Community-Based Long-Term Care for Older People

Ester Gavaldà Espelta

Director of Primary Care at Terres de l'Ebre, Catalan Health Institute, Spain

Assumpta Eixarch Conesa

Head of Social Rights, Amposta City Council, Spain

AMPOSTA

INTEGRATED CARE MODEL

Generalitat de Catalunya

Institut Català de la Salut
Atenció Primària
Terres de l'Ebre

Ajuntament d'Amposta

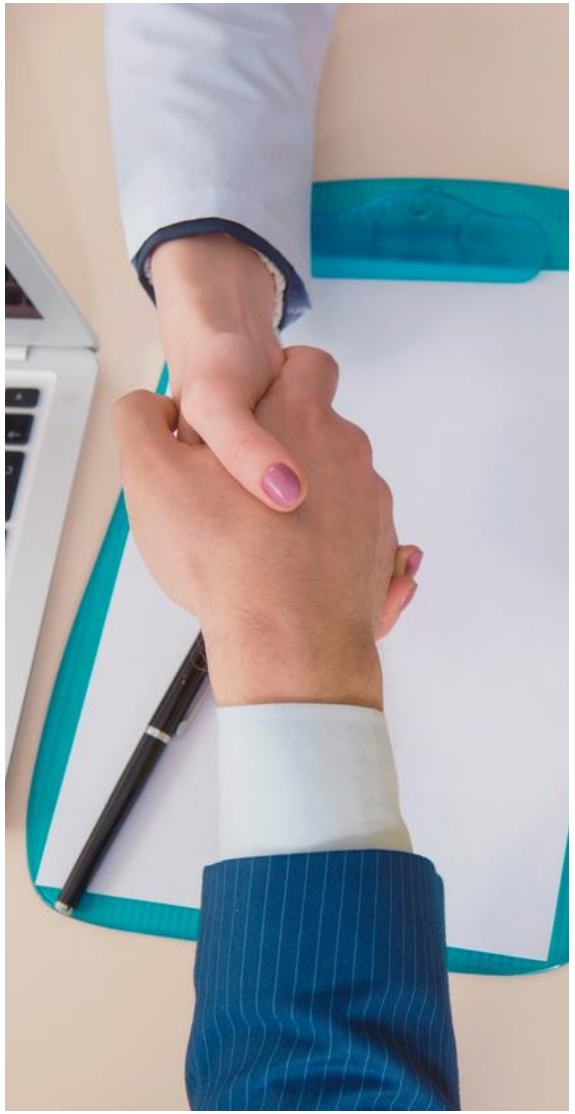
AMPOSTA

Population: 22,500 inhabitants

20,4% people **+64 years old**
4% people **+84 years old**

	Catalunya 2021	Amposta 2021
Ageing index	127,2	122,72
Overageing index	16,9	17,18

Amposta
Terres de l'Ebre



DUAL CASE MANAGEMENT MODEL

Lead and support professionals to follow the integrated care model

DRIVERS

CAP Case Manager

Primary Care Centre (CAP)

(Catalan Health Institute - ICS)

Catalan Government

Social Work Referent

Social Services Basic Area

(ABSS)

Amposta City Council

MAIN GOALS

GOAL 1

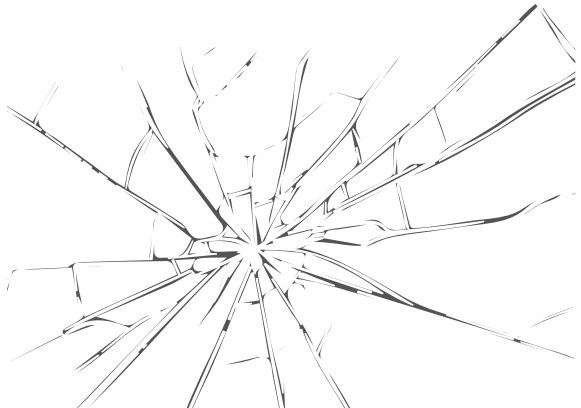
Respond to complex health and social needs that require an integrated care to mitigate the effects of the systems' fragmentation

GOAL 2

Promote coordination and networking from a community perspective

GOAL 3

Guarantee the quality of care for transitions to discharge in a joint way to assess the resources suitable for the person and the family



1 . VALUE PRACTICE

SALUT+SOCIAL

1. VALUE PRACTICE: SALUT + SOCIAL

Salut + Social experience is an integrated social and health home care programme with a community perspective

Aimed at people in situations of social and health complexity or at risk

Systemic vision

Lifelong learning

Peer-to-peer vision

Opportunity to see the two systems operative allowing us a peer-to-peer vision and, at the same time, to have a shared and real holistic vision at decision and responsibility level

Resource optimisation

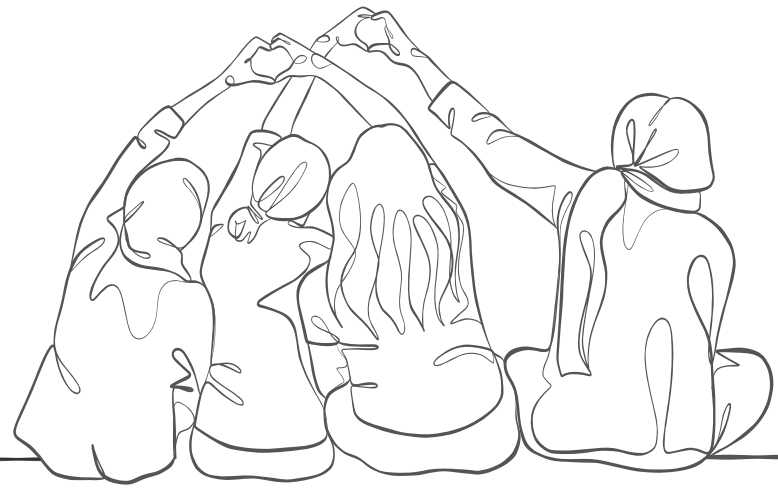
Care quality improvement

Common goal

Change in the work methodology allowing a common and shared care work plan, with the aim to provide a unique response to the needs of the person, the family and their environment

