Desarrollo de Capacidades para Cuidados de Largo Plazo de Base Comunitaria

Capacity Building for Community Based Long Term Care

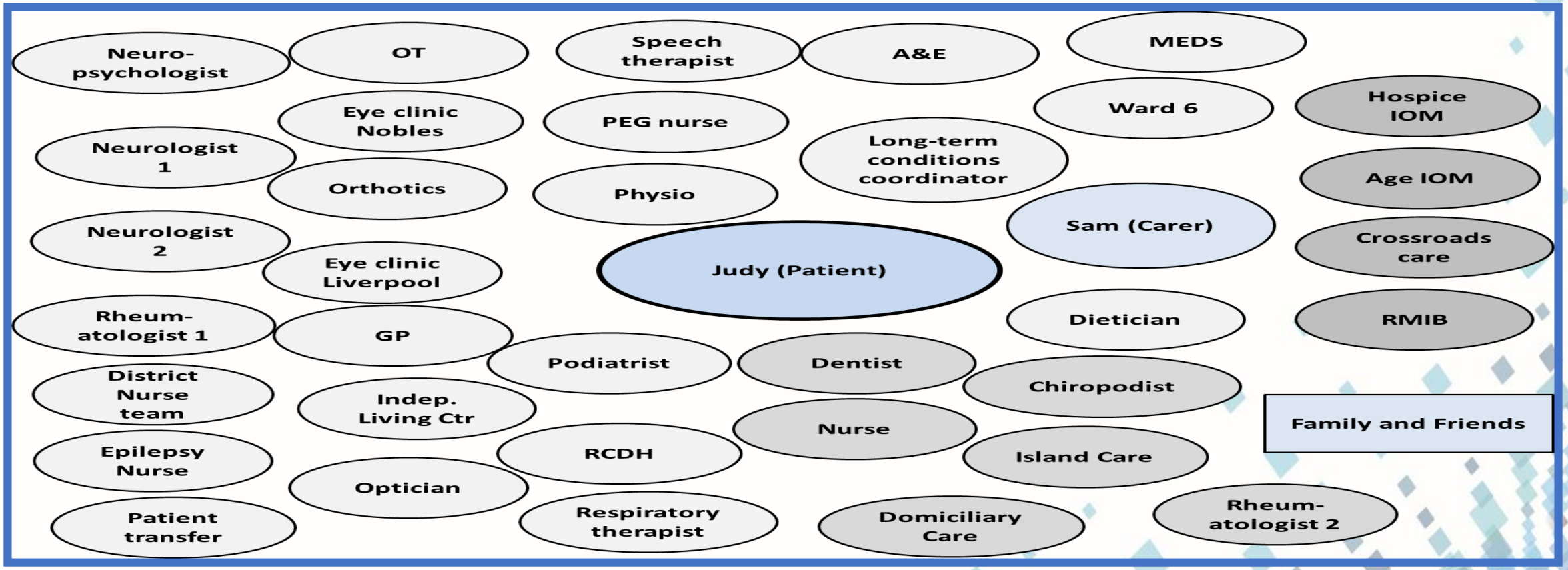
Systemic approach to long-term care

Professor Anne Hendry

Director, IFIC Scotland

International Foundation for Integrated Care

Why we need a Systemic Approach



Source: From Vision to Reality - Island Plan for Integrated Palliative and End of Life Care, Isle of Man

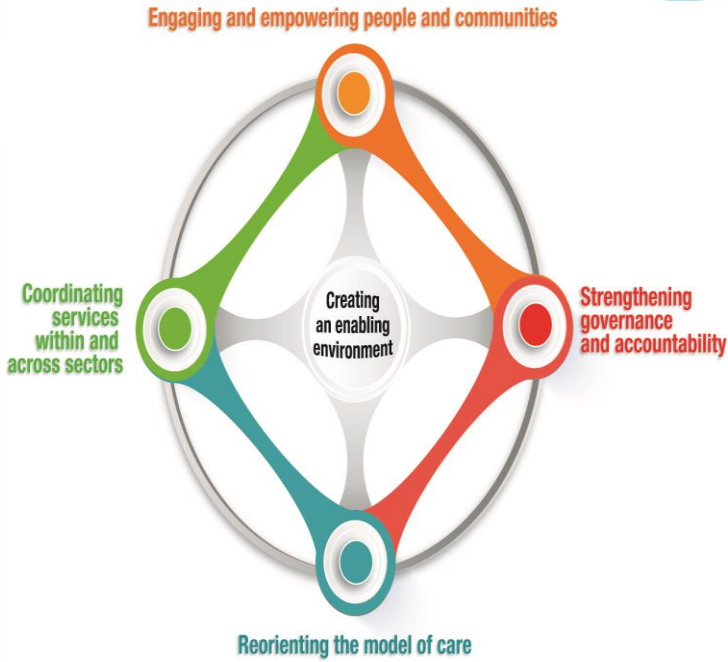
What Matters to Me

"My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes" **National Voices**

- Coordination and continuity of care
- Trusted relationships
- Accessible information and advice
- Good communication with, and between, staff

Health and Social Care Academy

WHO Global Framework for IPCHS



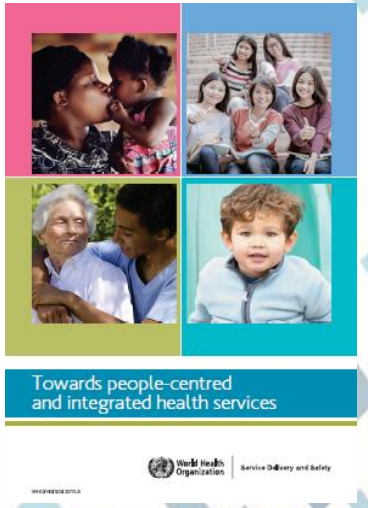
Engage and empower people and communities to take an active role in their health and health services.

Strengthen governance and accountability to build legitimacy, transparency and trust, and achieve results.

Reorient the model of care to ensure care at the right time, in the right place, and in the right way, while striving to keep people healthy and free of illness.

Strengthen coordination of care across providers, organizations, care settings and beyond the health sector to include social services and others.

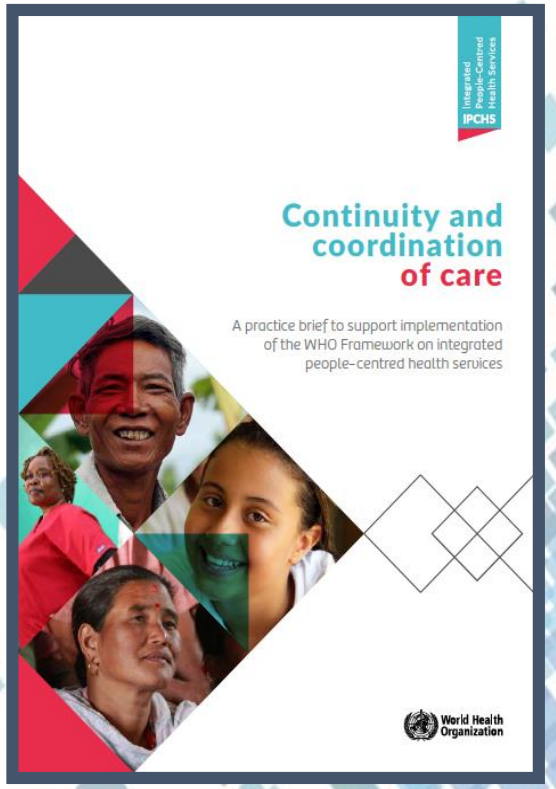
Create an enabling environment to facilitate transformational change through enhanced leadership and management, information systems, financial incentives and reorientation of the health care workforce.



http://www.who.int/servicedeliverysafety/areas/people-centred-care/advocacy-products/en/

Continuity and Coordination of Care: Eight Priorities

- Continuity with a (primary care or community care) professional.
- Care planning, shared decision-making and support for self management
- Case manager or navigator
- Co-located services, hub or a single point of access
- Rehabilitation, intermediate care and transitional care
- Comprehensive care along the entire pathway - including long term care and hospital care
- Information and digital technology support
- Interdisciplinary education / workforce development



http://www.who.int/servicedeliverysafety/areas/people-centred-care/advocacy-products/en/

Integrated Care for People with Frailty

www.advantageja.eu

- a single entry point – in community, generally in Primary Care
- simple screening tools in all settings
- comprehensive assessment and individualised care plans
- tailored interventions by interdisciplinary team – at home and in hospital
- case management and coordination across providers
- effective transitions across teams and care settings
- information sharing and technology enabled care
- policies and procedures for eligibility and care delivery

International Journal of Integrated Care, 2018; 18(2): 1, 1–4. DOI: https://doi.org/10.5334/ijic.4156

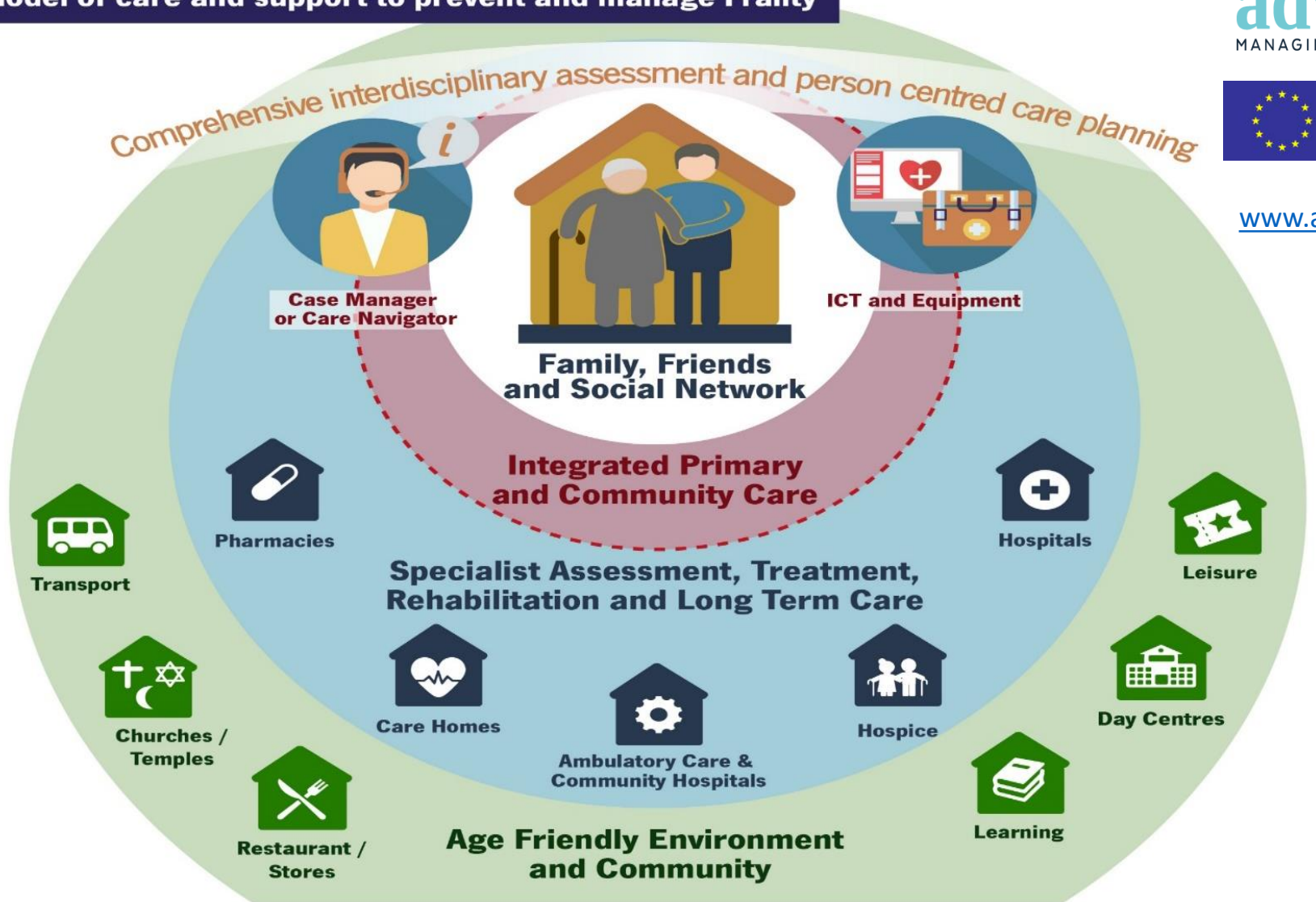
INSTITUTO NACIONAL DE GERIATRÍA | APEC | Organización Mundial de la Salud | Organización Panamericana de la Salud | RECITES Red Colaborativa de Investigación Traslacional para el Envejecimiento Saludable

