



Most common EU approaches regarding integrated¹ home care: Basic guidelines for integrated home care implementation

Monika Gabanyi

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¹ Integrated service is the definition of both, medical (including rehabilitation etc.) and social care provision



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Abbreviation

ADL	Activities of Daily Living
FPh	Family Physician
GP	General Practitioner
PHC	Primary Health Care
MoF	Ministry of Finance
MoHSA =	Ministry of Health and Social Affairs



I Homecare

“ Many countries, such as Belgium, France, Italy, Portugal, Spain and the United Kingdom, have an organizational model in which the “health” component of home care is part of the health system and the “social” component is part of the social system. In other countries, especially Denmark, Finland, Sweden, policy makers recognized the advantage of providing home care within a single organization under the responsibility of one institution: the municipalities.

For example, municipalities have provided home care in Denmark since 1992. In contrast to local governments-oriented single-agent solutions, Germany and the Netherlands, for example, have a single funding stream (insurance-based) that covers home nursing and social care services. In addition to these institutional actors, voluntary, charitable and for-profit providers of home care services have extensive roles.”²

Homecare is an evident complementary service of PHC and comprise integrated service packages for clients living at home or in residential settings. According to clients’ needs medical as well as social services are combined and a care provider serves both.

According to international standards, per 25,000 populations’ one homecare service provider is considered, not taking into account a certain age structure, because home care providers should cover everybody who can be discharged from a hospital to community care. Although it is evident that mostly elderly people benefit from the services provided.

Researched proof the positive outcome of integrates home care services. Amongst them are reduction in hospital and nursing home use, cost effectiveness or cost savings and increased patients’ satisfaction enhancing quality of their life.³

II Scope of Services

The services provided are to be distinguished in medical and social services including basic care and household support. Additionally, rehabilitation and terminated care are part of the offers as well.

The services offered by the health/social care system are described as follow, taking into consideration that they need to be integrated both within the different levels of care of the health system; vertical integration from hospital- to community care and horizontal integration within social services social and medical care.

Basic care and household support

Services belonging to basic care comprise activities of daily life (ADL) and the package consists of:

- Help the client dress/undress
- Help the client move, get out of bed or go to bed
- Help the client to eat and drink
- Take part in body care activities (shower, bath, private routine, mouth wash, nails and hair)
- Takes prevention measures against diseases and supervises the health of the skin, monitoring the evolution of vital functions (temperature, pulse, breath, blood pressure)
- Applies moistures and drops
- Small bandages, that do not require sterilisation
- Prepares the medication and administers it according to nurse’s instructions

² Home Care in Europe, WHO report 2008, p 13

³ CPRN Research report “Frameworks of integrated care for elderly; A systematic review”, April 2008

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- Change the urine bag if the client wears a tube
 - Gives the client the urine bag and cleans it afterwards
 - Changes the bed garments, with or without the client in the bed
 - Cleans and throws away the garbage
 - Suggests measures to prevent domestic accidents
 - Does the household work, necessary in the client's s environment
 - Transportation

Medical care services

Services belonging to medical care comprise⁴:

- Monitoring physiological parameters: temperature, frequency of breathing, pulse, blood pressure, diuresis and excrements.
- Medicines ` administration – oral, i.m., i.v., subcutan, by intra bladder tube, by endo venous perfusion, on the surface of skin
- Medicines ` administration in general
- Measuring glycaemia by glucometer
- Artificial feeding by gastro or nasogastric tube, through gastrostoma and passive feeding – for patients with deglutition problems
- Clistier for evacuation and therapeutic purpose
- Decubiti excoriations : mobilization, massage, treatment and devices
- Therapeutic methods for avoiding pulmonary complications : change of position, physiotherapeutic respiratory procedures
- Therapeutic methods for avoiding vascular complications on the inferior limbs
- Treatment and care of simple wounds, infected wounds, stomas, fistulas
- Care of drain tube and tracheal canola
- Change of urinary bladder tube
- Monitoring of peritoneal dialysis
- Manual removal of stool ; application of bedpan, diapers , etc.

Rehabilitation

Services belonging to rehabilitation comprise:

- Early and continuous rehabilitation delivered
- by physiotherapists
- speech therapists

Terminal and Palliative Care

Services belonging to terminal care comprise palliative care offered in the community

Other services

Lending medical and nursing supplies:

- Orthopaedic devices
- Wheelchairs
- Beds
- Other medical devices

- Training for informal carers and clients including lifestyle advice.