2. VALUE PRACTICE

ESCOLA DEL CUIDAR



2. VALUE PRACTICE: ESCOLA DEL CUIDAR

Training and mutual support experience, born from the desire to support informal carers who continuously care for people with cognitive impapairment or dementia and a certain degree of dependency.
Its main purpose is to provide the caregiver with the necessary skills to improve their quality of life and provide the tools that allow them to live the experience of caring positively.

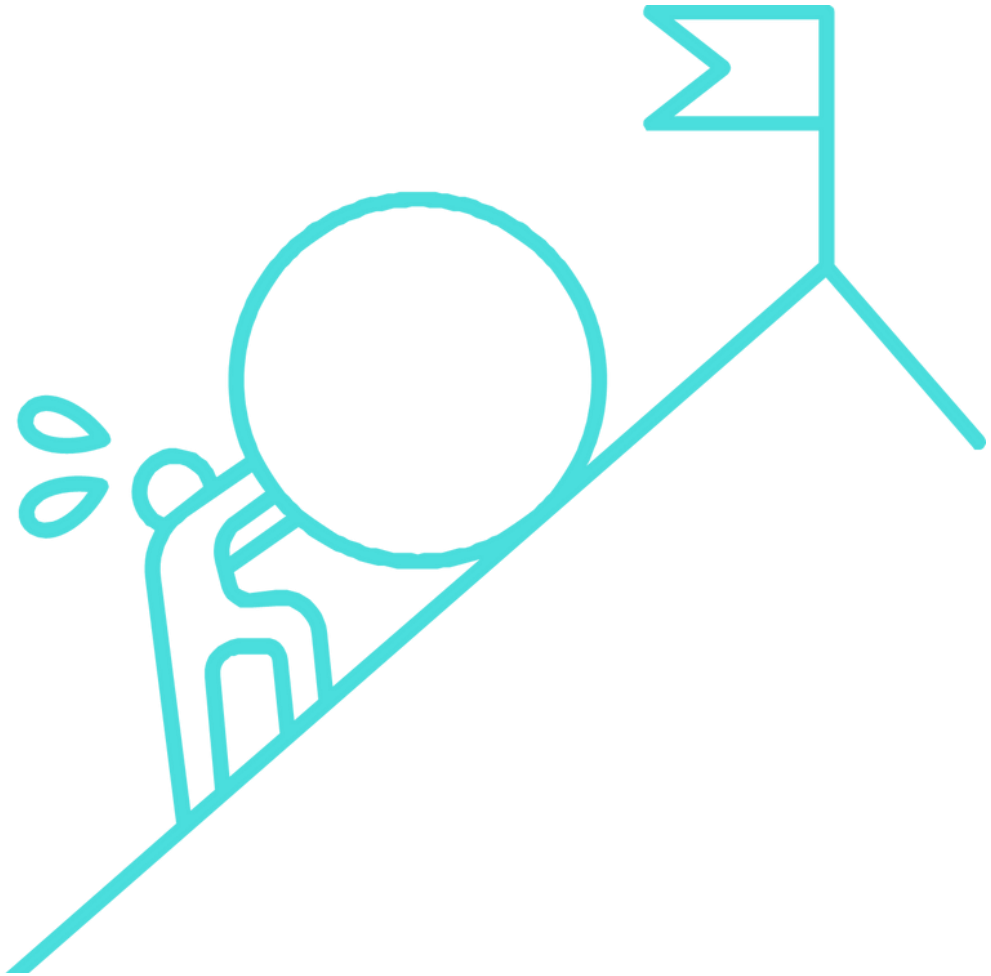
- Intervention design based on people's needs
- Shared work between health, basic social services and a third sector entity (Alzheimer's Patients Association)

- Core group interdisciplinarity: practitioner, social work, nurse, psychologist
- Incorporation of a post caregiver vision into the core group
- Expansion to the whole Catalan territory
- Social relations improvement and stregthening

RESULTS AND CONCLUSIONS

- Positive assessment by people served and professionals.
- Decrease of the overload feeling of caregivers and improvement of their emotional well-being.
- Fast and smooth communication between primary care and basic social services.
- Streamlining management with data sharing.
- Development of shared care plans, with the consequent improvement in attention and the optimization of resources.
- Increased adequacy of resources, reducing the use of emergency rooms and hospital admissions.
- Individualised response to the care needs of the person in a situation of social and health complexity.

Challenge



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Questions for Discussion

1. Turn to your neighbour(s) and discuss (10 min)
2. Share the outcomes with the group (20 min)

1. Are you **involved** in the delivery/development of community care older people?

2. Could you share your **experience**? What **works well**?

3. How can we make community care for colder people a **success**? What can other organisations **learn** from you?

4. Bonus: What is needed in terms of **workforce** development to make the transition to community care happen?

Rapporteur: Kelly Hall Reader in Social Policy University of Birmingham, United Kingdom