advantAGE MANAGING FRAILTY

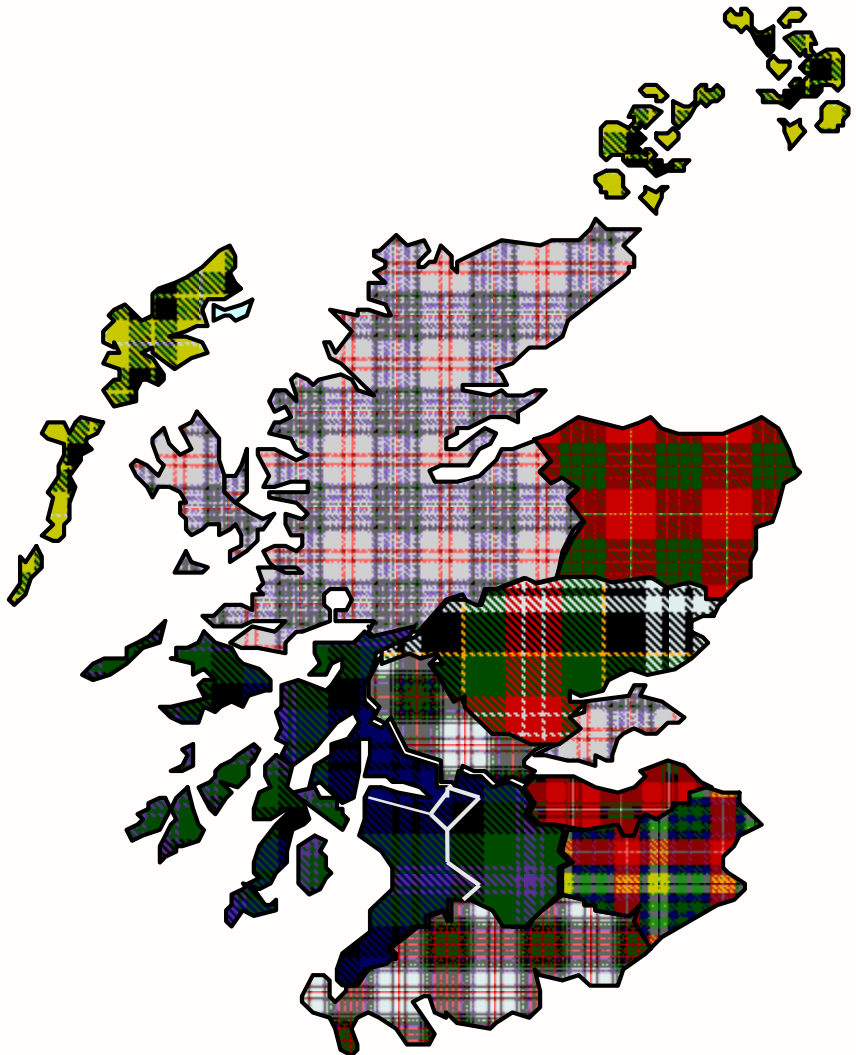
Co-funded by the Health Programme of the European Union

www.advantageja.eu

Integrated model of care and support to prevent and manage Frailty

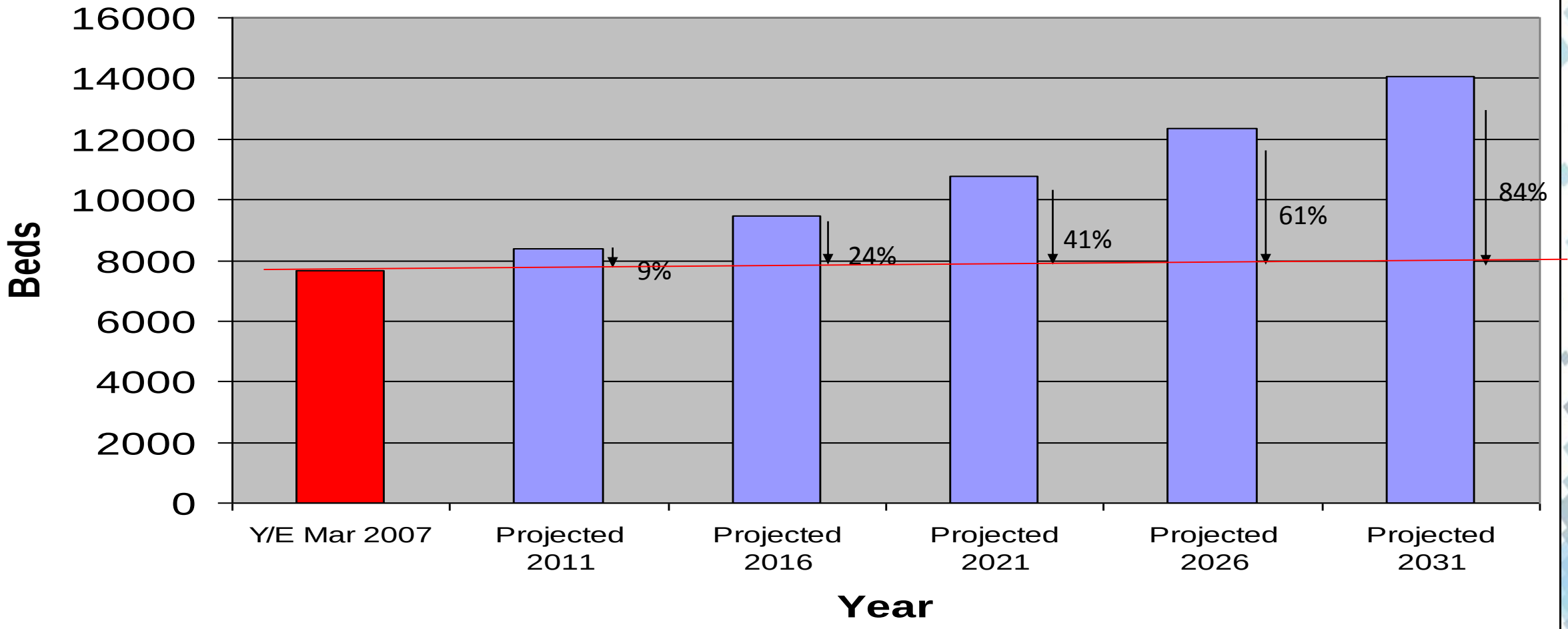


Scotland Case Study



- Population 5.4 million
- 19% age 65+
- National Health Service
- Universal coverage, no co-payments
- 14 Health Boards
- 32 Local Government Authorities
- Free personal care for age 65+
- Carer's Allowance
- 80% of social care provision is by voluntary and independent sectors, commissioned by public sector

Demographic change for population aged 65+ Scotland
Potential impact on emergency bed numbers 2007-2031



Calendar year '07 estimate

P Knight Scottish Government

Cross Government Collaboration

Minister for Local Government and Community Empowerment

"We want those who use health and social care services to get the best care and support, based on their own personal circumstances, and which is focused on what matters most to them."

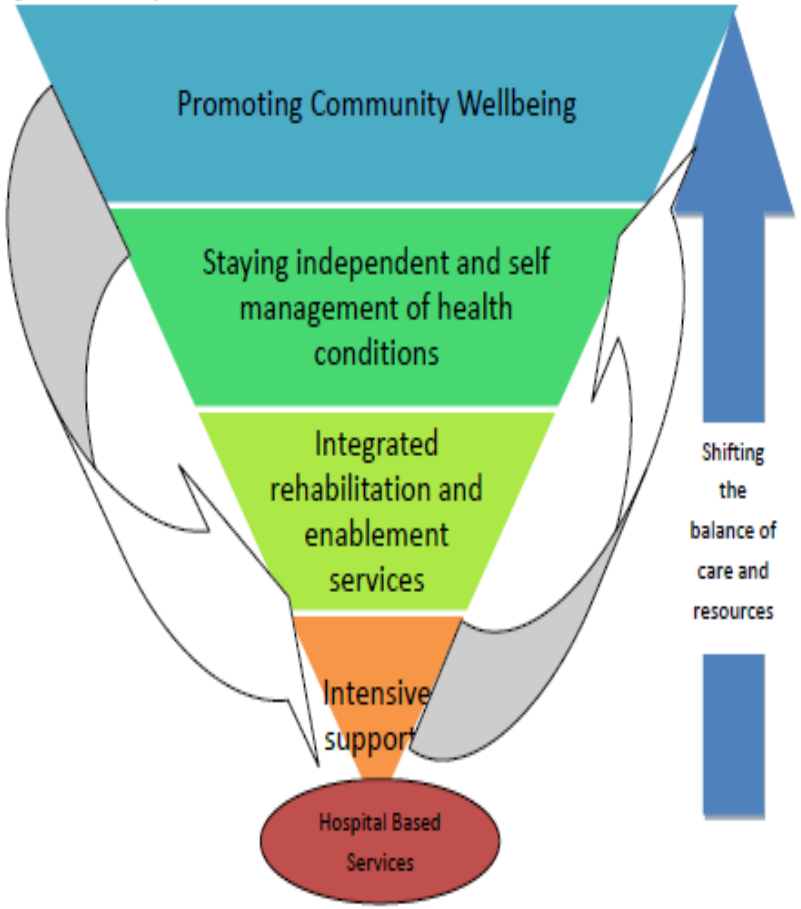
Cabinet Secretary for Health and Wellbeing

"In the next five years, let us ensure that Scotland is a person-centred country in the delivery of care and support to all citizens".

