Policy Brief

Implementing Homecare Services in Albania

1. Introduction

The increasing demographic trends of the population aged over 65 years old in Albania indicate a similar pattern of evolution as the one in member states of the European Union (as stated in the Report "Population Aging - Situation of Elderly People in Albania", which estimates an increase of the elderly population from 15% in 2020 to about 29 % in 2060). Health care organization in Albania is mainly focused on hospital care that generates high rates of avoidable hospitalization, especially hospital admissions for conditions that can be treated at PHC and at the community care level.

Despite the unequal distribution around the country, the PHC network of family physicians and nurses represents the main pillar for the provision of affordable basic services to the population and in particular to the most vulnerable citizens.

The social system responsible for care provision to the elderly people is represented by an insignificant number of public and private institutions providing institutionalized care for the elderly, mainly for those living in Tirana and in a few other major cities.[1]
The Albanian culture is based on strong family links with the elderly being cared for by the close family; however, the current models promote working further away from home, in towns or abroad which starts to pose a challenge for families and their elders.

2. The steps taken by the Albanian Government towards planned home care services

An important strategic step taken at national level was the merging of the Ministry of Health and Ministry of Social Welfare into a single institutional entity; this is a preliminary, yet important step to facilitate/support the development of field-based integrated medical and social home care services.

The provision of home services is part of Basic Package of Services[2] that should be provided by the Health Centres based on a specific/ detailed fashion for two major categories of people in need: pregnant women and children 0-12 months of age, and based on a more general fashion for patients suffering from different health conditions making them unable to commute to the Health Centres[3].

The recent approval of the Strategy on Development of Primary Health Care Services[4], covering the period 2020-2025, could be a lucky and fortunate momentum as this document provides for a comprehensive and logic framework on how to pilot and expand the home-based care services by integrating them with social component and providing fundamental resources (human and financial) on this topic.

Significant progress has been recently made in the social sector with the regulation of social care services, introduced in the Law no 121/2016 "On Social Care Services" and particularly in the Decision of Council of Ministers ***"On Social, Community and Residential Care Services, eligibility requirements and procedures and personal expenses amount for organized service beneficiaries".***

The eligibility criteria have been also defined; eligible individuals are the ones that meet the following criteria:

- elderly or people with disabilities who are incapable of taking care of themselves and they cannot receive help by the family members or a caregiver;
- people that need a service that is not provided in the community of the territory they live.

Eligible services have been defined as:

"Family-based services are social care services that are provided in the family to elderly and persons with disabilities, for whom it is impossible to receive daily community or residential services, and who are incapable of taking care of themselves and cannot be helped by family members or caregiver/personal assistant".

The services in family include:

- rehabilitation services, development, psychological or legal counseling, as the case may be;
- distribution of ready meals at house;
- provision of medicines, according to the prescription of the doctor or other services of a medical nature;
- personal hygiene;
- fulfilling other daily needs, according to the cases' assessment, on a case by case basis.

These new provisions in terms of social responsibilities of the Local Governments highlight the need for ongoing development of social care services plans and following up on the social needs of potential beneficiaries.

3. The Current Findings of the Assessment Study on the Home-Based Care Needs in Diber and Fier Regions

The qualitative study undertaken showed that:

- The current provision of home-based services is medicalized and focused on medical emergencies and not on planned services for elderly patients or those suffering from chronic diseases;
- The human resources are underutilized in terms of range of services that

they are entitled to provide or due to lack of knowledge and skills (clear underperformance and under-use of nurses in health education and health promotion services, preventative and chronic disease management services, basic home nursing care);
- Nurses carry out specialized segmented duties, mostly in the presence of family physicians in Health centers. Home assessments or interventions are rarely done; nurses in nurse-led Health posts have a broader scope of practice, but given the level of equipment and infrastructure, these services are very basic;
- Unemployed trained nurses are available on the market and they accept informal jobs as home carers in order to make a living;
- Home carers as professionals providing care services are not foreseen yet within the nomenclator of professions (occupations) and no specific trainings are designed to this end;
- There is a poor horizontal and vertical inter-institutional collaboration / integration of services, but there is openness for such cooperation;
- There is an increasing need for planned home based services for patients characterized by high degree of physical dependencies and are chronically ill with NCD such as: cardio-vascular diseases, diabetes, cancer, pulmonary diseases, mental health diseases. In addition, those most in need, also comply with social vulnerability criteria such as poverty, no family ties (home alone and dependent patients).

4. Recommendations for the future provision of planned home-based care in Albania

4.1. Specific Short-Term Recommendations

Implement the pilot demonstration projects that will test and develop specific guidelines and protocols for planned home based services. Proper monitoring and evaluation during implementation would facilitate how to define appropriate policy changes, i.e. gradual adjustments to the benefits package, etc. The demonstration project shall reinforce values as equity, transparency and respect of patient entitlements.

Developing basic horizontally integrated home care services

Four models of increasing complexity have been defined for the development of the planned home care services:

- Model 1: Basic model with existent HC nurses reorganized at the HC level, by enlarging the scope of their activities and providing planned home care services.
- Model 2: Vertical Integration: Homecare for elderly dependent persons after their discharge from the hospital.
- Model 3: Horizontal integration: Complementing the nurses' home care team with a part time social worker.
- Model 4: Comprehensive Horizontal integration: Complementing the nurses' home care team with part time social worker and formal home carers.

The focus should be primarily on developing the comprehensive model of the horizontally integrated home care services for elderly dependent persons.

The approach of introducing planned home-based services should be **gradual** in order not to exceed the capacity of the new service for which practice guidelines need to be developed, and the personnel needs to be trained and coached during early implementation phase.