⁴ The list is an example of services provided in EU countries and has to be checked against the Chinese regulation(s)



III Provision of Services

Human Resources

The combination of medical-social services and the focus towards the patients that they are dependant from at least both, medical treatment and social support, but also rehabilitation and others requires certain compositions of staff.

Medical care is in the responsibility and supervision of a GP/Family Physician⁵ and, usually the services provided in practise is managed as teamwork by different professionals, usually the physician and nurses. But also accompanied by others, like physiotherapists, speech therapists, psychotherapists etc. for rehabilitation, auxiliary staff and informal carers⁶.

Social care is sometimes seen as a service that can be done by everybody, regardless whether the person is a professional or not. To some extent this opinion is right, but it bears a danger. E.g. a patient suffering on symptoms after a stroke, who enjoys social services at home by a lay person (informal care), can be jeopardized due to the appearance of a bedsore. A lay person is not aware of the first signs or, nobody showed and gave advice what has to be done every day in order to avoid this. The consequence might be a worse condition for the patient and lower quality of life and higher costs for the social security institution due to the intensive medical treatment needed.

That does not mean that social care, managed by lay persons make no sense or, that auxiliary staff cannot take over ADL issues. First of all, the services needed and provided have to be defined by professionals for each individual client according to assessment indicators to be developed, and the process of care has to be assessed frequently as well. Regardless, whether professionals, auxiliary staff or lay persons are involved in the care cycle.

Therefore the staffs needed for social services at home consist at least of nurses and auxiliary staff. But the rehabilitation services shall not be neglected. As mentioned above, physicians have to take over the responsibility for medical treatment and, given the fact the patients enjoy both, medical and social services, the physician in close co-operation with the head nurse will be responsible for the entire process of treatment and care.

Despite of the composition of different professionals who will be working together, the number of professionals and auxiliary staff has to be defined according to indicators taking into account a geographic area and the age structure of the population, epidemiological specifics, clients' dependency level and, connected to this item, the time to be spent for the clients served by a provider.

This allows deciding the necessary number of staff, split in professional and auxiliary staff and the costs for them. And, the funding of medical and social services, can be clearly divided according to costs arose taking into account the services provided, personnel needed, equipment, maintenance of the service provider with all overhead expenditures and the facility itself .

Human Resources for medical-social care at home

Profession	Task
Care Manager (Physician)	Management of all client needs
Nurses	Medical care/ training for informal carer
Home carers	Basic care (ADL) and others
Rehabilitation Personnel	Rehabilitation

⁵ Depending on the organization of a PHC system. In general, medical care is to be recognized by physicians.

⁶ Informal care, respectively lay person, is defined as a person who looks after family, partners, friends or neighbors in need of help and is unpaid.



Social workers
Psychologist

Social needs
Psychological support for clients and staff

Care Manager: Care managers co-ordinate all patient needs in order to guarantee integrated coverage of services.

Nurses: The nurses are responsible for medical care which is part of the integrated care services.

Home carer: The duties of home carers comprise assistance and support of activities of daily life (ADL).

Rehabilitation personnel: The rehabilitation personnel identify client's needs for recovery and needs of remedies and the training how to use it adequately. The rehabilitation may also be undertaken by other professionals working with the client but under the supervision of the rehabilitation personnel.

Social worker: The social worker is the person educated to give assistance of social services to clients like legal advice, paper work.

The Clients

The question who can enjoy medical-social care services and to what extend depends on the definition of the term "dependency on care" and the level of dependency which has been assessed.

The term „dependency on care“ is strongly connected to the incapability of an individual for ADL as a frequent manner but at least for a certain period, e.g. the following four months. This certain period should also take into account that patients in the terminal phase of their life are in need of social support as well.

Incapability can be characterized as:

Loss of movement, loss of functions of inner organs and other sensual organs, loss of functions of the central nerve system, endogen psychosis, neurosis or another mental handy cape.

Usually, the assessment of the level on dependency distinguishes three degrees which are connected to the number and type of services identified.

For example a client is assessed to

- level 1 when once per day a service is necessary to be provided,
- level 2 when 3 times per day the services have to be provided and
- level 3 in case the support lasts to 24 hours per day.

Furthermore, the minimum time consume for each level has to be defined as well. As a start for the assessment of the dependency and also for the calculation of personnel needed and the costs in total. And, last but not least to limit or extend the number of beneficiaries. In case the minimum times consume per day, necessary for medical care and/or ADL is reduced to one hour, the number of beneficiaries will increase dramatically, and vice versa. This time frame is one tool among others to manage/control the system.