Cabinet Secretary for Finance, Constitution and Economy

Reshaping Care for Older People

Figure 2 Reshaping Care for Older People Model



- Ring-fenced £300 million as a Change Fund 2011-15
- Change Plans agreed by health, social care, housing, voluntary and independent sector partners
- 20% of funds invested in support for carers

INSTITUTO NACIONAL DE GERIATRÍA | APEC | Organización Mundial de la Salud | Organización Panamericana de la Salud | RECITES Red Colaborativa de Investigación Traslacional para el Envejecimiento Saludable

Reshaping Care for Older People

Preventative and anticipatory care

- Build social networks and opportunities for participation
- Early diagnosis of dementia
- Prevention of falls and fractures
- Information and support for self-management and self-directed support
- Prediction of risk of recurrent admissions
- Anticipatory care planning
- Suitable and varied housing and housing support
- Support for carers

Proactive care and Support at home

- Responsive, flexible, self-directed home care
- Integrated case/care management
- Carer support
- Rapid access to equipment
- Timely adaptations, including housing adaptations
- Telehealthcare

Effective care at times of transition

- Reablement and rehabilitation
- Specialist clinical advice for community teams
- NHS24, SAS and out-of-hours access ACPs
- Range of intermediate care alternatives to emergency admission
- Responsive and flexible palliative care
- Medicines management
- Access to range of housing options
- Support for carers

Hospital and care home(s)

- Urgent triage to identify frail older people
- Early assessment and rehab in the appropriate specialist unit
- Prevention and treatment of delirium
- Effective and timely discharge home or transfer to intermediate care
- Medicine reconciliation and reviews
- Specialist clinical support for care homes
- Carers as equal partners

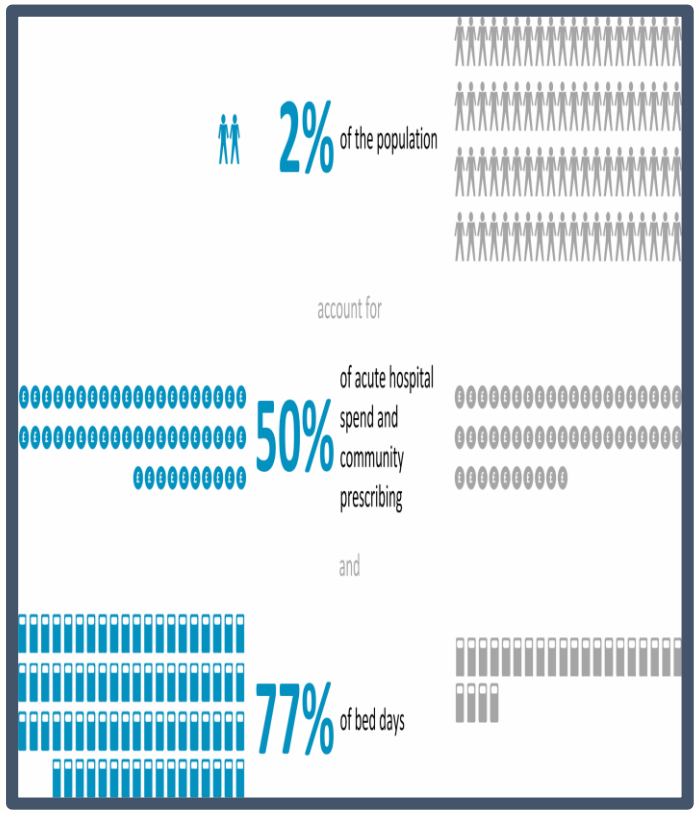
Enablers

Outcomes-focused assessment

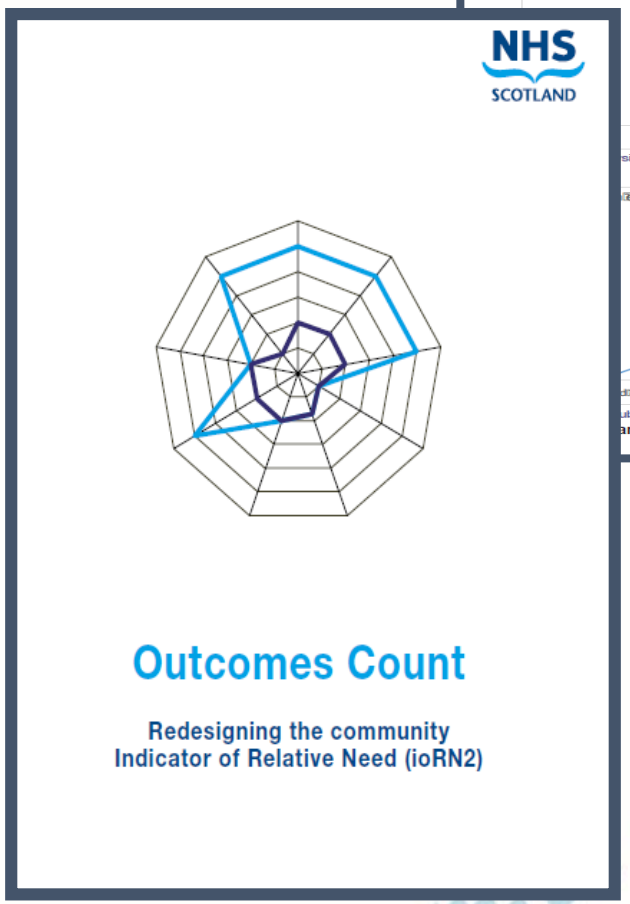
- Co-production
- Technology, eHealth and data-sharing
- Workforce development, skill mix and integrated working
- Organization development and improvement support
- Information and evaluation
- Commissioning and integration resource framework

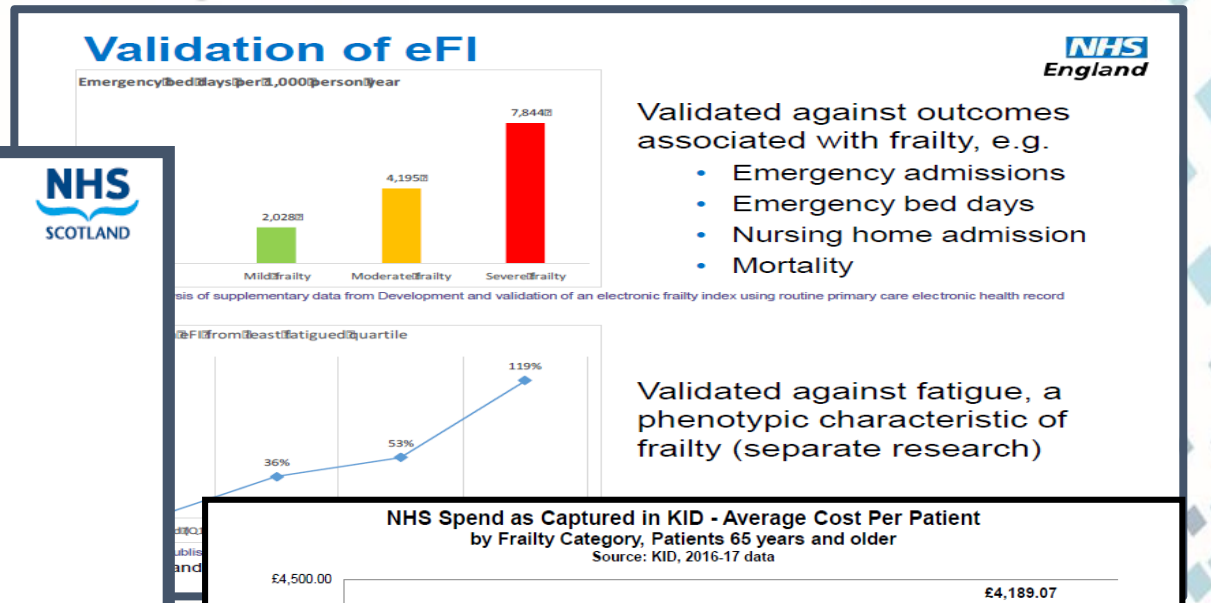
Longwood Publishing Corp. *Healthcare Quarterly* Vol.19 No.2 2016

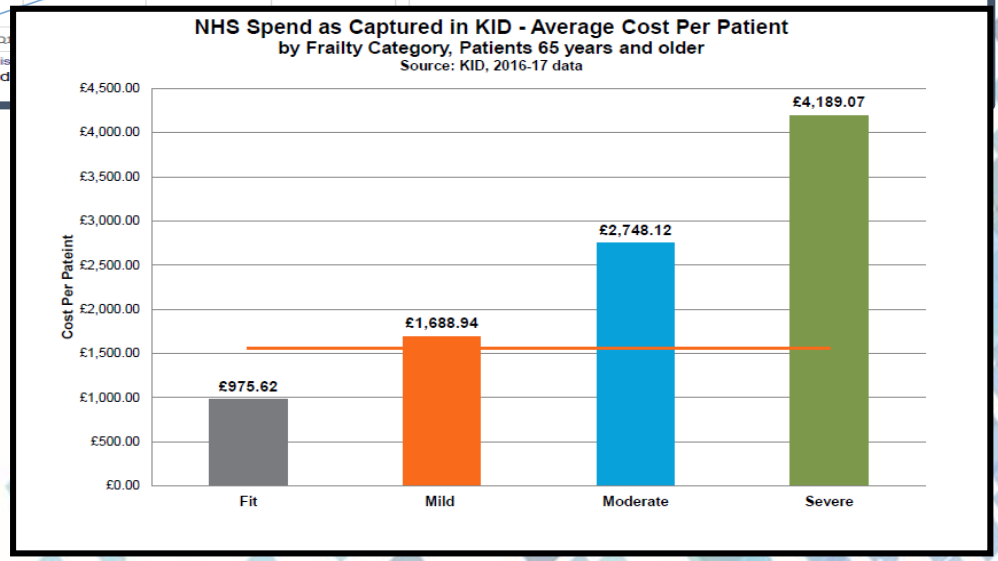
Stratify Risk, Dependency or Intensity of Need



Data provided by ISD.







Invest in Prevention and Early Intervention

Frailty is a progressive age-related decline in physiological systems that results in decreased reserves of intrinsic capacity, which confers extreme vulnerability to stressors and increases the risk of a range of adverse health outcomes (WHO 2015).

Robust	Pre-Frail or Frail	Functional Limitation	Disability	Dependency
Healthy life style advice	Technology enabled support for self management	Reablement support , telecare, ADL advice and support	Rehabilitation, equipment, housing, care and support	Care coordination, carer support, palliative and end of life care




INSTITUTO NACIONAL DE GERIATRÍA | APEC | Organización Mundial de la Salud | Organización Panamericana de la Salud | RECITES Red Colaborativa de Investigación Traslacional para el Envejecimiento Saludable

Build Community Capacity for Healthy Ageing

Scottish Older People's Assembly

Connected and Included: Action and support to foster spaces and places where older people can socialise, interact with others and be part of their community.

Living Independently and in a Warm Home including practical support to live well and high quality care packages

Access to suitable transport to support inclusion and access to the services needed

Well designed spaces and public services which meet the needs of older people - in practical terms but also a sense of worth while using them

Generations Working Together

Intergenerational approaches to improving health and wellbeing

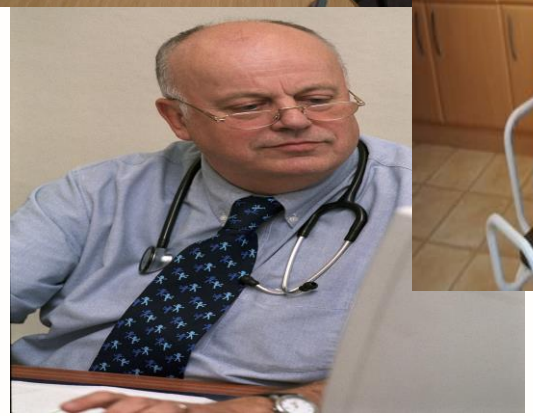
NHS Health Scotland

Invest in Intermediate Care and Falls Services

- **Transitional Care Services**
- **Rapid Response / Supported Discharge**
- **Reablement home care**
- **Step Up / Step Down community beds**
- **Hospital at Home outreach**




