SOCIAL PROFILE OF PATIENTS WITH COMPLEX CHRONIC (PCC) DISEASES. THE PCC SOCIAL EVALUATION

English version summary

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SOCIAL PROFILE OF PATIENTS WITH COMPLEX CHRONIC DISEASES. THE PCC SOCIAL EVALUATION.

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(English version: Helena M. Diaz Duran)

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Health social work, Complex Chronic Diseases, social data, social valuation

Abstract

The analysis of the social and family data in Patients with Complex Chronic Diseases shows that as long as a health progressive loss occurs certain social problems that produce unease in patients and their families arise. Those social problems and their psychosocial derived malaise interfere in the optimum approach of the health problem of the health services and require interventions in the social field on health with the purpose of:

- Working on improving the health-related life quality of patients with chronic diseases, their families and their social environment.
- Working for the optimum / appropriated balance and stability of the social functioning to face the health problem from the daily personal / familiar sustainability.
- Contributing to the proper use of the health services.

In Primary Care, the proactive social work in the PCC frame is a preventive work line that anticipates the socio familiar events and determinates the social factors that will be taking part with the ageing and the needs that will appear.

The proactive work also allows identifying hidden social risk situations contributing to prevent and decrease social and health expenditure. Furthermore, it increases the patient satisfaction with regard to the all-round services provided.

In hospital care, the social programs of systematic attentions represent the key axis of the all-round attention. The approach of the social risk in health at hospital care is the key to guarantee the continuum healthcare and reduce the worsening risk of the health situation. The social intervention in hospital becomes relevant in debut situations with complex chronicity due to a traumatic origin or high clinic complexity pathologies.

In the health social dimension of PCC takes value the multidisciplinary approach with the specific social view, very close to the sanitary look inside the sanitary institution itself.
INTRODUCTION

The evolution and the efforts of the health social view of contributing to improve in quality and efficiency on caring the chronic complex patients require an analysis of their social profiles.

Social workers serving in health institutions contribute the social view of the health within the integrated model of caring health. They work systematically with chronic complex patients in a proactive frame to detect and anticipate the social risk situations or social needs/ psychosocial needs that difficult the health attention.

Anticipating the patients' complex social situations facilitates both the sanitary institution and the professionals –in their different levels of assistance- their predictive work to carry out with the patients.

For patients, the contribution of an advanced social diagnosis together with a defined and managed intervention plan minimizes the impact that a complex health situation or a sudden dependency could have on the patients' social situation. Simultaneously, this kind of planned diagnosis and interventions could improve their life quality and the satisfaction of their needs.

After two years of proactive social work in the Insitut Català de la Salut (ICS) with PCC there have not been found empiric data related with chronic patients within the social sphere that express in their profile aspects and specific variables to take into account to advance in the health social dimension.

The health problems affect the social functioning of the person and this can carry new health problems or their worsening. Therefore, health and social functioning are tightly linked, they affect each other reciprocally.

In the chronic patients care, the health needs, besides being taken care from the integrative conceptualization where social view is already present, also it should be approached in an integrated way between the health system and the social care system.

During 2013 and 2014 health social workers in ICS - systematically in Primary Care in the quality standards framework (Estàndard de Qualitat Assistencial, EQA) defined in ICS and in hospital care according to the institutional objectives - carried out valuations and interventions to the PCC. In order to know the reality of these patients and being able to improve the services offered to them - improving the social view of the health - it is necessary to analyze the social data compiled in the fulfilled social valuations.

The information provided by the health social workers will contribute to redefine and develop those areas of the social aspects of health and their specific services letter for the chronic patients that could require them. At the same time, they will help to improve the quality of the activity / services of social work in ICS.

What is the profile and the social situation of the chronic patients valuated and looked after for the health social workers? Which kind of social functioning do they have, in relation to the health situation they already have? What improvements in social attention can be proposed in a close future, attending to their profile and reality? These questions are the ones suggested in on this present analysis.
OBJECTIVES

1. Describe the social situation and the social functioning related to the chronic patients’ health.
2. Identify opportunities to improve the attention of the social needs of the chronic patients.