The assessment itself should be done by independent professionals in order to avoid conflict of interests towards the funding institutions. The assessment results include the level of dependency

and the care plan, but it should also describe appropriate measures for reducing the incapability or, at least to avoid dependency progress.

Rehabilitation is the keyword for these efforts and the effect is at least twofold because the client can keep or improve his/her status and the funds take into account cost containment in a long term perspective. Also, because of rehabilitation the client can improve his/her status and become either independent or, it might be a follow up assessment comes to the result to a lower level of dependence.

Public and Private Providers

Whether a home care provider should be, in legal terms, a private entrepreneur or public is not the crucial question to be answered. Both legal forms should run the home care services and among them it might be found NGOs, foundations, genuine private entrepreneurs and public providers.

Important is that all of them have to fulfil accreditation and licensing criteria in order to become part of the network of providers and being contracted by the social security institution fund and financed by local budget and other sources.

As, the providers must fulfil quality standards for contracting with the financing institutions the following quality indicators have to be taken into account and have to be the basis for concluding a contract, regardless whether the provider is public or private.

Quality indicators consist of quality of structure, quality of the process quality of outcome⁷.

1. Quality of structure:

Quality of structure emphasises and focus on providers' personnel available related to the patients' needs and management capacities, the time to be on duty and skilled staff. Defined quality indicators are the professional background of the manager who has to have a solid professional education and exam plus additional education in home care requirements and specific management skills.

The provider should assure that the personnel employed are promoted to attend further education offers and internal supervision rounds.

2. Quality of process:

The clients have to be clearly informed about the time on duty and, in geographic areas with high dense population, the providers should go in co-operation with other providers for sharing "emergency" services outside of the normal working hours.

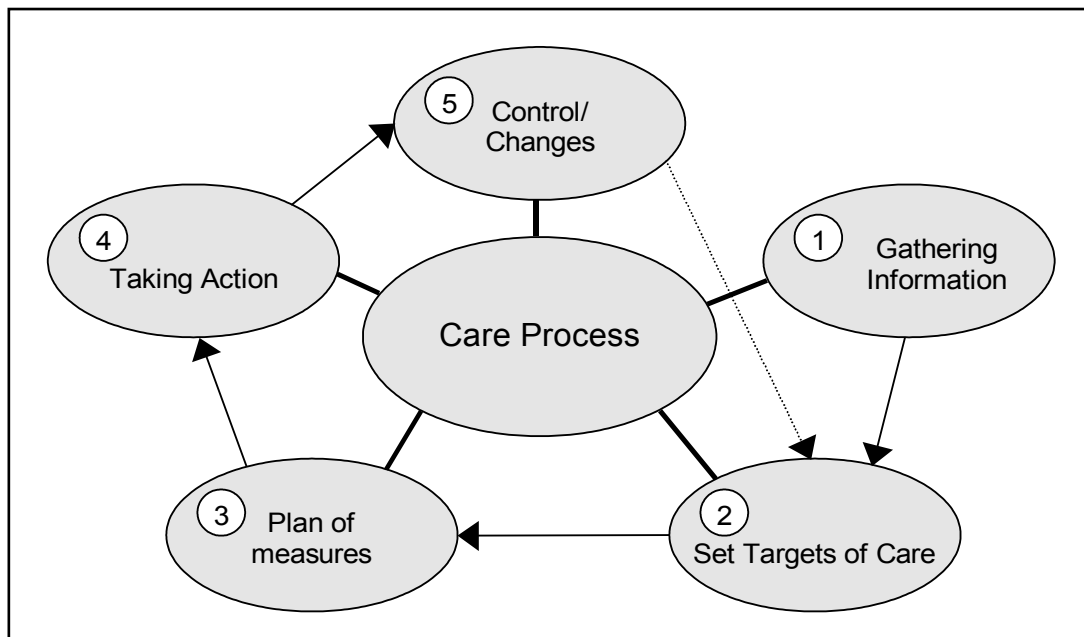
The so called terminus "quality of process" refers to the genuine care process and the work with beneficiaries. In order to provide services of high quality it is necessary to follow such a care cycle. The cycle consists of:

- a) Anamnesis and defining the targets to be achieved through the care, treatment and rehabilitation services. This has to be done and agreed upon by the client wishes as well.
- b) The care plan has to be elaborated and a documentation on care measures has to be individually recorded to the professionals who are part of the care process (e.g. head nurse, auxiliary staff, GP, rehabilitation personnel etc.). One copy of the documentation has to be stored in the household and one at the services provider(s).

