persons with complex needs given the close association with age. On the basis of this study we have researched the literature for scientific evidence on the kind of intervention and organisational models required to enable professionals, facilities and bodies to deliver the intervention in the most efficient manner. The literature reveals **activities should be progressively more preventive and proactive, and services coordinated and person-centred** (Figure 1)**.**

Figure 1: PCN needs/Older people



The project development approach was as follows: following analysis of the literature, the proposal was designed and subsequently validated by an equal number of collaborators from the health and social care sectors, who offered their observations and contributions on the model and strategies for effective implementation.

4.- Intervention model

In this section we consider firstly, the bibliographical references related to the overall intervention framework and the activities and elements to be included, secondly, the intervention proposal itself, and lastly, the strategies needed to ensure the success of a complex needs management programme.

4.1.- References

Intervention is the core of the care model. It encompasses the relationship between the programme and the person/caregiver in the organisation of health and social services and in the provision of support to the different contexts (Windh J, April 2016).

Complex needs care programmes have certain features in common which can be divided into activities carried out and elements they are composed of (McCarthy D, Oct-2015).

4.1.1.- Activities

This section provides a brief overview of the main activities to include when designing a comprehensive complex needs programme (see Figure 2).

1 / IDENTIFY the persons who will benefit most from the intervention using a process of risk classification and stratification based on needs. Existing data should be employed and professional judgement applied. The intervention should be aimed at those patients for whom it has been shown to be effective. According to the literature, these are persons with high needs who are those suffering both from multiple (> 3) chronic conditions and from functional limitation in their daily lives.

2 / Comprehensive and functional ASSESSMENT in a visit to the person's home to assess risk and needs and to identify and classify the intensity of intervention (low, moderate, high) needed, bearing in mind the family and community situation.

3 / DRAW UP *Care Plan* in consultation with the person/caregiver. It should include the preferences of the patient and meet their shared needs (person-centred care). This entails treating the person with dignity and respect. The care programme must be customised, have a clear overview of the needs of the person, and integrated into routine activities.

Figure 2: Complex needs management: activities

4/ EMPOWER service users to look after themselves with the help of the family. It will be necessary to work with carers and the family and it depends on the type of person, as the person may suffer from cognitive and/or functional loss and this will affect skills needed for daily routines.

5 / COORDINATE service care, with one single contact point between the person and the team, and between the different members of the team themselves.

6 / PROVIDE the most suitable services and support based on the objectives and priorities of the person being cared for. The portfolio of social and health care services must be accessible and flexible; it must be possible to prescribe and authorise services from one single point; and the care plan should be adapted according to changing needs. Considerable attention must be given to moves from residential care back to the community.

7/ MONITOR the progress and development of the programme and make the changes and readjustments necessary.

4.1.2.- Elements

In this section we list the professional profiles of the personnel and the key tools needed to implement complex needs management (Figure 3).

Figura 3: Complex care management: elements

1 / The LEADER of the programme has a complete overview of the situation and manages and reviews care. The leader is responsible for identifying persons with complex needs eligible for the programme and establishes their degree of need and the level of intervention required. The leader appoints the team and the case manager and applies a Plan-Do-Control-Act approach to programme management.

2 / The CASE MANAGER is the single contact person for the person and the family. The case manager discusses care planning with the person/caregiver, preferably in the patient's home, and carries out a comprehensive assessment. The case manager coordinates the care team for specific events requiring different professionals, and coordinates transitions. He or she re-evaluates the care plan according to the person's changing functions and needs and allocates support resources needed, making them easily accessible and adapted to patient needs. The case manager is the single contact person for the person/caregiver with the team. He or she monitors the implementation of care and support services, evaluates results in quality of life and makes readjustments when necessary.

3 / The community-based INTERDISCIPLINARY TEAM should be adapted to patients' needs for intervention and be made up of personnel able to meet the objectives set. The team is coordinated by the case manager. The following expert areas should be included when creating a *care plan*: family doctor, social worker, pharmacist, community nurse, nutritionist, medical specialists such as geriatrician/psychiatrist/rehabilitation therapist, physiotherapist, occupational therapist, psychologist, and various social services departments. Depending on the number of cases managed by teams it should be possible to optimise resources and share professionals. The majority of interactions between members may not be in person. Occasional interventions may be incorporated in order to contribute knowledge and improve efficiency.

4 / TRAINER in behavioural change techniques and self-care skills. The function of the trainer is to provide guidance in what to do in the case of an emergency, the personnel who need to be contacted, and which resources need to be resorted to at the different times of day.

5 / ITC to be targeted at reducing the workload associated with these care models. ITC should be employed to simplify communication between professionals and the person in care and to assist carers in distance care and in monitoring. It is essential for information on the person to be shared with all members of the team.

