

CONFERENCE ABSTRACT

Care at home for elderly – lessons learnt from the Swiss Red Cross “Integrated Home Care” in Eastern Europe/CIS

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

Christine Rutschmann

Swiss Red Cross, Switzerland

Introduction: The Swiss Red Cross (SRC) is supporting local partners in Eastern Europe/CIS in developing services to allow elderly a dignified ageing in their homes. SRC promotes integrated medico-social home care services in agreement with the local partners, their strategies and capacities. “Help to self-help” is crucial besides the provision of good quality low cost services, accessible for people in need. In many post-Soviet countries, cooperation between Health and Social Ministries is rather weak. Access to health/social care services is a challenge for older people due to low pensions, lack of transportation means and low self-mobility. At policy level, the SRC facilitates the collaboration between health/social care policy makers and fosters exchange with advisory boards or working groups. At practical level, the SRC links medical and social care workers and puts a model of nurse-led care into practise.

Objectives:

- Strengthening health care systems and enabling access for all,
- Engaging in advocacy for health and social inclusion,
- creation of workplaces for nurses and new profession of home-helpers/care assistants

Results: In all six SRC partner countries, SRC and partners gathered their experiences:

The health and social needs and type of services to be provided needs to be confirmed by in depth surveys/assessments and to be demand-driven, with user- and provider integration.

In all five countries, approx. 12'000 elderly, chronically ill persons are cared for by 60 home care centers[1] and authorities (local, national) are co-funding.

The existing legal framework is an important factor when considering sustainability issues.

Integrated medico-social home care services are nurse-led/managed services in close cooperation with General Practitioners and stationary public services. Many countries accept only medical doctor led services for reimbursement. Promoting nurse-led services requires a shift of paradigm and changes in legislative frameworks. This requires evidence based advocacy to withstand the strong doctor's lobby.

The continuous training of home care staff is crucial, particularly in quality of care, in dementia and palliative care issues. Countries lack legislation, regulations and guidelines in how to care for such persons. Home care staff often are the only persons taking care of patients, living alone, with dementia or being terminally ill.

In 2013, the SRC and partners established their knowledge management group with all six partner countries. The aim was to analyse different home care models and define core areas for cooperation. To learn from each other bears many advantages. Successes in one country encourage others to work and advocate for positive approaches. Exchange also involved peer-trainings, peer-coaching and peer-reviews as well as peer-evaluations, mainly in 2015-2016. Based on the exchange, once a year a meeting in one of the project countries including field visits and every 2nd month discussions in skype-meetings proved to be effective. Hence the SRC has a community of practice established for the knowledge-management group in Home Care, Active and Healthy Aging on its intranet. Uploading and screening of applications, reports, evaluations is a common practice nowadays in the network between the six countries. In order to compare outcomes and effects in Home Care the SRC introduced core-indicators for measuring of the Outcomes in all six project countries and elaborated as well a toolbox (result chain) for home care. Thus, all members (SRC delegates in the countries and partner organisations) are involved in Knowledge-Management and sharing. This approach used to be satisfying, efficient, effective and improved the quality of the work enormously.

Evidence of functioning of the Home care model: Before any activity is started, sound and serious data collection is needed with surveys/studies and scrutinizing the existing policies, strategies, road-maps in a given country related to community health and social services. Important in the work of the Swiss Red Cross as humanitarian organisation is the aspect of vulnerability. Thus, the vulnerability capacity assessment (VCA) is one tool measuring the scale of vulnerability in different areas (economic; social; health; mental; livelihood; water etc). Focus-group discussions, household surveys, needs studies etc are part of the assessment in cooperation with the partner organisation and very often Government agencies and other international or national NGO's in a chosen country. Thus Home Care services are not build up based on a "wish-list", but on evidences in the given country.

Scalability and sustainability of the Home care model: In all six SRC countries in Europe/CIS, the partners are mostly the national, local Red Cross/Red Crescent Societies. In the West, RC/RC Societies often work auxiliary to Governments. This is not given in the countries where former socialist or autocratic systems were in place. Home based Care is a new issue in all these countries – thus before such model is adopted within the official health and social care system, SRC and partners have to extensively lobby and work evidence-based with operational research tools to show the gap in the public service provision, the need to have new quality, cost-efficient and effective care models for the growing parts of vulnerable populations not able to "pay-out-of pocket" and thus not having even access to basic services.

12'000 clients in 6 countries in 4 ½ years of work is a step forward in systems, that not think integrated and in interfaces and where health and social areas are strictly separated. Hence only in Moldova a small funding for "nurse led" home services are paid by the national Health Insurance Fund. In all other countries, either HIF is not existing (Semashko-system) or only

doctor-led services are funded and thus, changing of mind-sets in people and across the cultures is needed – behaviour change needs time. Nurse-led services present a change in paradigm in all these countries and cultures. Thus, social authorities and family doctors/general practitioners, Policlinics/hospitals, specialist doctors ought to be step-by-step taken on board as partners.

Not the competition on sometimes scarce funding in some countries should be the issue, but to build a case- and care-management and referral system. The aim is:

The General Practitioners/Policlinics/Social Workers & the Home Care staff form one "Care" Team with one goal: to improve the health and well-being of the client;

The information about the client is with all partners/stake-holders in the system (e.g. patient card);

Functional up and down-referral system is developed within the state/public system

In addition, to scale up, replicate and achieve sustainability changes in existing health/social care laws are needed (funding follows laws), regulations changed, new professions introduced e.g. Bulgaria: social care assistant (home helper); Bosnia/Herzegovina: care assistant. Quality standards for Home care centers and for a national minimal quality standard in Home care for Not-for-Profit-Organisations introduced; post-graduate trainings for nurses defined and accredited; volunteers found, trained and retained; paid services introduced i.e. multifunding approaches elaborated; benchmarking/costing study introduced etc.

Taking all in mind, we may even speak of a partial reform in "Primary health care/ Community health and social care". Before Governments are not ready to change for such new model scalability ought to be planned but the numbers of clients kept lower in order to not create new dependancies on external funding

We know from "Community based home care provision" in Switzerland, Austria and Germany that for building such a service a minimum of 15-20 years of continuous processes is needed in a stable economic environment.

Referenses:

1- By professional nurses, home helpers, care-assistants, volunteers.

Keywords: integrated care model; supporting carers; resilience/coping in old age; involving communities; older people's care in the home environment; promoting dignity and end of life