Interdisciplinary care and support at home or closer to home

Ayrshire and Arran's Integrated Health and Care System

Your community

Range of specialist support

GP Quality Clusters

Safeguarding and Protection

Multi Disciplinary Teams Children

Families

Hospital

Home

Acute Care

Carers

Regional Services

Primary Care

Locality Teams

Equipment & Adaptions And Resources

Technology Enabled Care

Primary Care
- GPs
- Pharmacy
- Opticians
- Dentists

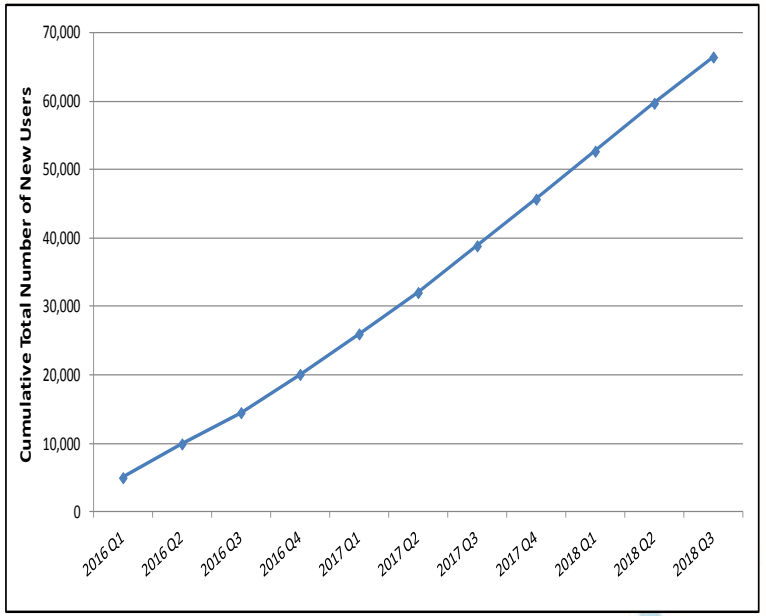
Locality Team
- District Nurses
- CPNs
- AHPs
- Pharmacists
- Community Connectors
- Social Workers
- Health Visitors
- Third sector services
- Care Homes

Specialist Support
- Complex Care Teams
- Mental Health
- Children's Services
- Learning Disability Services
- Child and Adolescent Mental Health Service

Exploit synergy with other policies

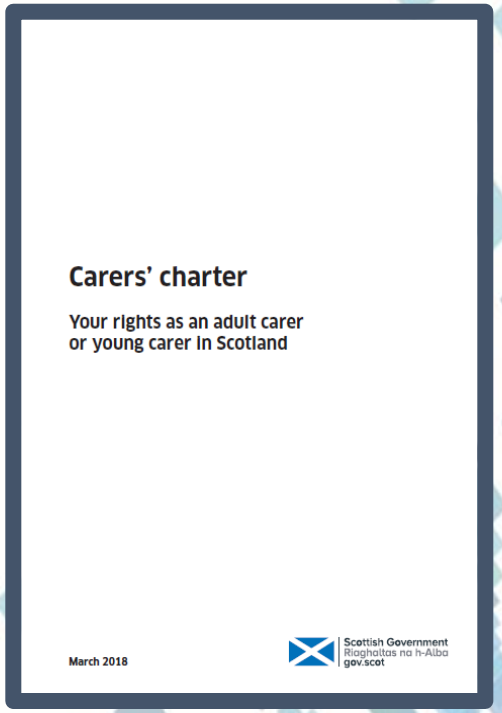
Dementia

Digital Technology

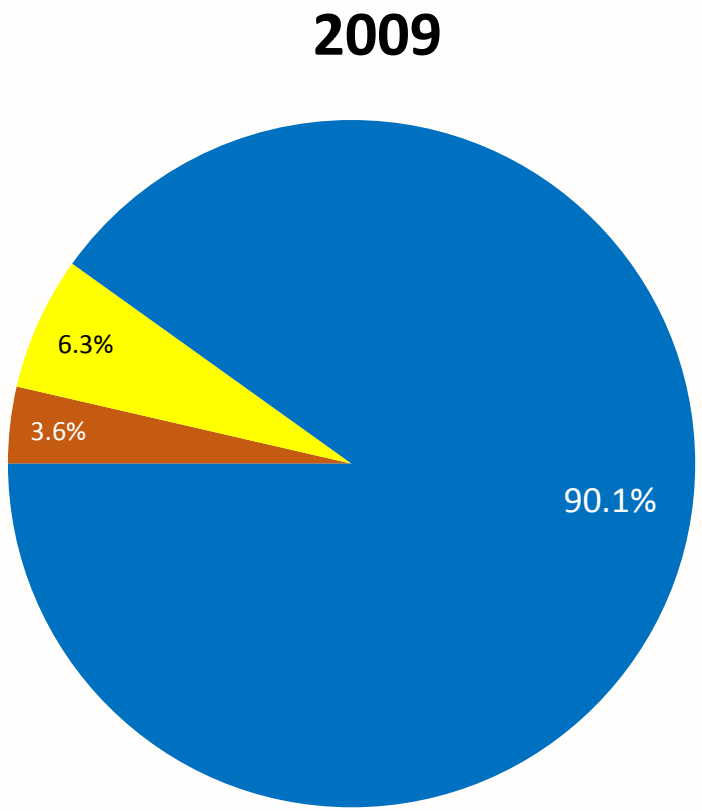


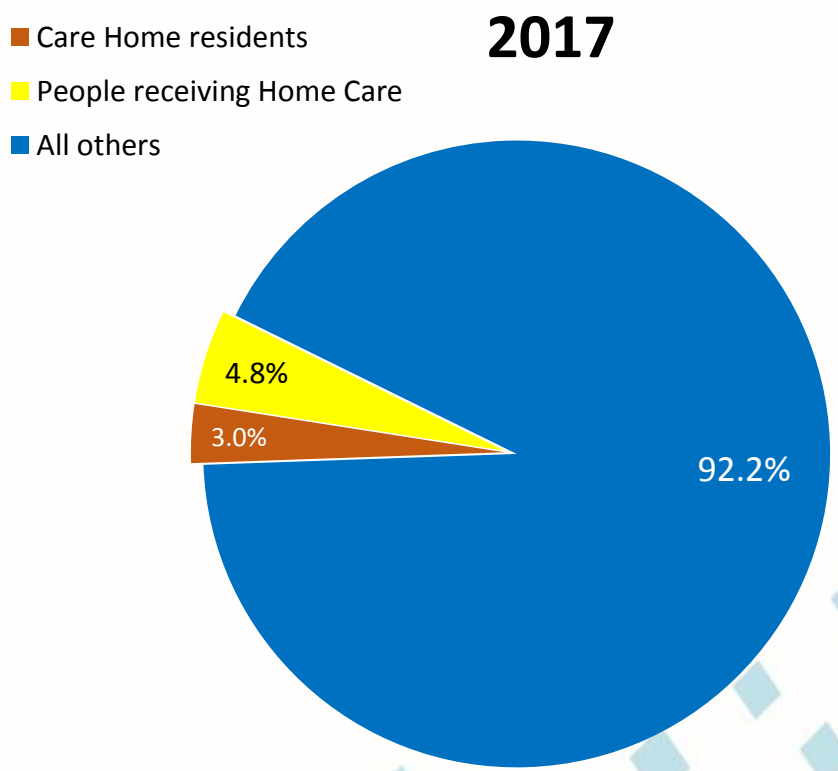
Cumulative increase in new Telecare users Jan 2016– Sep 2018.
Source ISD report Oct 2018

Carers



Reduction in proportion of older people in Scotland using formal social care services – excludes community alarams

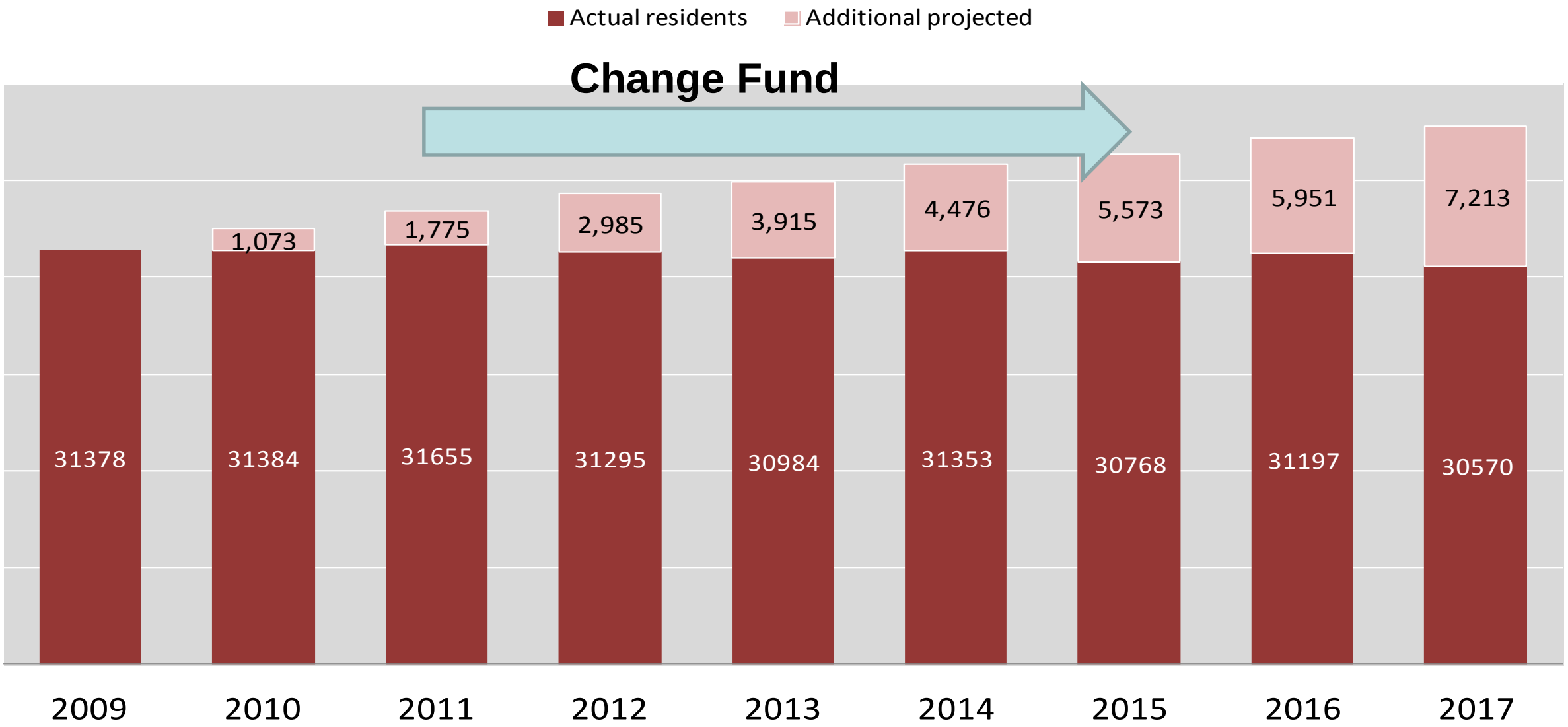




Data - Scottish Government & NRS
Chart by Peter Knight ISDScotland Sept 2018

Care Home residents aged 65+, Scotland

Comparison of actual vs projected (2009 base year)