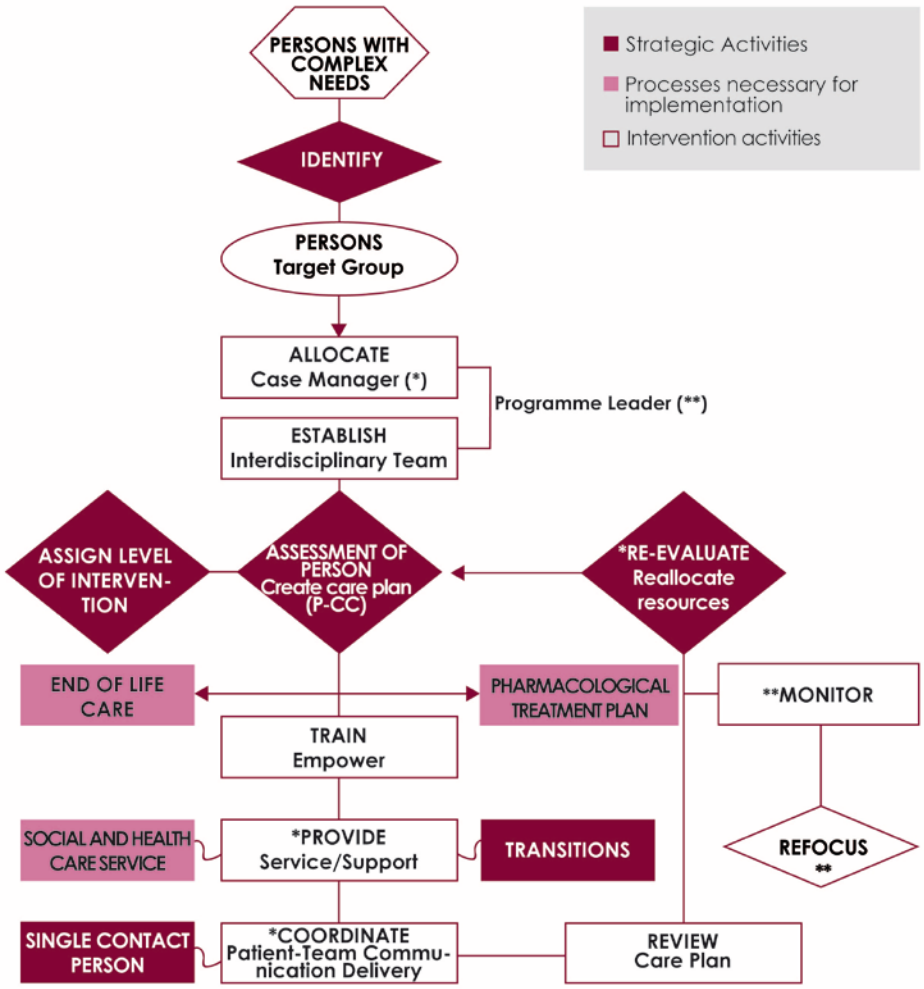
6 / MEASUREMENT of results and create a dashboard and carry out periodic analysis and implement readjustments.

7 / EXISTENCE of standardised processes for person/carers at the end of life and for reviews of pharmacological treatments plan.

4.2.- Proposal

An intervention model based on the activities and elements set out above has been drawn up with the activities recommended in the literature set out in the form of a flow diagram (Figure 4). The activities with a dark background are strategic and essential for the successful implementation of a complex needs management programme. The activities will be explained in more detail below.
The activities with a lighter background are the procedures needed to implement the intervention and need to be agreed and spelt out as processes (pharmacological treatment plan, end of life care, and portfolio of health and social care services). In this document we will not deal with the element of continuous training but we do consider training to be essential for the implementation of the plan in which there are proposals for new professionals, new functions and new ways of working.

Figure 4: Complex needs management: intervention model



The roles of programme leader and case manager are of key importance. They are essential for the running of the programme and they constitute the basic minimum needed. In the explanation below on these positions we set out the functions and activities that need to be developed, those in the flow diagram in bold. We also comment on the interdisciplinary team (IT) and on the role of training/empowering.

4.2.1.- Programme leader

The programme leader must be a leading specialist, respected by professionals, and able to demonstrate empathy and build teams. He or she should have worked in this type of care and have experience in the tools used. He or she should possess good judgement when approaching the uncertainties generated by the projects, have good communication and analytical skills, and be able to take decisions. The person must be respected by the different personnel in medicine,

nursing and social work. In the first phase it is advisable for the leadership to be shared between healthcare and social services professional in order to demonstrate the coordination between the two areas.