⁷ Please note: Quality is not simply a soft and subjective issue. Quality is a measurable as finance or activity, particularly in relation to process issues

- c) The measures have to include so called “activated care” which take into account the client’s capabilities and these capabilities have to be stimulated. Prophylaxis and rehabilitation are part of the measures as well.
- d) Frequently the process has to be assessed and, in case the aims of the caring process have not been achieved the measures have to adapted and revised.

Scheme of the Care Process



Providing the indicated items for the quality of structure and quality of the care process the outcome to be determined positive depends on several facts.

One might focus on the costs others look at staff’s satisfaction and again others determine patient’s/ client’s satisfaction as parameters for outcome quality.

All three mentioned items are worth to be taken into account and used as determinants for qualitative outcome(s).

Determination and fulfilment of these quality indicators is prerequisite for licensing and accreditation of providers but it is not important whether a provider comes with services on the market as private entrepreneur, NGO, foundation or they are public.

The quality of services is the key element. The most important thing is to have:

- a clear set of quality standards elaborated in a large partnership with all actors (providers of services, clients, financiers);
- a process of implementing in practice and maintaining the quality of services where all the staff to be involved all the time;
- a process of improving periodically the quality standards by organising e.g. every two years a new process of designing new standards based on the previous experience.



Co-operation with Medical Care Providers

In relation to home care services the GP/FPh should be the key professional who indicates the service and refer clients to providers. Often the idea is that home care is a service that is in practice only for patients that are discharged from the hospital and the referral are coming only from specialists in hospital or affiliated ambulatory institutions.

But one of the main scopes of home care services is to avoid hospitalisation for people that are dependent or jeopardized.

The assessment related to the degree of dependency and services to be provided, medical services, basic care, rehabilitation and household support should be done by a team of professionals (physician, nurse, rehabilitation personnel, psychologist) adapted to the community structure. The best way to assess is a visit in the clients' homes because in step with actual practise, the assessment meets more exactly the necessary services, also taking into account remedies like special beds or wheel chairs etc..

An assessment has to be repeated after a certain period. The time between the assessment sessions depends on the degree of dependency. E.g. a client in dependency degree 1, with rehabilitation measures, should be re-assessed after three months because it might be that the client is not further in need of home care services or the services can be limited due the recovery progress.

Referring back to the tasks of the GP/FPh in the process of homecare he/she should be involved in assessment cycles with the providers of home care services. Given the fact, that the GP/FPh is indicating homecare and medical services to be provided by the home care provider, a regular update (check-up) of the procedures and the success of those has to be done together.

Special attention must be given to rural areas because of the availability of providers in general. In case there is a scarcity of home care providers, the GP/FPh Physician should receive additional funds for nurses and/or auxiliary staff who are belonging to his/her team and tackling home care services.



IV Recommendations for planning

Capacity and type of professionals for home care

Calculation:

Home care providers structure teams and one team should cover a minimum of 35 clients with a mixed need structure. Among them are clients with social needs and medical-social needs grouped in three levels of dependency. International researches show that a mixed client structure per professional avoids to become overburdened (also burnt out) and vice versa to become bored. A team should consist of nurses, auxiliary staff, rehabilitation personnel, social worker and in certain circumstances a care manager.

For 35 mixed clients (level I – III) a team consists of:

- 6 auxiliary staff
- 2 nurse
- 1 rehabilitation personnel
- 1 social worker

In case one provider covers double and more clients the team has to be doubled or multiplied by three and

- 1 care manager (Physician) should to be employed.

Per geographic area with 25,000 populations one provider, consisting of three teams is an ideal situation.

The calculation figures refer on a eight hours working day for the staff and 12 hours availability of the services for the clients from Monday to Friday. In special circumstances a client can be cared during the weekends.