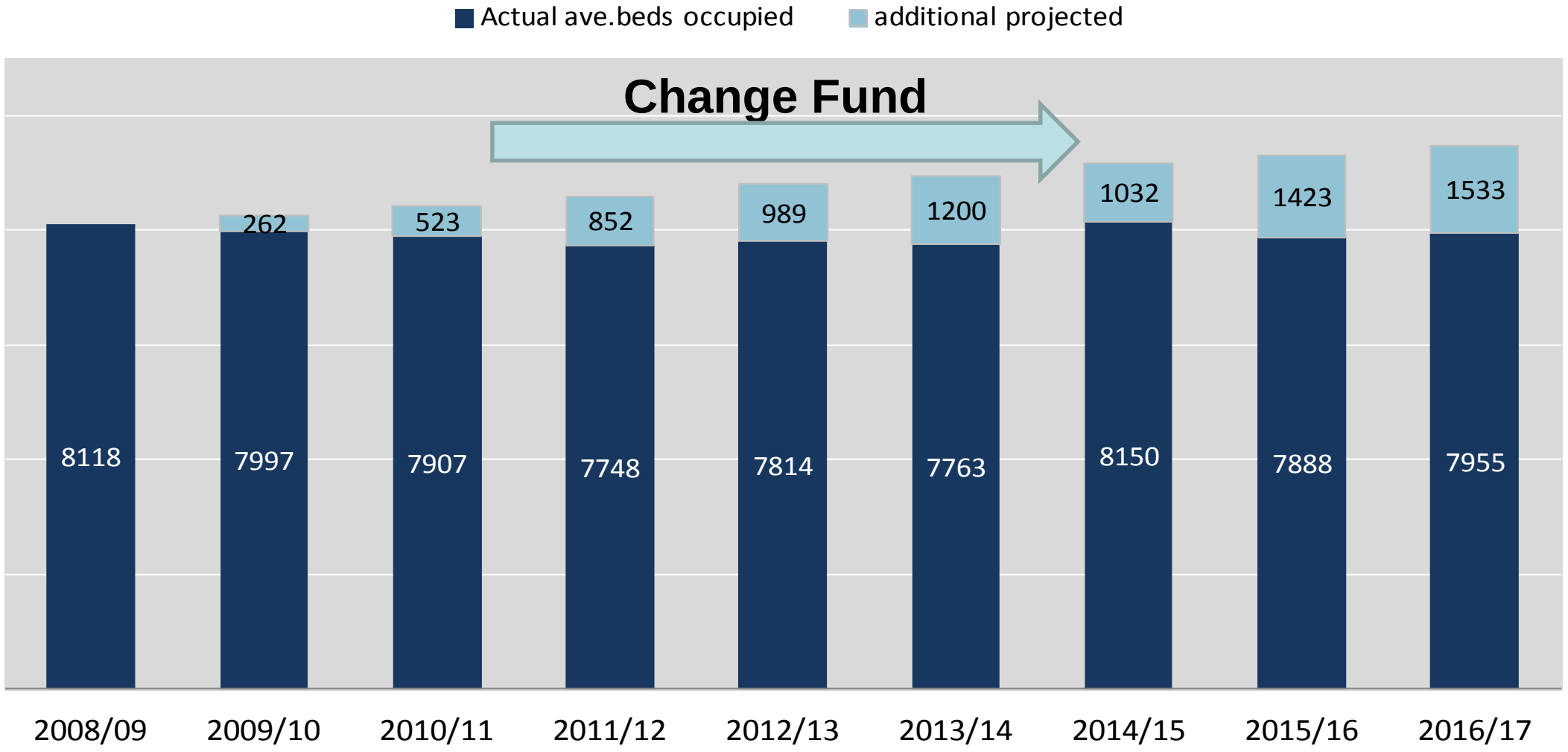


Data: Care Home Census, ISDScotland & NRS
Chart by Peter Knight ISDScotland Sept 2018

The Scottish Government

Hospital beds used for emergencies: people aged 65+, Scotland

Comparison of actual vs projected (2008/09 base year)



Data: ISDScotland & NRS
Chart by Peter Knight ISDScotland Sept 2018

The Scottish Government

Institutional Care Costs Avoided

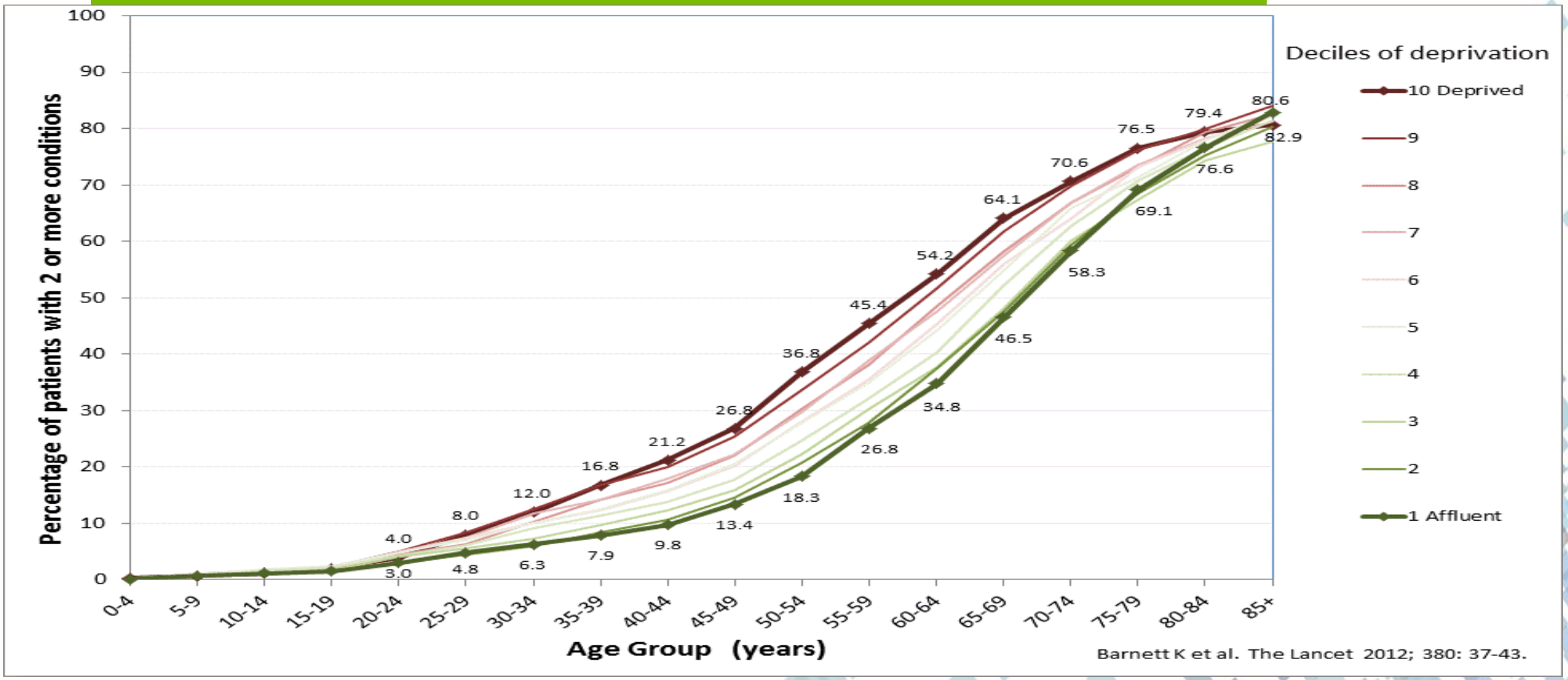
By 2016/17: 2 years after conclusion - Change Fund ROI @ 6:1

Older people spent around 3.2 million more days at home per annum than ‘expected’

Around £480 million per annum

institutional care costs avoided - releasing around £1.3 million per day to invest in support at home and community health and care services

People living in more deprived areas develop multiple conditions around 10 years before those living in the most affluent areas



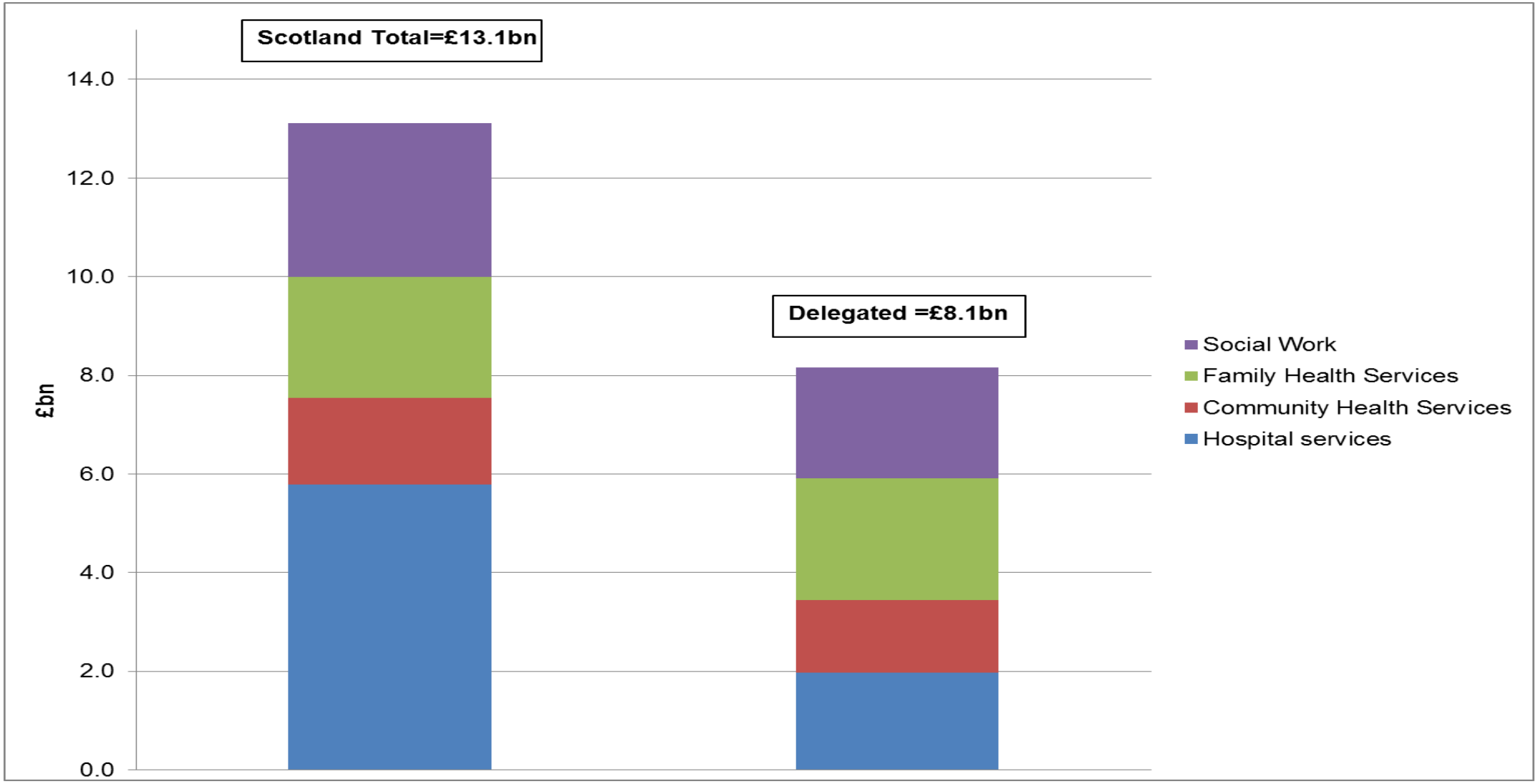
Legislation to Integrate Health and Social Care
Public Bodies(Joint Working) (Scotland) Act 2014

People are supported to live well at home or in the community for as much time as they can and have a positive experience of health and social care when they need it

- All adult care groups +/- children's services & criminal justice
- Principles for integrated health and social care
- Integrated governance : body corporate or lead agency
- Integrated budgets for health and social care
- Chief accountable officer has integrated oversight of delivery
- Nine national outcomes for health and wellbeing
- Strategic and locality planning based on population needs