The functions of the leader are to:

- Contribute to the design of the programme
- Ensure the application of the care model
- **Assign,** support and supervise the case managers
- **Establish** and support the interdisciplinary teams
- **Monitor and refocus** the programme in order to guarantee results
- Direct self-assessment of implementation of the care model

4.2.2.- Case manager (CM)

In order to carry out his or her task in a satisfactory manner, the case manager needs appropriate skills and experience in the following areas: they must be able to handle the responsibility to which they have been assigned; they must be able to carry out the functions and competences; and they must be able to support both the primary care team and hospital personnel in their relationships with the person or caregiver. The person's academic background does not necessarily play an important role in determining their effectiveness. Various studies have shown that case managers may come from a range of specialist areas, such as nursing, social work, physiotherapy and occupational therapy.

The care manager's functions are to:

- Carry out an comprehensive assessment at the home of the person and get an idea of their values and preferences
- **DRAW UP** the care plan/ISIP with the Interdisciplinary Team (IT) and the person or caregiver.
- Assign the level of intervention
- **PROVIDE** the health and social care service/support
- **ENSURE** the success of transitions
- Be the single point of contact
- **Coordinate** the relationship between the person/caregiver and the interdisciplinary team
- **Review** compliance of the *care plan*/ISIP
- **Re-evaluate** the situation and modify the *care plan*/ISIP
- **Re-assign** services/support

4.2.3.- Interdisciplinary team (IT)

The interdisciplinary team must include professionals who can contribute their specialist knowledge to the case in question and develop a *care plan* that is both suited to the person in terms of technical knowledge and takes into account the person's values and preferences. In order to achieve this, the IT should be created ad hoc for each person. The team should be composed of permanent members from both primary healthcare and social care and other members, specialists, who will be brought in when needed. They will be invited to join the team when needed, always via the case manager and in agreement with the primary health care team. The health specialists needed tend to come from: geriatric medicine, rehabilitation, palliative care, pharmacy, nutrition, psychology and other specialisms depending on patient needs.

4.2.4.- Training

Training is needed in order to empower the person/or caregiver and to provide them with the skills needed to help them care for themselves; to know how to proceed in case of doubt or an incident; and to provide patients with a procedures manual. There should only be one point of contact so that responses are provided as rapidly as possible. It is necessary to determine the most cost-effective professional to carry out this function whether this involves new types of professional or those already working in the health and social care sector.

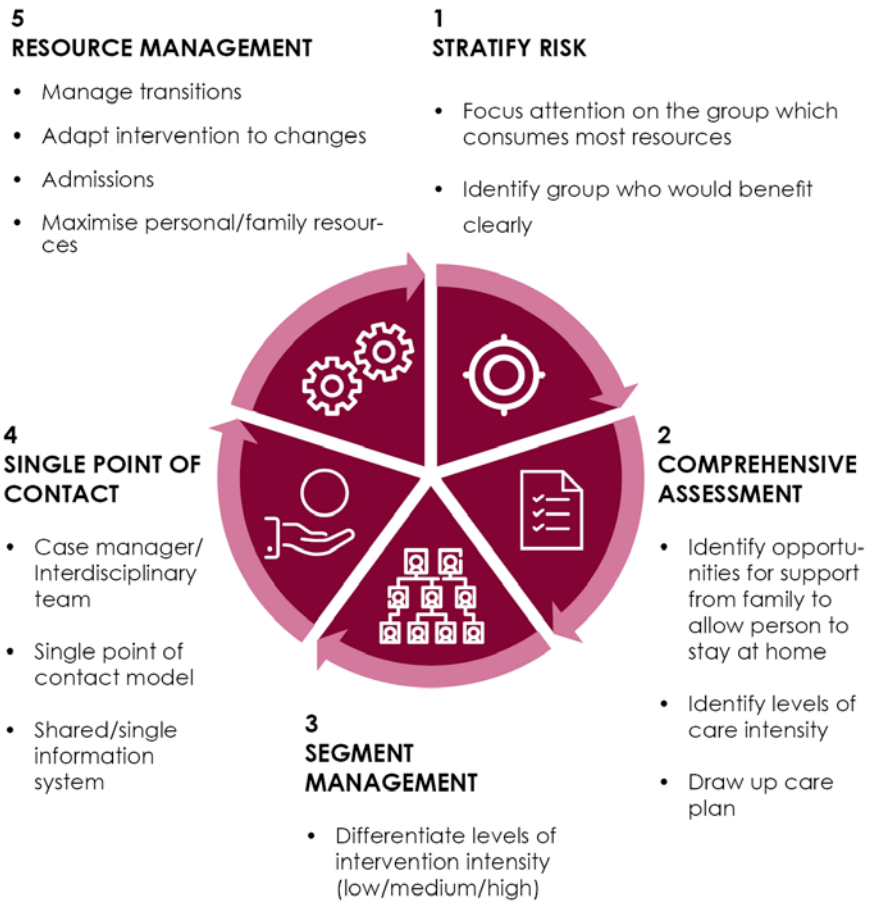
4.3 - Strategies

The key strategies enabling the success of a complex needs management programme(Windh J, April 2016) are set out in Figure 5.

