

# DISCOVER THE SUSTAIN SITES

## OSONA Catalonia, Spain

### DESCRIPTION

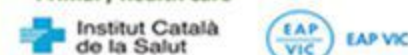
- Osona Program for chronic, advanced and geriatric care is a hospital-based integrated care programme where different care levels are coordinated: primary, acute, intermediate and long-term care)
- Proactive primary and intermediate care initiative with a focus on older persons living at home, above 75 years, with complex health and social needs, who live in Vic city or in surrounding rural towns
- Social care is provided from the different care levels and is well articulated with the social services provided by local councils
- Osona health care professionals have been using the individualised care planning tool since it was established in 2015. However these intervention plans were usually written only by general practitioners and nurses without the participation of specialists, who were not accessible to social workers from the local councils, and did not involve users and carers

### PROJECT: PIIC PLUS

- Elaborating an expanded Care Plan document – PIIC Plus - allowing multidimensional assessment of needs
- Creating a Manual on how to transfer the content of the *PIIC Plus* into the electronic health records of each user
- Consolidating the case conference: a formal, planned and structured interdisciplinary meeting involving relevant professionals for each user with complex social and health needs
- Consolidating meetings of the care team with users and carers to present, discuss and validate draft care plans resulting from the case conference.
- Training the staff that participate in the new care planning approach, emphasizing dimensions such as shared decision making and person-centredness

#### Institutions involved

##### ✓ Primary health care



##### ✓ Local social services, including home help to 65+ users



##### ✓ Intermediate, long term and acute health care



\*PIIC Individualised Care Plans already existed as care plans with a 3d format, it was created by the Interdepartmental Plan for Health and Social Care and Innovation (PIHIS) with the purpose of sharing information with health professionals from different care level settings in Catalonia. PIIC is part of the Electronic Medical Record of the user.  
\*\*PIIC plus improved PIIC including patient-centred information taken from the full care plan, developed as a result of the case-conferencing session and the follow-up interviews with the user (and carer), it is part of the Electronic Medical Record of the user.

### LESSONS LEARNT

- The case conference is a platform where all relevant care professionals can represent and express user's wishes, expectations and needs to the rest of the health and social team involved in their care. This is a key element in the multidimensional assessment of needs undertaken by the care team.
- The importance of social and health sector professionals working together to co-decide the most appropriate care solution for each user, by combining resources from the social and the health charters of services. Participation of case-relevant professionals in the care planning increases co-responsibility concerning how each user is cared for.
- The new approach promoting user participation (from consent to validation of the care plan) stressed the relevance of communication as a working tool and the need to enhance skills for advance care planning

### FUTURE IMPROVEMENTS

- Need to increase resources (human, time, financial) and to improve commitment from institutions at a local/regional level.
  - Otherwise, the continuity of integrated care as a working method remains fragile
  - Incompatible timetables of professionals sometimes meant working extra hours or delegating workloads to other colleagues
- Need to create an integrated IT system between health and social records.
  - Difficulties for sharing documents such as care plans
- Need to expand professional's knowledge on integrated care and improve communication skills with users and carers

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