The Scottish Government

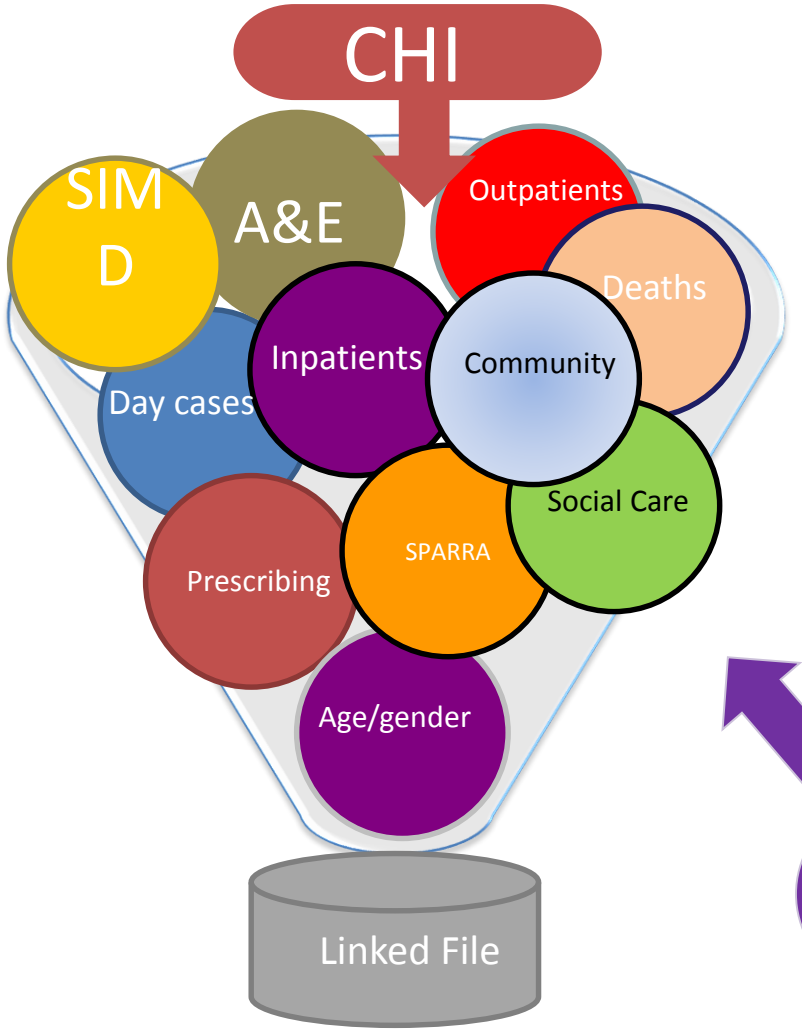
Integrated Health and Social Care Budget



Integrated Data

NHS National Services Scotland

Linked Health and Social care file at an individual service user level (Aggregated Activity & Costs)



Partnership Access Via secure platform

Intermediate Care

Hospitals @ Home

Housing and Homeless

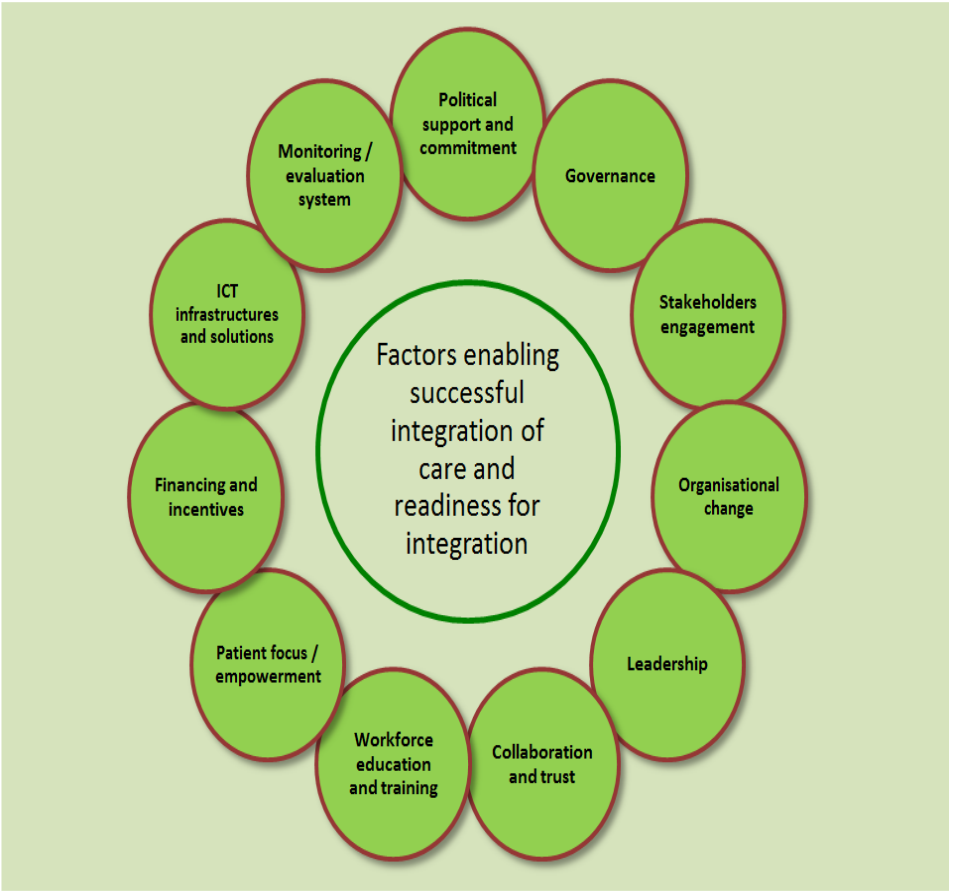
£

Integrated Regulation and Standards

- I experience high quality care and support that is right for me.
- I am fully involved in all decisions about my care and support.
- I have confidence in the people who support and care for me.
- I have confidence in the organisation providing my care and support.
- I experience a high quality environment if the organisation provides the premises.

Creating the Conditions

- Political will – cross party, cross government support
- Funding as a catalyst for change
- Disruptive innovation (social and technology)
- Investment in community capacity building
- Value and support carers as full partners
- Learning and improvement culture
- Professional leadership for interdisciplinary practice
- Legislation for integrated planning and budgets
- Contractual levers - primary care and pharmacy
- Focus on place, home, community and population health and wellbeing outcomes

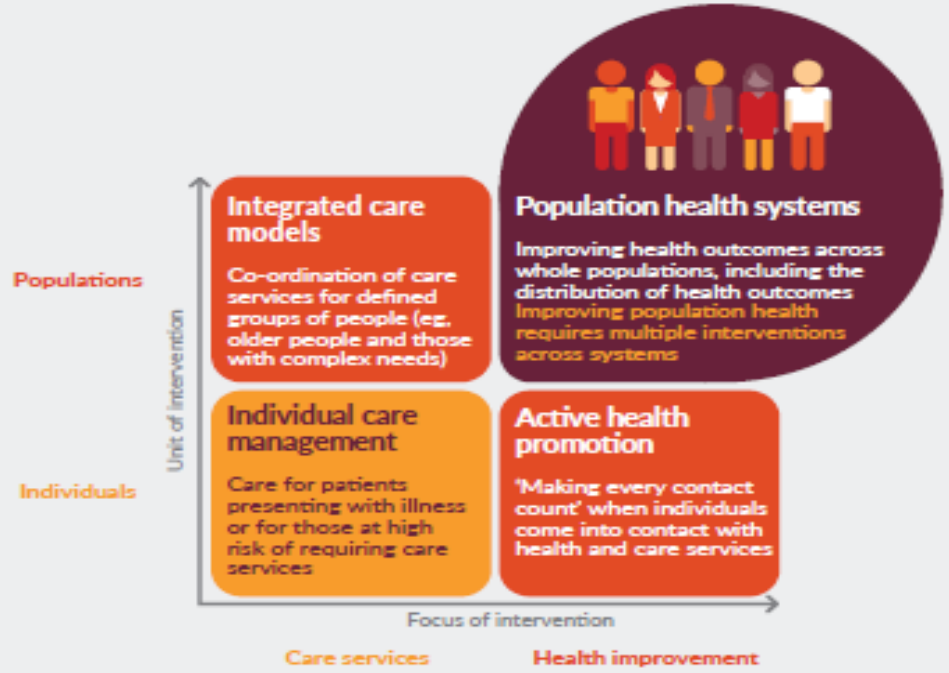


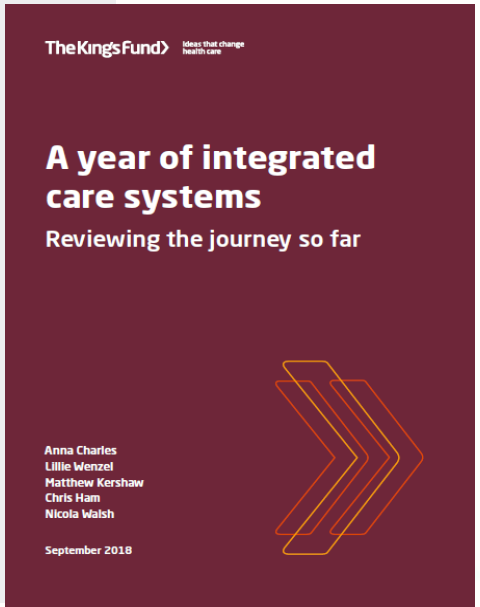
European Commission (2017). Blocks. Tools and Methodologies to Assess Integrated Care in Europe. Report by the Expert Group on Health Systems Performance Assessment.

Population Health and Wellbeing

Population health systems – going beyond integrated care

Most approaches to integrated care in England have focused on joining up services around individuals or around defined groups of people. These approaches have an important role in improving health and care, but we have argued that they must be part of a broader focus on the prevention of ill health and improving outcomes and reducing inequalities across whole populations. It is this wider focus that characterises what we have described as **population health systems** (*see Alderwick et al* 2015 for further detail).



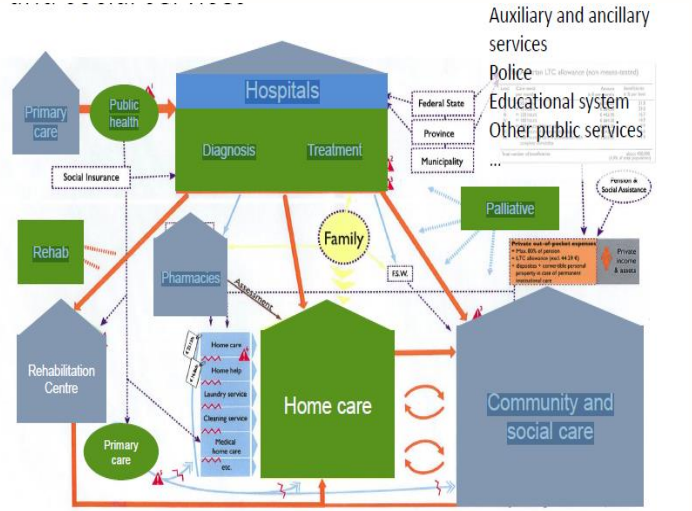


Social determinants of health

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.