1/ **Stratify** risk and focus attention on the population subgroup that consumes most health resources and/or that is most institutionalised. The intervention model must be shared, preventive and proactive. It must thus be based on updated databases which make it possible to identify clearly the target group. It is essential to **identify** the persons who will benefit most from the programme using a process of risk classification and stratification based on their needs. The degree of intervention and coordination amongst social and healthcare services will vary according to the target group. The intervention should be aimed at persons or caregivers for whom it has been shown to be most effective. According to the literature, they suffer from multiple chronic illnesses/multimorbidity and limited functions in daily life and are defined as Persons with High Needs (Hayes SL, August 2016). Age is a determining factor in these variables. The variables can be adjusted depending on the size of the group desired, and their needs for more active or more preventive care. It is only by combining quantitative and qualitative aspects in the identification process that a group can be identified for whom the intervention is most effective.

2/ Comprehensive **assessment** based on home visit to evaluate the risks and the needs of the person. This is essential for identifying and implementing the activities involved in the intervention. The assessment should make it possible, on the one hand, to identify the opportunities provided by the family and the caregiver(s) to enable the person to stay at home and in the community and to determine the services and support needed, and, on the other hand, to identify the level of care needed. The *care plan* is drawn up together with the interdisciplinary team on the basis of this assessment. It will also include the values and preferences of the person and will be agreed together with the person or caregiver (Person-centred Care).

Figure 5: Complex care management: strategies



Adaptació Windh J., Long-Term Quality Alliance 2016

3/ Resources should be **assigned** appropriately in order to meet differing degrees of need. This enables **management to be segmented.** A low intensity of care only needs distance monitoring. A moderate intensity requires regular visits by a social worker or nurse. Intensive care implies a longer period of time and requires the intervention of all or part of the team and the need for coordination amongst team members. Transitions and persons who are likely to need institutionalisation are high intensity and high risk situations.

4/ One of the main contributions of the intervention model is the implementation of a **single contact point** for the person or caregiver provided by the case manager (CM). This person works together with the interdisciplinary team, delivering one single care plan and a shared information system. The case manager is thus the single contact point for the person or caregiver in relationships with the team. The care manager proposes the *care plan,* monitors care implementation and support services, evaluates results relating to the person's quality of life and makes adjustments. ITC is essential for these functions and relationships.

5/To provide the most suitable services and support to meet objectives and the priorities of the person or caregiver, there must be an accessible and flexible portfolio of social and healthcare services which may be authorised or amended according to need by one person only. The case manager will revise the *care plan* regularly in order to adapt it to the changes in the functions and needs of the person and will allocate resources as needed. There are three key aspects in the **management of resources:** the allocation of services and support over time, whether this means increasing or reducing resources according to need; the management of **transitions** in order to settle the person in his or her new location and prevent any fall-back; and the management of the use of hospital and care home beds. Much care needs to be taken over the transition processes and placement in the community and all transitions need to be carefully managed by the case manager. They will involve: early notification of transition, commitment of the family, coordination of interdisciplinary team, monitoring and follow-up to adjust services. In conclusion, it is necessary to get the most out of the resources of the person, the family and the community, even it this means transferring some resources in order to allow the person to stay at home, to delay admissions to hospital or residential care. The response must depend on the needs detected, not on the capacity of the provider. Follow-up and adjustment and reallocation are important for all cases. A person must not be discharged from hospital if not authorised by the case manager so as to ensure that care is continued once the person leaves the hospital.

5.- Organisational model

Once the needs of the person and the activities required to satisfy those needs have been established, it is necessary to organise all the required facilities and persons and the relationships between them in order to provide the service in an efficient manner. Firstly we will review the literature on the subject and then set out our generic proposal.

5.1.- References

Evidence-based treatments for this group of patients are well documented and explained in a King's Fund article) which sets out the different components (Oliver, Foot & Humphries, 2014).

1.- **Ageing healthily**. In order to age in good health, it is important to live in a decent environment, to avoid loneliness or even isolation, to follow a healthy lifestyle (exercise, nutrition, no tobacco or alcohol), tackle minor problems which may be disabling (pain, incontinence, lack of mobility, problems with sense organs, teeth, etc.) and ensure appropriate vaccinations and screening.

2.- **Learning how to live with one or more chronic conditions.** To enable patients to live with one or more chronic conditions the following services should be provided to patients: appropriate level of care following a risk stratification procedure, coordinated services to provide continuity of care, training to empower self-care, telecare and the same access to care as the rest of the population.