WORK PLAN

1. SELECTION CRITERIA OF THE SAMPLE

PRIMARY CARE

Expected Sample: 1840 PCC cases analyzed by 184 health social workers.

The PCC are selected from the EQA TSS list from each one of the health social workers in Primary Care all around Catalonia (184). Every social worker is asked to analyze the data related with their 10 first patients in the EQA TSS list on January 2014.

HOSPITAL CARE

Expected Sample: Analysis on 96 patients PCC realized by the social work services in the 8 ICS hospitals (Josep Trueta, Germans Tries, Vall d’Hebron, Bellvitge, Viladecans, Joan XXIII, Arnau de Vilanova and Verge de la Cinta).

The PCC are selected when consultations are received to the social work services, following their arrival order.

2. INSTRUMENT

- Anonymous and individual form in order to collect data of every patient, in a virtual platform.
- Help guide to collect data.

The resultant information of the defined variables in each section will gather the social characteristics of PCC on both care levels: Primary Care and Hospital Care.

The questionnaire is divided in 4 sections: Health area data, Social area data, psychosocial area data: social unrest expressed, and the social work intervention data.

3. VARIABLES

To define the variables it has been taken into account the disciplinary contents of social valuation of PCC and the recommendations of the document “The health social work in the chronic patient care”.

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4. DISCUSSION GROUP

In order to analyze the data 3 independent discussion groups have been defined. The first discussion group was composed by 10 professionals from all over Catalonia that took part in a corporative group of "registration system and social work information". The second group was defined to execute the discussion and was composed by 5 professionals with research experience. The third group was composed by the social work referents at ICS in a mixed commission.

Methodology:

The discussion duration for each group was about 5 hours. It has been given one month interval between the first discussion group and the second one. And there was a three months period between the second and the third. All of them had a moderator / reporter. Data collection from groups has been registered in written records. Information was compiled manually and transcripted afterwards. Then, they were codified in order to be able to analyze them. In all three groups the same methodology has been followed.

The discussion order of the speakers, proposed by the group coordinator, allowed spontaneity in the group.

Both the generic ideas about the health social work practice and the social intervention with PCC, and specific ideas about each variable analyzed with the individual point of view of every participant have been exchanged in the discussion groups.
PROJECT RESULTS

PCC GENERAL DATA

Profile: By age, at Primary Care the 55% are over 80 years old. At Hospital Care 35% are over 80 years old.

The main location of the patients at hospital is at internal medicine and orthopedic surgery areas (87%). The medical discharge destination use to be private residence or socio-sanitary service (43%).

HEALTH AREA DATA

Team that look after the PCC on their last month of life: 63% by Primary Care Team. Complexity stratification, the Clinic Risk Group (CRG): grouper CRG 6 used in 64% of the cases. Dependency / autonomy measured with Barthel Test: 12% severe dependency or total dependency in Primary Care, 40% in Hospital Care.

SOCIAL AREA DATA

Case detection by proactively 100% Primary Care, in Hospital Care 68% are detected by consultations.

Fragility indicators: Social network: Living alone 32% in Hospital Care and 18% in Primary Care. Without caregiver or reference person: 19% in Primary Care, 26% detected in Hospital Care.

Indicators for economic dependency / risk of exclusion: Economic vulnerability having between Minimum Wage (MW) and the mount of a Non Contributory Pension (NCP) - In Catalonia it means between 649 - 370 €/month-: 24% detected in Primary Care and 30% detected in Hospital Care. Living on the street 8% detected in Hospital Care.

Social indicators for Dependency: 24% detected in Primary Care and 27% in Hospital Care already have a Certificate of Disability. 37% of PCC in Primary Care and 33% in Hospital Care already have recognized a Dependency Degree.