The organization of the services could be performed under the organizational umbrella of the Health Center, but within a separate team coordinated by a nurse having the following characteristics:

- Strong coordination with the medical services of the Health Center
- Nurses coordinate the home care service - one nurse coordinator and other nurses are assigned for this home care service
- Support from additional staff (nurses and home carers - formal care-givers that are trained and in cases of dependent and home alone elderly, can provide the necessary caring services, coordinated by the nurse); family doctors are available on call when needed (when the medical condition of the persons requires doctors attention)
- Service guidelines are to be developed and implemented specifying the steps and conditions for service provision (i.e. definition of eligibility criteria according to KATZ dependency scale , promotion of eligibility criteria, for the community to have knowledge of the entitlements, definition of care plans at community level, nurses' assessment of the patient's individual needs, nurses' definition of a patient's individual care plan, the specific provision of home care services by nurses and home carers, the monitoring and evaluation of the services provided, etc.)
- Job descriptions of nurses registered for performing such services should specify their responsibilities as case managers: their capacity for assessing individual needs of the elderly, their capacity to allocate resources - home carers/ informal carers – and define the individual care plan of each elderly beneficiary, the capacity to identify the moment when the coordination with the family doctor is needed, their capacity to manage the teams of home carers, etc.
- Eligibility of a patient group for a defined home-based service should be clearly defined; the number and complexity of the cases should be manageable for the home services team in a way that the team can apply the guidelines, have coordinating meetings to share upon their practices and learn within this process.

Capacity building for home care services implementation

- Train both nurses and social workers in assessing dependency levels, developing individual care plans, monitoring the provision of home care services; training both medical and social services staff in the same training venues shall enable the horizontal integration in a multidisciplinary team, the development of shared tools, such as patient files/records, the decision about who should be the case manager according to the type of patient needs, the coordination of medical and social services provided to a specific case, etc.

- Train carers in the provision of care services/ ensure job registration of the profession of home carers;
- Develop community care plans in pilot Fier and Diber communities (proactive identification of dependent persons in the community, assessment of their dependency level, define the number of staff needed to provide services to the dependent persons/elderly in the community. These community care plans can be developed gradually by promoting the eligibility criteria for the home care services, assessing each individual who requests services - i.e. highlighting his / her degree of dependency, assessing the level of effort needed from the home care team to fulfill service needed by each eligible patient, planning for the human resources needed (i.e. deploying new nursing or home care staff if needed) in order to be able to respond to the identified needs at community level.
- A package of refined general eligibility criteria should be developed during the pilot phase of the home care pilot program. These criteria should be clear (but flexible, not rigid) and easy to understand by both professionals and beneficiaries. A good information system, clear eligibility criteria and a good network of professionals for assessment of cases may avoid long waiting list and potential complains.
- Develop a legal framework to enable the vertical and horizontal integration.
- Staff motivation will be an important factor in the success of the program. Training and job enlargement may bring a further job satisfaction. Additional bonuses for covering beneficiaries in remote areas may also be of help in enabling the nurses to opt for being part of the home care team.
- Monitoring and evaluation of services delivery should be implemented, as well.
- Ensure sustainable funding for the planned home care services - more sources of funding may be envisaged, including a cash contribution from the beneficiaries/ beneficiaries' families. An integrated funding package from the public funds will support the provider with limited human resources to concentrate on the quality of the services provided and not on reporting on a large number of budget lines.

Further development of additional specialized home-based services

In addition to the basic models of home care service described above, a focus on specific target groups can be addressed based on the prevailing pathologies/ expressed needs by population of the catchment area.

Additional support for specific target groups (i.e. cardiac patients/ cancer patients, COPD patients, etc.) should be considered only when the basic home care services are in place at a community level. Additional services could then be added for specific patient groups,

especially for advanced stages of the diseases/ for dependent patients such as:

- Home based monitoring and control of High Blood Pressure,
- Home based monitoring and control of diabetes,
- Home based monitoring of Chronic Pulmonary disease,
- Home based Palliative services for terminal illnesses,
- Home based monitoring and control of chronically mental ill, etc.,
- Use of telemedicine devices to support monitoring of specific chronic patients as described above.

The potential HAP support during the remaining of its Phase 2 would be a great opportunity to test a few of the best models of home-based care, to assess the benefits at the end of the demonstration pilots and to support further Government decisions aiming a wider scaling-up of such services countrywide.

1. Shërbimi Social Shtetëror (2019).Raporti vjetor - 2018 Marrë nga http://www.sherbimisocial.gov.al/wp-content/uploads/2019/01/ANALIZA-E-PUNES-SHSSH-2018.pdf aksesuar në prill 2020
2. 2018 - Raporti Vjetor për Fondin e Sigurimit të Detyrueshëm të Kujdesit Shëndetësor
3. Vendimi i Këshillit të Ministrave Nr. 101, datë 04/02/2015 "Për miratimin e paketës së shërbimeve shëndetësore, në kujdesin shëndetësor parësor publik, që financohet nga Fondi i Sigurimit të Detyrueshëm të Kujdesit Shëndetësor".
4. Vendimi i Këshillit të Ministrave Nr. 405, datë 20/05/2020 "Për miratimin e Strategjisë për Strategjinë e Zhvillimit të Shërbimeve të Kujdesit Shëndetësor Parësor në Shqipëri për periudhën 2020 - 2025".
5. Indeksi Katz për Pavarësinë në Veprimtaritë e Jetës së Përditshme, i njohur ndryshe si Katz ADL, është instrumenti më i përshtatshëm për të vlerësuar statusin funksional si matës i aftësisë së klientit për të kryer në mënyrë të pavarur veprimtaritë e jetës së përditshme.

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