Approaches to funding home care

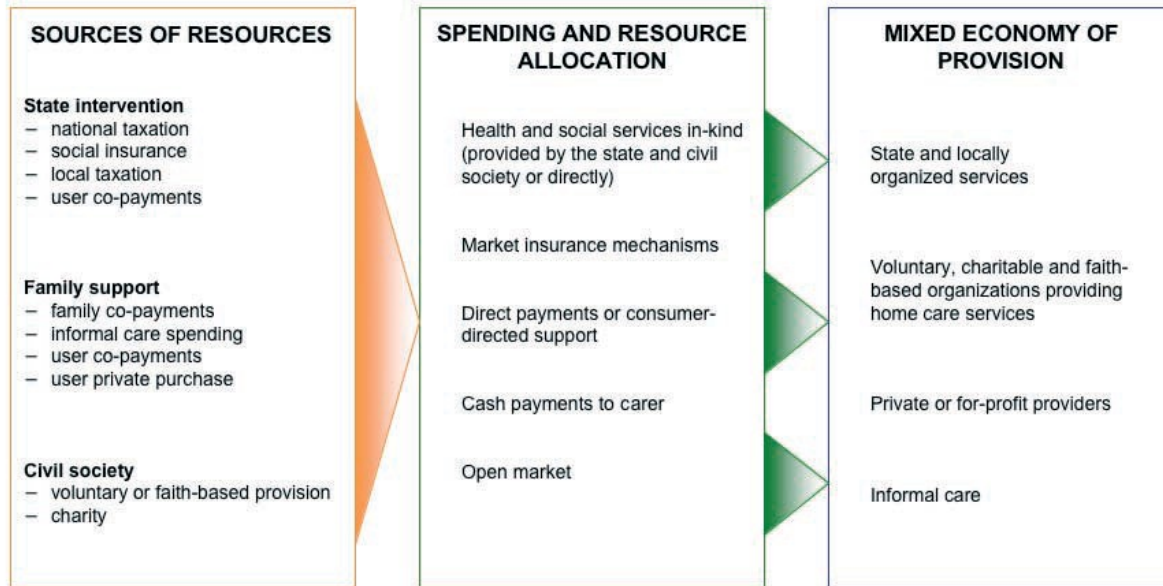
“ A range of potential home care funding mechanisms derives from state intervention, market purchases and the contributions of family members and resources of civil society.

Inputs and contributions for home care enter individual systems as services in kind and as various forms of financial resources, such as cash to service users and/or informal carers.

The combination of these public, family and private resources shapes the mixed economy of home care, which operates within each specific national setting. Hence, determining the precise quantity of public resources dedicated to home care is not easy, since they are often drawn from across health care, social security and social service budgets, and private purchasing of home care makes a major contribution to the overall levels and quality of home care packages.”⁸

⁸ Home Care in Europe, WHO report 2008, p 18

Funding, allocating and deploying home care ⁹



Payment Mechanisms / Reimbursement

While medical services for medical-social clients should go along with already chosen reimbursement methods, like salary plus bonus system for the GB/FPh etc., the reimbursement method for medical-social services have to be defined in a new manner and according to needs.

Medical-social services, defined as combination of medical care and support of ADL, need more attention to the clients in terms of time and, dependent on the capability/incapability of them, this time consuming is longer or even shorter.

Important to note: For medical-social services the amount of money per person per months should be reimbursed as lump-sum and capped. The ceiling is connected to the degree of dependency and the necessary time for services provided per day.

And, in order to avoid moral hazard, the ceiling should be equal per person regardless whether they receive medical-social care in institutions or from home care providers. The amount of money paid for clients in medical-social beds per month might exceed the amount which is paid for homecare services. In order to establish no incentive for “moral hazard” the price difference has to be paid out of pocket. This monthly ceiling on expenditures for in and outpatient services is a common tool in practice also for cost containment.

Basics for Cost Calculation¹⁰

Personnel costs for home care providers are:

Manager (Physician) of Institution
Auxilliary staff
Nurses

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¹⁰ The calculation model refers back to EU settings but can be adapted to Chinese as well



Rehabilitation personnel
Social worker
Psychologist
Administration
House maintenance
Reception desk
Taxes and Insurances
Personnel Costs Total

Overhead costs and other items for home care providers are:

Water, Energy, Heating
Material for medical care
Cars and fuel
Communication costs
Institution maintaining
Material for administration
Rent of facility
Others (investment but included depreciation)
**Overhead costs and others
Total**

The number of providers and personnel according to needs are to be calculated as follows:

Home Care Providers

Population in total	0	
Threshold	25,000 inhabitants per provider with 3 teams	Number of
Providers		
1 team per 35 mixed clients	7 home carers 1 nurse 1 rehabilitation 1 social worker	
3 teams for 105 mixed clients	1 care manager	

Reference

Overview of Measures for the Gold Plan 21