3.- **Support for complexity.** Proactively identify and evaluate fragile persons, implement fall-prevention programmes, encourage daily exercise, reduce dependence on too many drugs and take special care of persons with dementia.

4.- **Accessibility and effective support in unstable or crisis situations.** Accessibility and continued care provided by primary care services; response from social and healthcare services 24/7 with response times of 2 hours during the day and 14 hours during the night; coordinated and aligned emergency services; careful supervision by social and healthcare services of high risk persons; monitoring at home with telecare and telemedicine; accessibility to specialist care; community geriatric teams; comprehensive geriatric assessments before and after hospital admissions and home hospitalisation.

5.- **High quality acute person-centred care.** Comprehensive geriatric assessment for all patients admitted, focus on fragile patients, create an acute geriatric unit, establish clinical safety programmes and programmes to minimise the risk of hospitalisation, give special attention to

psychogeriatric patients, apply person-centred care and ensure care continuity between specialist care and primary care providers.

6**.- Good discharge planning and post-discharge support.** Plan discharge well in advance, ensure agreement and involve the person/caregiver in the discharge arrangements, allow discharge 7 days per week, ensure good communication with professionals, carry out assessment and support following discharge, and following discharge provide early health and social care services.

7.- **Effective physical and social rehabilitation.** Share the comprehensive geriatric assessment and the ISIP, apply best evidence-based practice, allocate services based on results, ensure continuity of rehabilitation services (at home, day care, residential), occupational therapy, and ensure transition processes are completed effectively.

8.- **Good, person-centred care in care homes (P-CC).** Prevent admissions if avoidable, share computer systems, ongoing comprehensive assessments, apply P-CC methodology

9.- **Ensure patients have suitable support, whilst retaining control and decision-making powers at end of life.** Well-trained teams, identify those who are reaching the end of their life, ensure previous decision plan, coordinate and plan discharge in consultation with the hospital, receive access to palliative care and support at home or improve end of life in the hospital and involve the person/caregiver.

In order to ensure that these activities are carried out services must be coordinated, preventive and proactive.

5.2.- Proposal

The organisational response to the intervention model must involve the coordination of services. Coordination means providing care to persons regardless of the normal divisions between physical and mental health, social and healthcare services, primary and specialist care. High quality service must be delivered at the appropriate time and in the appropriate place and must take into account the preferences and values of the person.

Care provided must be organised on a regional basis and managed locally. The intervention must be provided within the community but due to the type of person to be cared for and their needs, it must be organised both within the community and between the hospital and the community, and transitions between the two must be facilitated. The service must provide a 24/7 response.

All the regional organisations with the territory have to work jointly and as part of a network. The number of entities and professionals involved tend to have very different cultures and are concerned about losing their roles and their status. There is uncertainty about the lack of practice and skills when taking on new roles and there may not be enough ways of sharing information between healthcare and social services which make it possible to offer coordinated care and guarantee continuity of care. In order to make this possible and lasting it is necessary to consider the clinical integration of professionals, leadership, information system and legal aspects.

5.2.1.- Community care

The intervention model should be centred on the person/caregiver and should be provided within the community. The aim is to enable patients to keep their independence for as long as possible whilst they are in a stable condition and to delay their institutionalization for as long as possible. Once the regional target group decided has been decided, the programme leader will be proactive in applying the case detection process and will assign a case manager to those detected. Together they will establish an ad hoc interdisciplinary team for each case.