From Structures to Networks and Partnerships

Hierarchy & Network: Two Structures, One Organisation, John Kotter https://www.youtube.com/watch?v=ZIGkUDhuUJc



Source: Pathways for long-term care provision in Austria, Project Interlinks, European Centre 2009

The King's Fund — Ideas that change health care

Canterbury District Health Board — Te Poari Hauora o Waitaha

Neighbourhood Care Models

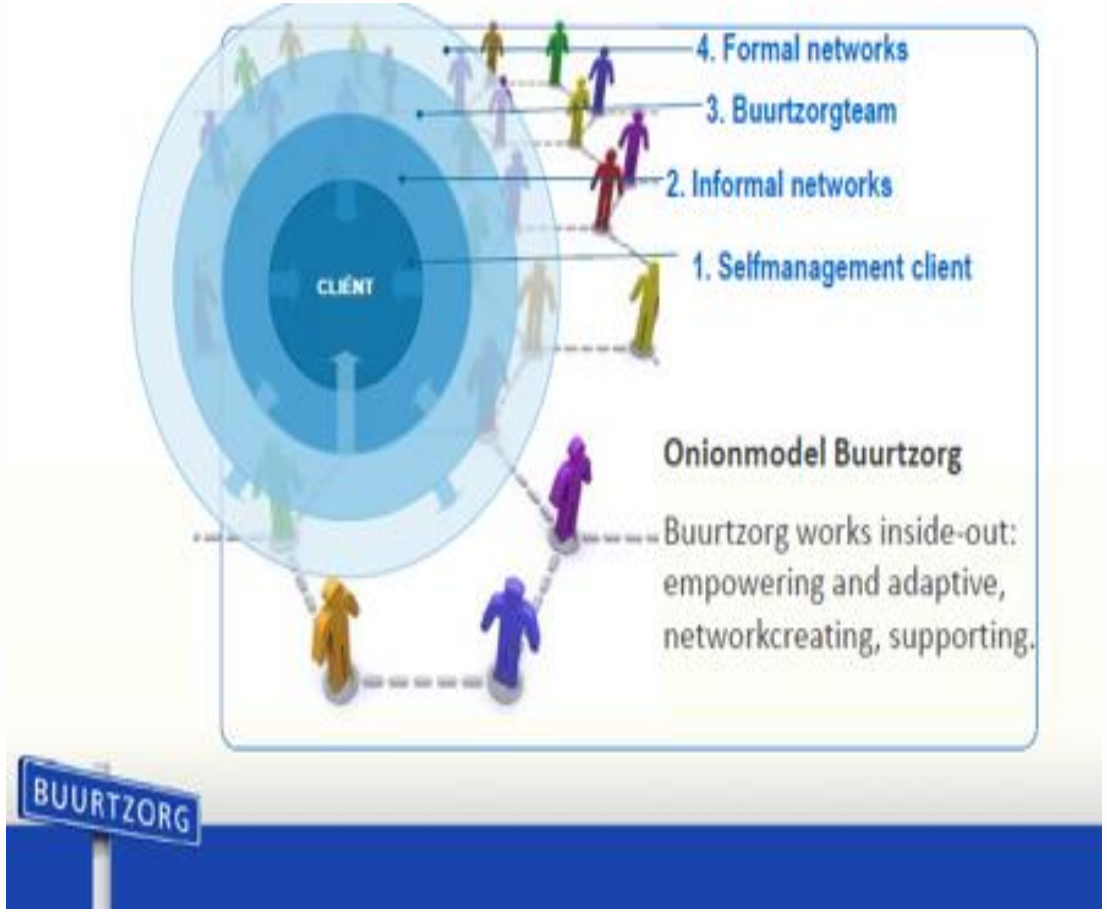


Image by Jos de Blok

Integrated Community Care:

TransForm Project

Case Studies 2018

https://transform-integratedcommunitycare.com/publications/case-studies-on-icc/

TRANSFORMANDO JUNTOS

LITORAL NORTE

‘’We know the family but the Community Health Agents go to the home and bond – there is trust.
They disseminate information, encourage, persuade, motivate and care.’’

Social development Secretariat

Transformation and Large Scale System Change

‘’a deliberate, planned process that sets out a high aspiration to make **dramatic and irreversible changes** to how care is delivered, what staff do (and how they behave) and the role of patients, that results in substantial, measurable improvement in outcomes, patient and staff satisfaction and financial sustainability.’’

- http://www.health.org.uk/publication/constructive-comfort-accelerating-change-nhs

https://www.england.nhs.uk/2017/09/practical-guide-for-large-scale-change-

Systems Leadership

- the authorising environment tolerates risk and accepts multiple paths to outcomes
- willingness to cede organisational goals for collective ambition
- positional authority is not the only source of legitimacy
- builds on local and place-based initiatives and networks
- relationships and influence allow challenge and difficult conversations
- challenge, conflict and ‘disturbing the system’ are integral

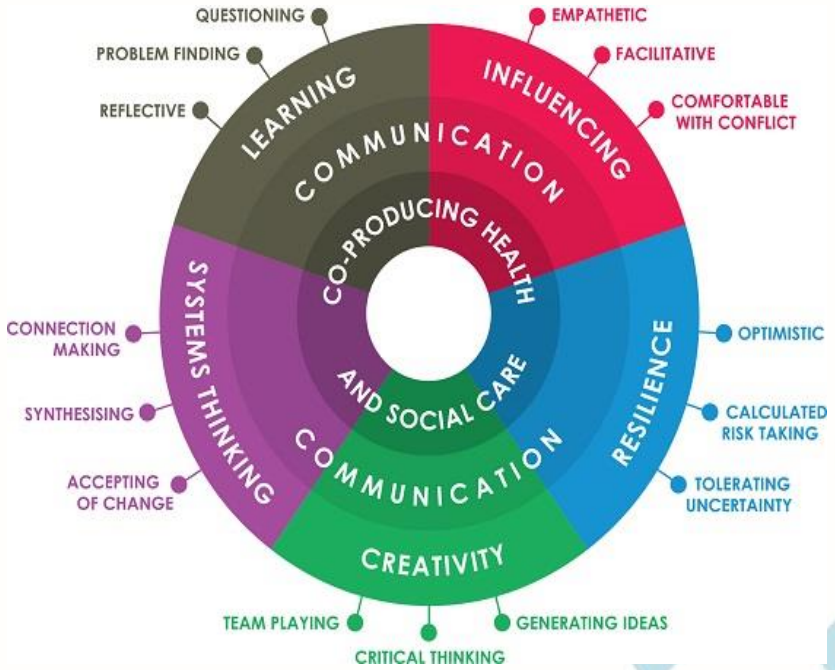
http://www.cevi.org.uk/docs/Systems_Leadership_Synthesis_Paper.pdf

Relationships and Trust

- **Trust**
  - Contracts can't anticipate and resolve every type of problem; each party needs a genuine belief in integrity of the other side
- **The 'right' personalities**
  - Avoid competitive relationships where people are possessive and defensive about their areas of responsibility
  - Need to share and openly address problems without fear of reprisal
- **Openness in communication**
  - High levels of communication between organisation, partnering team and individual
- **Organisational culture and organisational learning**
  - A shared culture enhances commitment and consistency of individual behaviours, aligns goals and promotes trust
- **Teambuilding**
  - Important for aligning the differing perspectives of participants and for building trust
- **Leadership and senior management**
  - Crucial for reinforcing partnering concept, countering arguments of detractors and nurturing partnering process

Workforce Development

NHS England, Skills for Health and Health Education England



Lucas and Nacer (2015)
https://www.health.org.uk/sites/default/files/TheHabitsOfAnImprover.pdf

New Roles and New Models of Care

MODELS OF HOME CARE (HC):

HC 1: Primary care (UBS) and Family Strategy teams supported by NASF (multiprofessional team) and specialized services as rehabilitation.
***this model is already financed by primary care policies.

HC 2 and 3: multiprofessional teams of home care services. Depends on: intensity/ frequency of visits, procedures and use of expensive technologies, palliative care and others. A caregiver is mandatory.

HC SERVICE FOR CITIES AT LEAST WITH 20.000 PEOPLE

30-60 PATIENTS EACH HC TEAM

SUBSTITUTIVE

DESINSTITUCIONALIZATION

VULNERABILITY AND CARE INTENSITY

LONG TERM CARE

POST ACUTE TERM CARE

PALLIATIVE CARE

COMPLEX PATIENTS

CAREGIVER

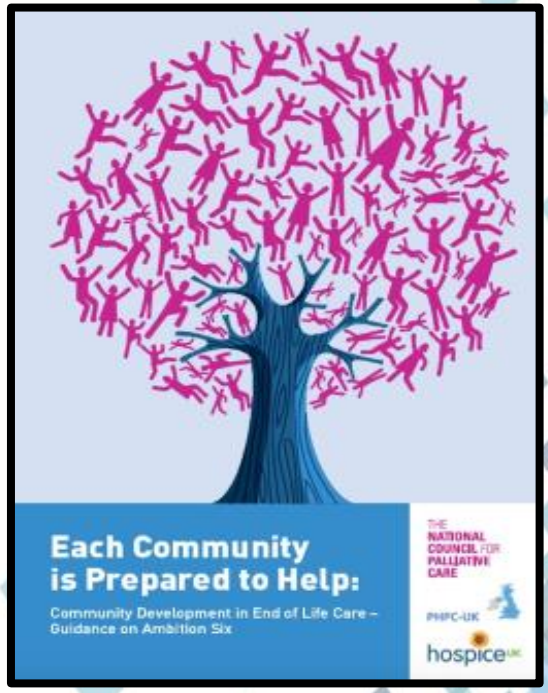
Interdisciplinary Team
Ilhabela, Sao Paulo

- 02 Médicos,
- 01 Enfermeira,
- 02 Técnicos de Enfermagem,
- 01 Fisioterapeuta,
- 01 Fonoaudióloga,
- 01 Nutricionista,
- 01 Psicóloga,
- 01 Assistente Social,
- 01 Dentista,
- 02 Auxiliares Administrativos,
- 01 Motorista.

Compassionate Communities

compassionate
INVERCLYDE

https://ardgowanhospice.org.uk/how-we-can-help/compassionate-inverclyde/



" A Compassionate community is a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in an emotional and practical ways"

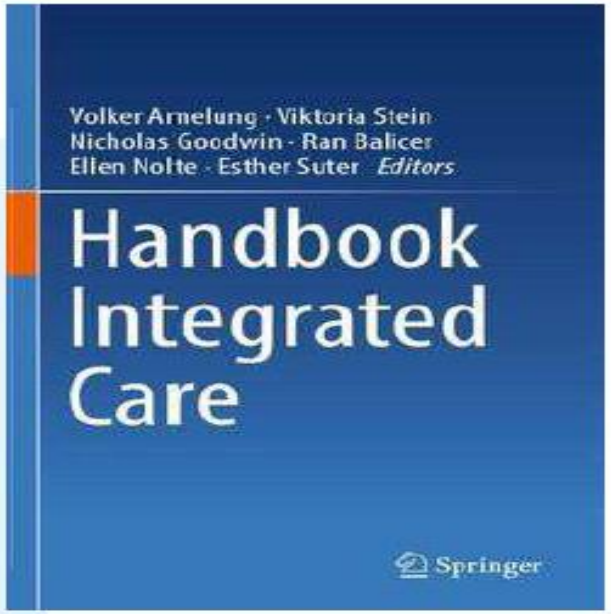
Decade of Healthy Ageing 2020-2030

- Develop age friendly communities
- Ensure person centred integrated care for older people
- Provide older people who need it access to long-term care within their communities

https://www.who.int/ageing/decade-of-healthy-ageing

Key Components of an Implementation Strategy

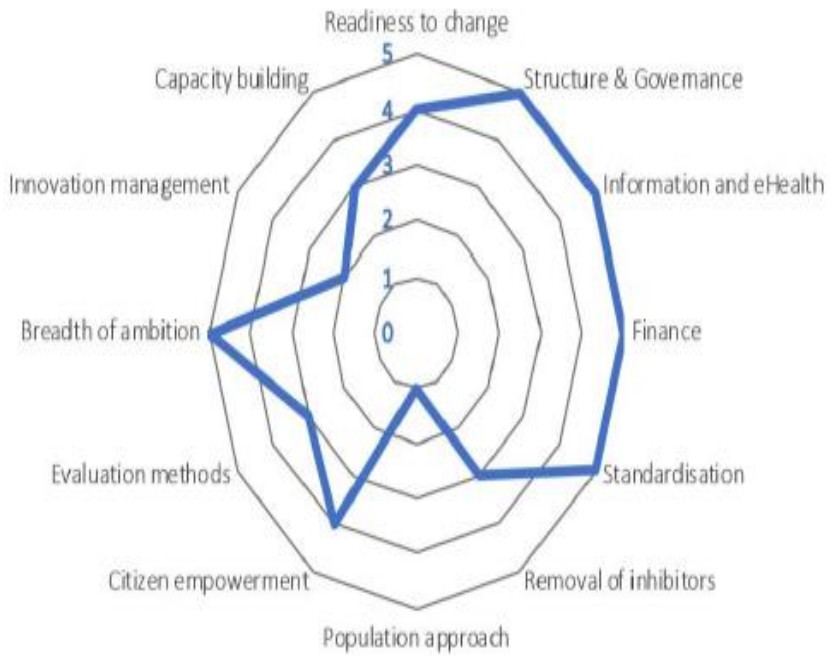
1. *Needs assessment*
2. *Situational analysis*
3. *Value case*
4. *Vision and mission statement*
5. *Strategic plan*
6. *Ensuring mutual gain*
7. *Communications strategy*
8. *Implementation and institutionalisation*
9. *Monitoring and evaluation: continuous quality improvement*



Goodwin N (2017) Change management. In Amelung V, Stein V, Goodwin N, Balicer R, Nolte E, Suter E (Eds) (2017) The Handbook of Integrated Care. Springer International Publishing, p.253-276

SCIROCCO – Scaling Integrated Care in Context
Self Assessment of Maturity

https://www.scirocco-project.eu/maturitymodel/



Integrated Care Performance Assessment (ICPA)
EU: CHAFEA 2018

Domain	Indicators
Advancement of integration	• Personalised plans • Shared care plans • Alignment of resources to population needs • Take-up of case management • Quality of case management • Take-up of multi-disciplinary training
Use of Care Services	• Home and/or community-based long-term services and support • Coordinated transitions across continuum of care • Medication review in patients receiving multiple and/or long term medication
Health outcomes	• Improved level of independence in patients with identified impairment • Patient reported outcomes measures (PROMS)
Patient experiences of care	• Level of met needs among people receiving care • Satisfaction with the level of social contact • Carers quality of life • Quality of life for people receiving care • Experience of case management • Inclusion of carers

- https://ec.europa.eu/health/systems_performance_assessment/key_documents_en

International Foundation for Integrated Care

IFIC is a non-profit members' network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.