Social indicators for Social Care: 38% PCC in Primary Care and 78% PCC in Hospital Care had some relation with social services in the last two years. At the analysis moment, there were followed up by social services the 24% PC and 40% HC.

Psychosocial area: 39% PCC in Primary Care express unease about their health due to inability to manage the daily lack of health.

Social valuation: Social functioning with risk indicators to attend their own health 30% in Primary Care and 44% in Hospital Care. Moreover, 5% in Primary Care and 21% in Hospital Care present some social dysfunction.
There is a distinct PCC social profile between Primary Care and Hospital Care.

As more social complexity, more complex becomes the health situation or the patient can live more worsening episodes.

The proactive contact, in Primary Care or by consultation, distinct and will condition a social intervention either predictive or reactive. In acute care, at consultation to the social workers, it is done a previous social triage based in defined social risk indicators. The situations that need to be socially predicted will not be taken in account as they can become more percentage of social crises at the hospital discharge.

At Primary Care patients present less cognitive impairment. So, the work plan consists in a preventive work and following up the diseases that will increase as the ageing does.

At the hospital, patients already appear with their pathologies whether they have just appeared or because they have developed an acute process and there can be changes within their social and family environment.

Poverty tax is higher in patients that turn to hospital than those who are attended at Primary Care.

Population profile is medium-low class with incomes, per residential units, around one thousand Euros. In a high percentage of the cases, the family incomes only proceed from the patient pension.

Related to the social risk indicators and the social functioning with risk indicators, during the discussion it has given a consensus about the "spheres of social risk" for caring and health attention in the PCC own social familiar environment. The risk indicators areas that base the social diagnosis and the social intervention, incorporated in the social valuation at the multidisciplinary therapeutic plan, are:

1. Organization of the care area
2. Family unit area
3. Family cohesion and affective clime area
4. Structural conditions, security, comfortability and privacy area
5. Environment area
6. Relational network area

**Organization of the care area**

- Difficulties in the sphere of the caregiver: Absence of caregiver, ineffective caregiver, caregiver with fragile health...
- Difficulties in the material and economic support.

**Family unit area**

- Weak family unit: member with toxic habits, young sufferer, single-parent family, single-parent family with dependent minors, etc.
- Complex relations between some of the members in the family unit: Toxic relations, trauma, etc.
• Elderly head of household and developing a caregiver role.
• Disagreement in the decision / intention of the patient / family about the place where to be cared and to die.
• Precedent of mistreatment

**Family cohesion and affective clime area**

• Affective disaffection, affective detachment, rejection, etc.
• Imposition of the care, caring as a duty, caregiver compelled, and dependent caregiver (psycho emotionally, economically or socially)...

**Structural conditions, security, comfortability and privacy area**

• Marginality
• Home rotation (itinerant patient)
• Difficulty in/for the house adjustment to the minimums required for the home care needed.
• Living space / personal space inadequate or precarious.
• Living space / personal space uninhabitable for extreme unhealthiness
• Destitution

**Environment area**

• Socio geographic isolation
• Insurmountable architectural barriers.

**Relational network area**

• Uprooting due to displacement from the place of origin.
• Absence of social support network.
• Distinguishing aspects in care, customs, beliefs, language, etc.

**CONCLUSION**

PCC have a distinct social profile depending on whether they are attended at Primary Care or at Hospital Care (social profile more complex).

The proactive health social work in PCC is a preventive work line that anticipates to daily social risk factors and to the socio familiar events in health care and contributes to the proper use of the services and to the patients’ satisfaction.

Disciplinary consensus exists about the social risk spheres in PCC.


ACORD GOV/28/2014, de 25 de febrer, pel qual es crea el Pla Interdepartamental d'Atenció i Interacció Social i Sanitària (PIAISS).


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. PPAC. Programa De Prevenció i Atenció Al Crònic Del Departament De Salut. Generalitat e Catalunya