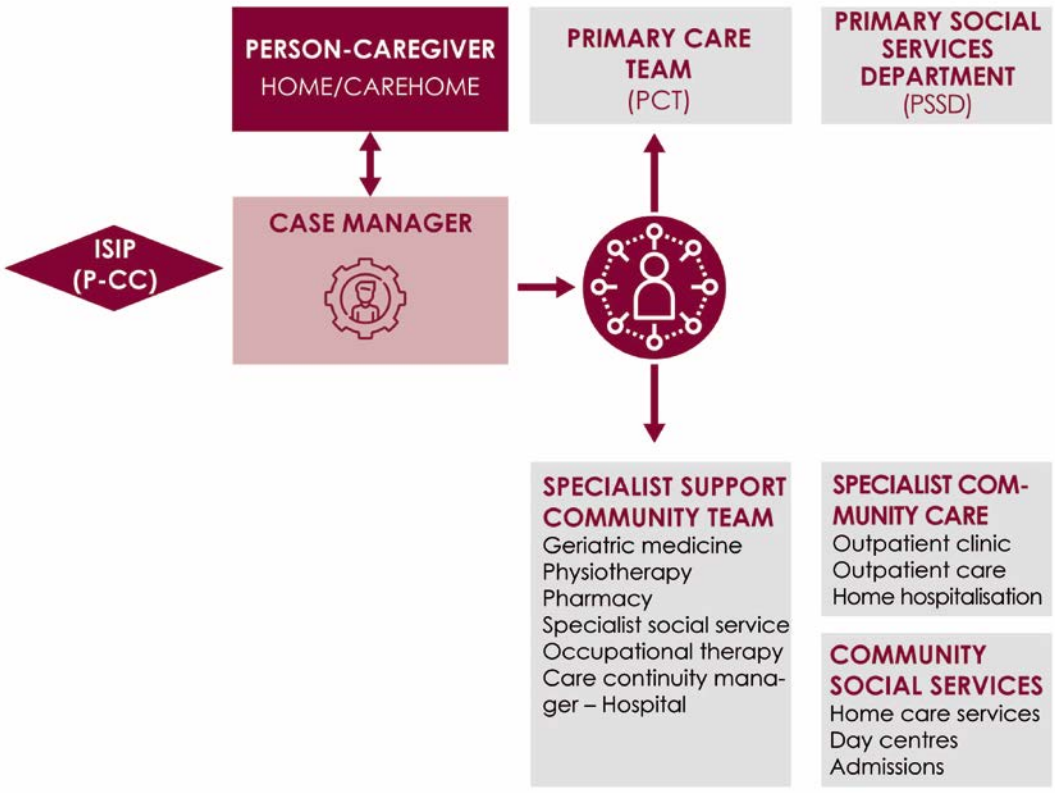
The organisational components in this area are as follows (Figure 6):

i/ The person/caregiver is at the heart of the model and, as far as possible, must be the person who takes decisions affecting his or her care. A large number of these people, however, have cognitive deficits and this makes it impossible to take decisions affecting them. For this reason it is important to work with the family/caregiver or other people who know the patient in order to determine their preferences and values and respect them as far as possible (P-CC). The person will be assigned a case manager and a working hours primary care telephone number which will act as a single point of contact. The person will be trained and empowered to provide to look after themselves and they will be given a manual and training on how to act and who to get in touch with for emergencies and questions 24 hours a day and 7 days a week. Every person will be provided with an agreed *care plan* (ISIP), published in the Catalan Shared Medical Records Service so that it can be shared by all those working in social and healthcare services. The ISIP will be reviewed at least once a year for those in a stable condition or whenever there is a major issue and if requested by the person/caregiver or the social and healthcare services professional. The necessary services and support will be based on the *care plan* and will be allocated according to the level of intervention decided. Service provision must be swift and flexible and it must be possible for the plan to be amended every time it is reassessed.

ii/ The Case Manager is the cornerstone of the model. Persons in this role must be provided with real power and authority which is recognised by the organisations involved so that they can carry out their functions properly. The CM does not replace the functions of the social and healthcare professionals, but simply enables the services to be carried out suitably, acting as the link between

the person and the professionals, the contact point between the professionals, and the connection between the community and the hospital. As explained, in the IT there are some permanent members who provide key support to the CM. These are the primary social and healthcare professionals. The family doctor, the family and community nurse and the social workers are the core decision-makers. The case manager assesses the person's situation in their own home, draws up the *care plan* together with the IT and the person/caregiver, assigns the services and support and reviews compliance, coordinates relationships between the patient and professionals as well as amongst professionals, whether they are in-person or distance. The CM is the contact point for the person/caregiver and manages the resources and services to be provided as well as ensuring the success of transitions. The CM is the community contact point for the hospital and must authorise discharges from A&E or from hospital and thus ensure continuity of care. The care plan will be reassessed and resources reallocated after each setback or on an annual basis in cases where the patient has remained stable.

Figure 6: Organisational model – community level



iii/ Primary care: Primary healthcare and social services should be located in the same place. Social workers should work from the primary healthcare centre. Sharing the same location, workplace and information system will make it easier to coordinate healthcare and social services.

Then it will only be a case of planning times and workplaces for assessments that are needed by the case manager. Social and healthcare professionals will participate in the assessment and the creation of the *care plan* of the people assigned to them and will monitor what has been agreed. In cases of incidents or alerts, the case manager will establish contact with the appropriate primary care professional and will arrange suitable resources. The case manager will take care to ensure administrative steps are processed (appointments, home care, contact with hospital, etc.) and appropriate transfers arranged.

There is not yet any clear evidence that there are better results or that the model is implemented more effectively if the primary care unit is applied rather than an approach focused on larger groups of geriatric patients.

iv/ Specialist Community Services Teams are specialist healthcare and social services teams with the appropriate knowledge to provide outpatient care. The professionals in these teams are responsible for setting up the unit and providing the outpatient care. They are set up when needed and always via the case manager and with the agreement of primary care.
Access to these specialist teams has been proved to be effective.

