
CONFERENCE ABSTRACT

Social Work and Health Care Continuum

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In the year 2012 will set in motion the PCC/MACA on the part of the Department of health of the Generalitat of Catalonia.

Integrated care for persons with diagnosis of PCC/MACA (Chronic Complex Patient/patient with advanced chronic disease) is one of the objectives and challenges of the public health and primary health care centers. This proximity the patient provides the ability to perform a task of continuum of care that improves the quality of life for these patients, as well as a rationalization of the resources of the health and social network.

In this new vision of the cases, the task of social work becomes essential to be able to intervene in a comprehensive manner with the patient, performing an assessment of the social situation, with the corresponding diagnosis and intervention plan, and that in many cases also come with a task of providing resources and support to a good quality of life. The role of social worker as a nexus of union and facilitating the continuity of care between the various devices, as well as interlocutor of the demands of patients, and from a proactive intervention.

The demographic data show us the need to consider intervention projects focused to meet the needs of the current population pyramid, bearing in mind that the average age of patients assigned to the program PCC/MACA is 81.9 years with a standard deviation of 11.2 years (source: ECAP)

A central element of the change that has taken place at the level of institutional culture to work with the well-defined objective of the PCC/MACA.

The intervention of the health social worker with these patients involves the monitoring of cases, be the person between the various healthcare devices (social) in order to facilitate the continuity of the intervention and as a driving force in the management of support resources.

This fact can be verified with the following data extracted from the coordination carried out by social work in patients PCC/MACA with:

- Acute Hospital: 30,6%
- PADES: 9.3% (Home health care program)
- Care Unit: 18.6%
- Municipal social services: 37,2%

In relation to the results of the application of the social program (in 2014), we obtain the following data:

- total population assigned to the ABS Tower included in program PCC/MACA: 383
- Patients cared for by social work: 60% (220 patients)
- patients with processing of the recognition of the law of Dependence *: 27%

The evaluation of results leads to conclusions:

- Although the results show a thorough follow-up by the social worker health in the area of basic health, it has to continue working to achieve the goal of 100% of patients included in the PCC/MACA with at least one annual visit social work.
- need to increase coordination with resources/health services currently are not well developed as intermediate and PALLIATIVE Healthcare Units, resources would be where the joint work would raise the effectiveness of those.
- The coordination of cases with the social services of the territory in these patients is sine qua non to ensure the implementation of home help services quickly and tailored to the needs of each patient.

Since its startup the program has created a constructive discussion among the professionals that we have to put aside the vision focused on the services to put the focus on the patient and his career in the different medical devices. However from the social side is valued as a much needed greater involvement between health and social resources, in order to avoid repetition of basic and cuts in the health care continuum, and above all based on two key concepts:

- That the patient can have a single point of reference on social level, which as has been pointed out to be the interlocutor of this with devices
- Social worker concerning the possibility to activate the necessary resources to support at home in order to avoid duplication of procedures in many cases involving administrative delay in the startup of the resource.

These actions obviously must be accompanied not only by a change in the direct care professionals, but also between the heads of institutions and of social and health policies.

As in all new program implementation has led to resistance, but along the way and with the necessary changes through their constant evaluation, that the professionals of different devices to work with this line of action.

Keywords: social work; health care continuum; coordination