International Journal of Integrated Care

Integrated Care Solutions©

Knowledge Centre

Integrated Care Academy©

IFIC HUBS

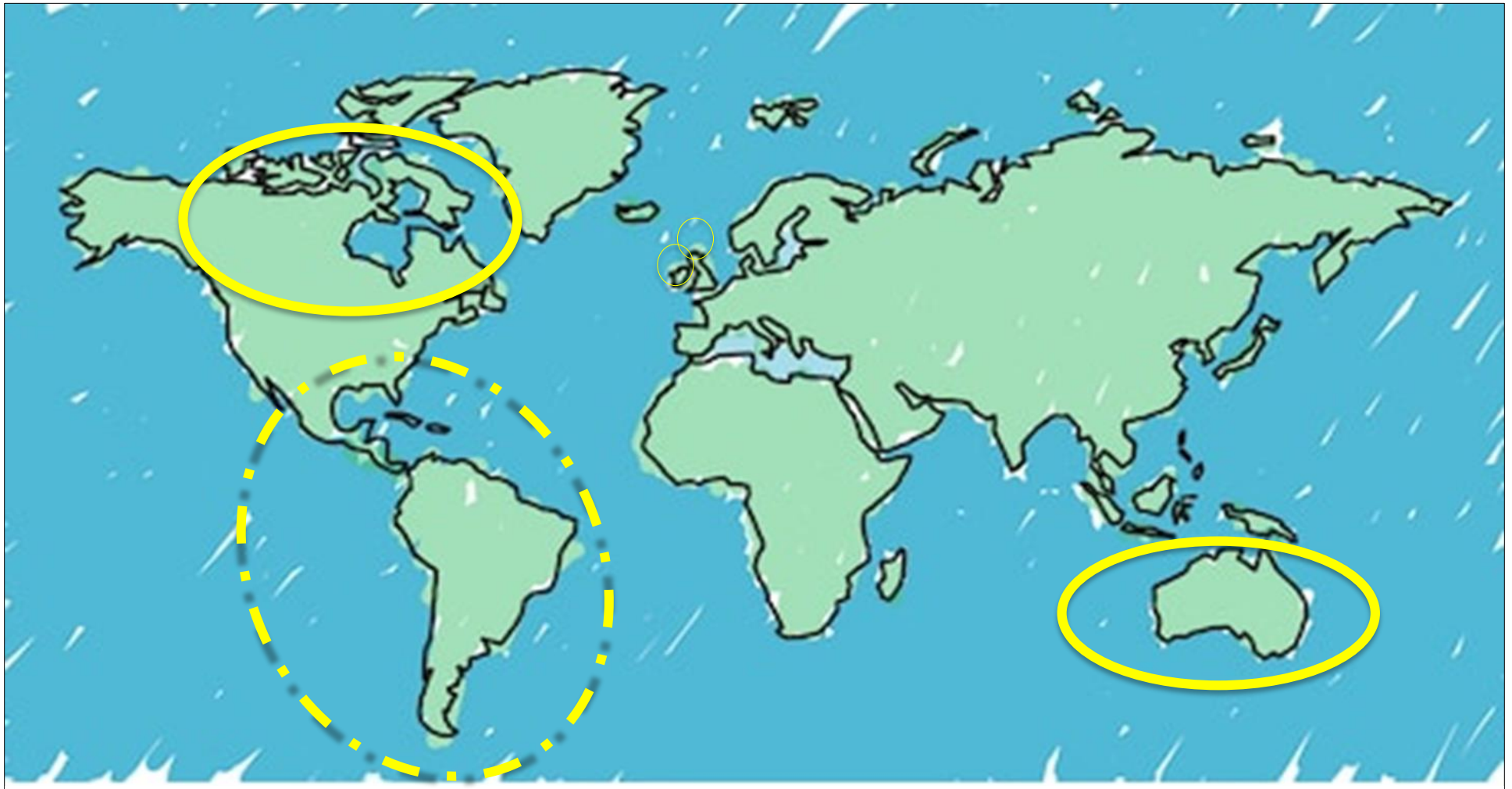
ERPIC

SIGs

Research & Development

Senior Associates

IFIC HUBs



IFIC AUSTRALIA | IFIC CANADA | IFIC IRLANDA | IFIC ESCOCIA | IFIC AMÉRICA-LATINA

Contexto, visión y objetivos de IFIC Latinoamérica

Contexto:

- La Agenda 2030, Declaración de Astana de Octubre de 2018 (OMS) y el reciente Informe de la Comisión de Alto Nivel "La salud universal en el siglo XXI: 40 años de Alma-Ata", presentado por la Organización Panamericana de la Salud.
- IFIC crecimiento y colaboración mundial para promover la atención integrada y centrada en la persona.

Visión:

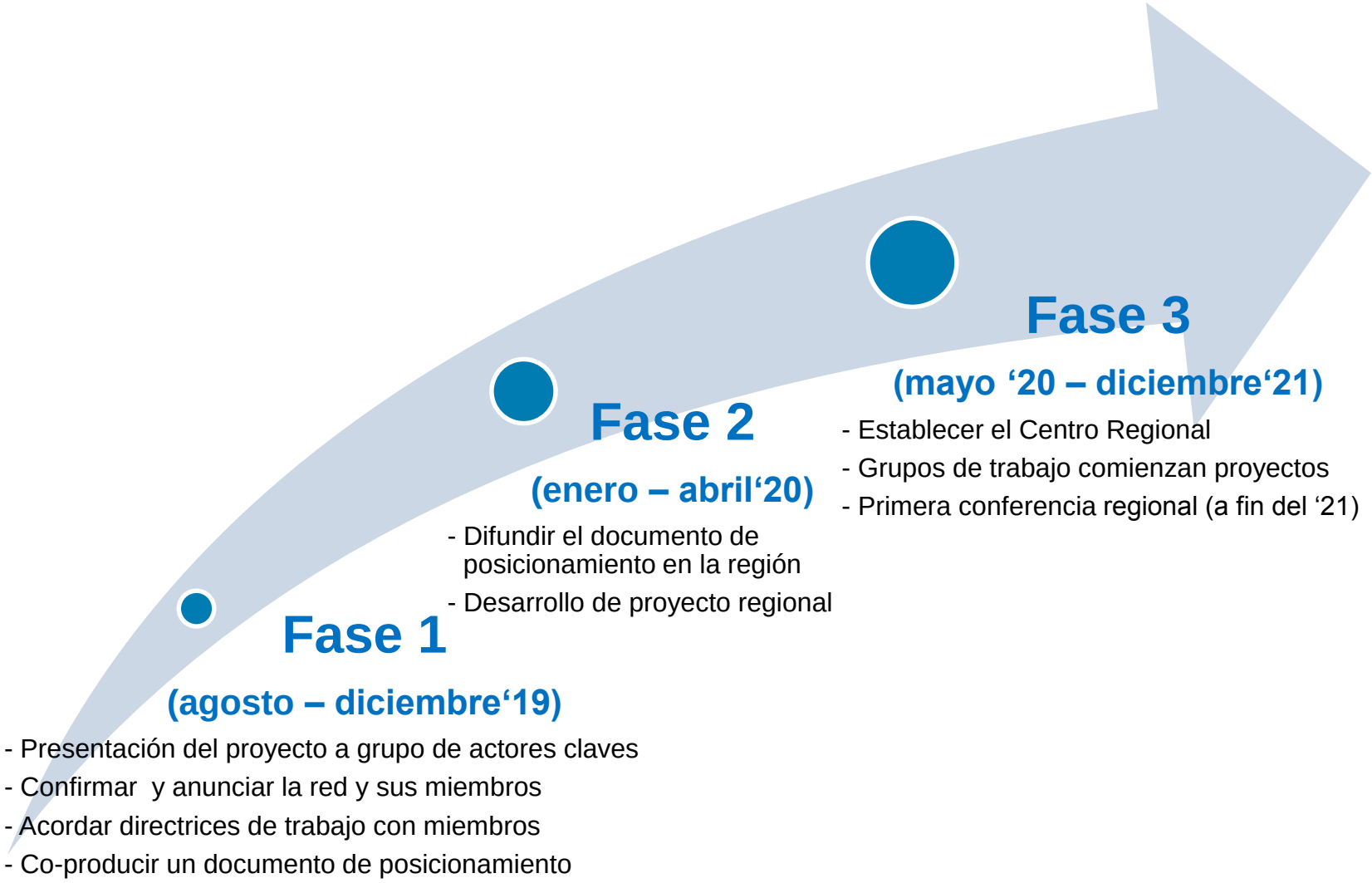
En el 2021, América Latina cuenta con un Centro Regional (en formato de red colaborativa) que lidera la agenda de la atención integrada y centrada en la persona en la región.

Objetivos:

- Reconocer y conectar actores clave, para contribuir al desarrollo de estrategias locales, nacionales y regionales mediante una plataforma compartida.
- Facilitar el intercambio de ideas y conocimientos entre los actores claves y apoyar la implementación de la atención integrada dentro y fuera de la región.
- Acordar con los actores clave las directrices de trabajo de la red y organizar una reunión regional a más tardar en el 2021.

Socios y fases de trabajo

- Hospital Italiano de Buenos Aires (ARG).
- Escuela de Salud Pública, Universidad de Costa Rica (CR).
- Universidad Austral de Chile (CHI).
- Asociación Colombiana de Salud Pública (COL).
- Asociación Interdisciplinaria de Atención Primaria de Salud (BOL).
- Universidad Autónoma Metropolitana (MEX)
- Instituto de Salud Pública, Universidad Veracruzana (MEX)
- Confederación Iberoamericana de Medicina Familiar.
- OPS/OMS.



International Foundation for Integrated Care

Gracias

Anne Hendry, IFIC Scotland Director, International Centre for Integrated Care
Anne.hendry@lanarkshire.scot.nhs.uk

Toni Dedeu, Director Ejecutivo , IFIC (UK) tonidedeu@integratedcarefoundation.org
Galileo Pérez-Hernández, Consejo Directivo, IFIC (MX) phgalileo@gmail.com +5215540412783