5.2.2.- Hospital care

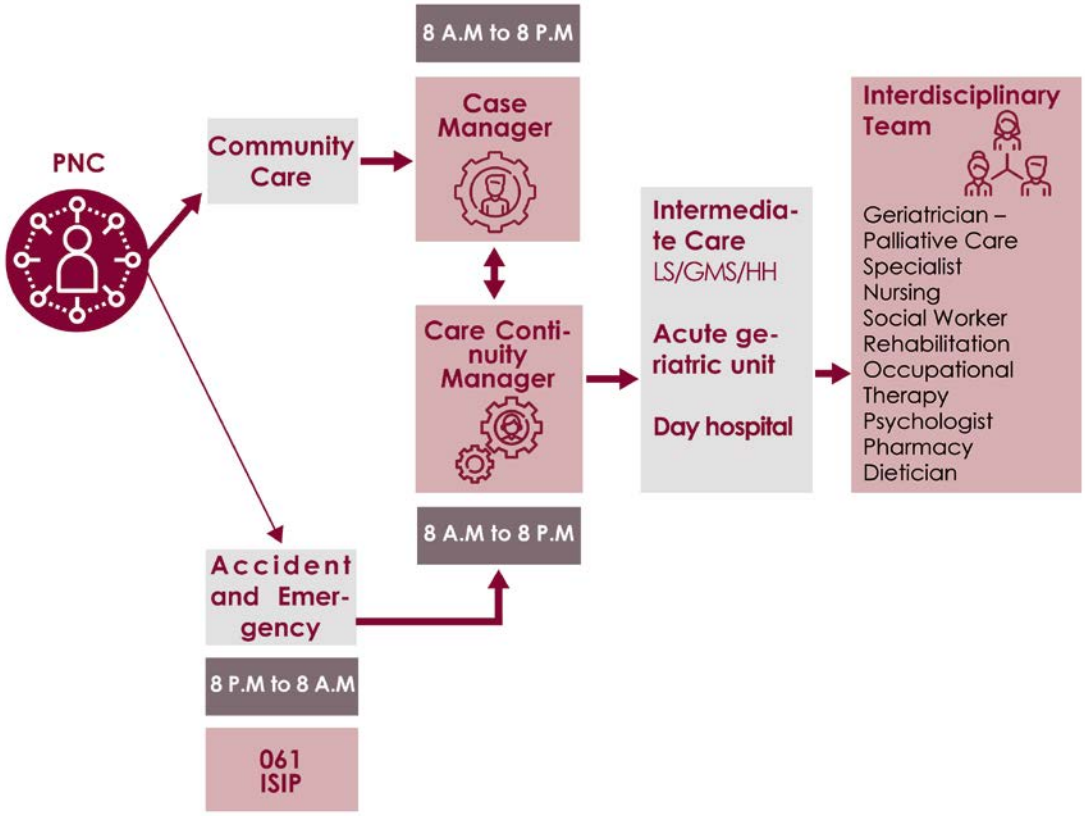
Patients in crisis or who have suffered setbacks are referred to hospital when they cannot be treated within the community. Whenever possible this should be planned by the Case Manager. Emergency services should be used to bring the person to emergency care only when the patient is fragile or the incident has occurred outside primary care hours. The key personnel in the hospital context are the care continuity manager and the interdisciplinary team. Accident & Emergency, acute geriatric units, intermediate care, day hospitals and home hospitalisation have been demonstrated to be the most effective units for dealing with this kind of situation (Baztan JJ S. F., 2009) (Figure 7).

i/ Care Continuity Manager (CCM) The care continuity manager is the person at the hospital who is the direct link with the case manager and community care providers. The CCM enables access to the unit and the professional providing the intervention and must be available during the same working hours as the case manager (normally from 8 a.m. to 8 p.m.). One of the tasks of the CCM is to assign the person to the most cost-effective location or hospital unit, in response to an algorithm based on the following variables: clinical status or situation, degree of diagnostic precision, required intensity of treatment, estimated duration of treatment and patients' capacity for movement, either in hospital or at home. Outside these hours or in emergency situations the 061 emergency service will be reactivated and will act on information contained within the ISIP. In these cases the Care Continuity Manager will initiate the assessment in ER and will assign the person to

the most suitable unit. If needed, the person will have the support of the specialist doctor responsible.

The relationship between the case manager and the care continuity manager not only covers access to hospital resources but, more importantly, discharge from hospital, whether the person has been admitted or has been treated in Accident and Emergency. In these cases, as explained, a patient must never be discharged until approval has been issued by the case manager.

Figure 7: Organisational model – hospital



ii/ Interdisciplinary Team (IT) The work of the interdisciplinary team is very important in the hospital as team members are responsible for undertaking a comprehensive assessment of the person and setting the appropriate objectives for the different areas (clinical, functional, psycho-emotional and social). The appropriate professionals will be active in the different hospital units and their involvement will depend on the intensity of the case. One important aspect is to work on the discharge from the first day.

iii/ Accident and Emergency (A&E) Accident and Emergency is open 24 hours a day, 365 days a year, and is staffed with qualified professionals, making it an ideal place to refer patients to when they suffer a health setback or if their diagnosis is uncertain. It should not, however, be the usual mode of admission to the hospital, and even less so for the target group we are dealing with. Admissions should be planned jointly by the case Manager and the hospital care continuity manager, wherever possible. Patients should only be admitted via A&E when they are in a fragile state or have suffered a setback at hours when the 061 emergency service is activated. Given the high proportion of patients of this nature in the A&E departments, there should be trained professionals to treat these persons and a team of specialists able to act on demand to provide support. As mentioned above, the care coordination manager is part of this team and may be the contact person to make the first contact and assessment. Once the person has been assessed and the person is deemed to be fit to return home or to the care home, the care continuity manager must contact the case manager and organise the transition.

iv/ Acute geriatric unit (AGU) and day hospital (DH) The object of these facilities is to stabilise the person and/or carry out a diagnosis and a careful assessment with the aim of reducing the patient's functional loss so they can return to where they have been living. The Acute Geriatric Unit provides residential care and the Day Hospital outpatient care. They are units which are organised according to patient needs rather than by specialities. They are medical and surgical units staffed with nurses specially trained to look after this patient group and with generalist geriatric doctors who will carry out the comprehensive geriatric assessment and the interdisciplinary work approach with the professionals from other specialist areas. The pharmacological plan and discharge planning from the very first day are are key components of the Acute Geriatric Unit. The Day Hospital is a unit that enables some patients to be discharged early and avoids the need for admission for others whose clinical condition and ability to move allows them to receive occasional intensive treatment during the daytime.

v/ Intermediate Care (IC) and Home Hospitalisation (HH)

Once the most acute phase of a patient has been overcome, and provided there has been a precise diagnosis and the comprehensive assessment requires a residential stay in order to stabilise the clinical condition, intermediate care or home hospitalisation may be indicated to improve patients' functional capacity or to create the appropriate social context and allow the patient to return home. Depending on the family and social situation, home hospitalisation may be an option, but both facilities make it possible to avoid more traditional hospital admissions.

In order to ensure a smooth transition, home hospitalisation must be coordinated carefully with primary care providers.

5.2.3.- Clinical coordination of professionals and leadership

Having established the intervention model, it is essential to identify the kind of professionals who are best able to make decisions on activities on the basis of their academic background. This entails defining the kinds of competences needed to provide the best care service. The model should involve a new interdisciplinary work approach with a new way of taking decisions and thus new leadership. It will be necessary to establish the new context, plan the inclusion of new members and set up training. It will also be necessary to train all professionals in new skills, emotional and environmental training, a knowledge of the functions of other team members and changes in functions should this be necessary. Training should be carried out by the programme leader, the case nanagers or a person trained for the purpose.

5.2.4.- Information system and ITC

A comprehensive information system and ICT should be developed both for enabling decisions and for management and control. It should include data sharing for all involved, tools to ensure care processes and a dashboard for those in change of monitoring and management. It should include necessary devices and software to enable work and mobility. It should be designed by staff who are familiar with both social and healthcare information systems in the territory in question. Telecare technology should be exploited and may well be the principal tool for supporting and monitoring the person/caregiver at home. It is necessary to integrate the social and healthcare response in just one facility.

5.2.5.- Responsibilities and legal aspects

The organisational, business and governance model decided must be formalised amongst the bodies involved in the integration process, together with the pertinent legal documentation. In addition, it is important to ensure that the proposal complies with mercantile, data protection and labor law, and provides the appropriate solutions while complying with legal requirements.

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7.- Glossary

PSSD	Primary social services department
P-CC	Person-centred care
SC	Specialist care
CGE	Comprehensive geriatric evaluation
IC	Intermediate care
PC	Primary care
PHC	Primary healthcare centre
PHT	Primary healthcare team
SCST	Specialist community services teams
IT	Interdisciplinary team
CM	Case manager
CCM	Care continuity manager
HH	Home hospitalisation
CSMRC	Catalan shared medical records service
OC	Outpatient care
LS	Long stay
GMS	General medium stay
E-BP	Evidence-based practice
ISIP	Individual shared intervention plan
PWCN	Persons with complex needs
R	Rehabilitation
MES	Medical emergency services
IS	Information system
ICT	Information and communication technologies
OT	Occupational therapy
SW	Social worker
PCU	Primary care unit
A&E	Accident & Emergency
AGU	Acute geriatric unit

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