



A FRAMEWORK AND MODEL OF INTEGRATED SOCIAL AND HEALTH SERVICES

Albania, 2021



Disclaimer

This document is prepared by the Ministry of Health and Social Protection in close consultation with representatives of United Nations Development Programme (UNDP) Albania Country Office. Expertise and technical assistance have been provided by Ms. Albana Ahmeti EC, MPH, Ms. Eliona Kulluri PhD, and Ms. Mirjeta Ramizi PhD in the framework of the "Improving Municipal Social Protection Service Delivery" (IMSPSD), a Joint UN Programme implemented by the Government of Albania in partnership between four UN Agencies including UNDP, UNICEF, UN Women and WHO and the participation of UNFPA and ILO and funded by the Joint SDG Fund. The programme supports the Albanian Government translate the policy intent into proper local actions so that men, women, girls and boys living in poverty, or vulnerable situation have access to integrated, quality social care services, and supports the vision of an overall inclusive Albania.

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List of Abbreviations

AU	Administrative Unit
CPO	Child protection officer
CPU	Child Protection Unit
DV	Domestic Violence
EA	Economic Assistance
EASAD	Economic Assistance and Social Affairs Directorate
GE	Gender Equality
HCSO	Health Care Service Operator
ICDM	Integrated Care Development Model
ICT	Information and Communication Technology
IMSPSD	Improvement of social care provision at local level
M&E	Monitoring and Evaluation
MCCI	Model of Care for the Chronic Ill
MHSP	Ministry of Health and Social Protection
NARU	Needs Assessment and Referral Units
NGO	Non-profit organizations
PSSS	Psycho-social service in schools
PwD	Disabilities
PWD	Persons with Disabilities
RDPH	Regional Directorate of Public Health
RDSS	Regional Directorate of Social Services
RED	Regional Education Directorate
ROEVT	Regional office for employment and vocational training
SSS	State Social Service
WHO	World Health Organization

CAPTER 1

Introduction



Health is the most important cornerstone of an individual's well-being, therefore, it is considered a powerful tool for achieving protection and social inclusion. Good health enables people to work and participate fully in their communities and uphold themselves financially. Data and facts show that poor health reduces people's employment prospects and working hours and increases the likelihood of early retirement and experiencing poverty in old age. Likewise for children, poor family health is associated with lower school performance, as well as early and more frequent drop-outs, which in turn increase the risk of exclusion throughout adulthood.

Therefore, the health sector can play a key role in supporting the social sector in its goals of reducing poverty and reducing social exclusion, the same way that the social interventions simultaneously improve the health indicators of the target populations and individuals. According to the WHO *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* a definition which is still valid today.

The Government of Albania has recognised the importance of developing social care services and has now put in place a strong legal framework (Law No. 121, 24.11.2016, On Social Care Services in the Republic of Albania).

The current Social Protection Strategy (2019-2022) states that:

This strategy aims at developing an integrated functional system of social care services [at national level by 2022] for every man, woman, boy and girl, a system that promotes choice, independence and encourages full and effective participation in society, based on an equal access for all citizens seeking services.

The Strategy goes on to say that:

A specific objective is also establishment of an integrated system of social and health services at the local level for families, children and individuals in need. The link between "health services" and "social services" allows for multidisciplinary treatment for the individual and his / her family.

This is to be based on a life cycle approach.

By 'integrated services' we mean, in line with best international practice, the range of activities, implemented to achieve more efficient coordination between services and improved outcomes for service users.

Three dimensions of integrated care (identified in the literature) are:

- ▶ It seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well co-ordinated around their needs.
- ▶ Integrated care is necessary for anyone for whom a lack of care co-ordination leads to an adverse impact on their care experiences and outcomes.
- ▶ The patient or user's perspective is the organising principle of service delivery.

1. Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.



The goal of Health 2020

is to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality.

In 2012, all 53 Member States in the European Region adopted Health 2020, the new common European health policy framework, and committed to developing integration policies with all sectors in addressing the social and economic determinants of health and well-being. The most effective actions to achieve greater equality in health outcomes are those that ensure an adequate level and delivery of social protection throughout life and as required.

Social protection refers to policies aimed to protect against the risks and needs associated with unemployment, parental and caring responsibilities, sickness and health care, disability, old age, housing and social exclusion in the form of social assistance and social insurance. Social protection can create a buffer against income loss and redistribute income both over the life-course and between individuals.²

All-inclusive social protection policies can be particularly powerful in protecting health amid economic crises. Evidence shows that investing in social protection helps protect individuals and families from the adverse effects of economic crises. Societies that invest in social protection achieve greater overall health progress and can also improve the health of more vulnerable individuals to a faster pace.

Health 2020 policy framework has been adopted by all WHO Member States within the European Region in order to address Europe's major social and health challenges, calling on the health sector to lead and work with all diverse sectors and parties in the ongoing work to improve people's health and well-being. More equal societies are happier, healthier and generally better off. By working together, the health and social sectors can contribute to improving the living and working conditions of individuals, families and communities in the European Region, reduce inequalities and support human development, not only by improving good health and well-being, but also by upholding resilient communities and economies.

The goal of Health 2020 is to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality.

The social sector can help create healthier people and communities by working with the health sector:

- ▶ to support children, their families and communities to ensure the best start in life;
- ▶ to support young adults to help them transition into work;
- ▶ to provide integrated and adequate support for older people and to foster an active healthy older population;
- ▶ to ensure that groups at risk of poverty and exclusion, including people with disabilities, are empowered and enabled; and
- ▶ to reduce gender-based inequalities, including their role as the main employers of women.³

In Albania, the establishment of the Ministry of Health and Social Protection by DCM No. 508, dated 13/09/2017 "On determining the scope of responsibility of the Ministry of Health and Social Protection" marked a watershed in this context, based on this new vision of health and social protection policies. This vision is based on the fact that the health and

2. WHO, *Health 2020: Social Protection and Health*, May 2015.

3. *Ibid.*

social sectors have many types of synergies and overlapping goals, and working together will be a potential for better outcomes for individuals, communities and societies, to address the needs of vulnerable groups and ensure a healthier future for all.

This is why the term “*integrated services*” in the literature refers to a range of activities implemented to achieve efficient coordination between services and improved outcomes for service users.⁴

Integrated social and health services take various forms to improve the health of the population, with different levels of coordination even beyond geographical boundaries. Forms of service integration are manifold, depending on sectors, target groups, governance level (local, regional and national), the objectives and the level of integration between two or more public bodies.

Strategic documents for categories in need in Albania emphasize inter-institutional cooperation at central and local levels to improve people’s lives. Although integration in all sectors is a trend in Albania, there is still limited understanding of work practices beyond these cross-cutting boundaries.

There are various forms of integration, which aim at achieving coherence and synergy between organizations and professionals, and enhance the quality and efficiency of delivery. The social sphere is considered to have a central role in supporting people to manage their lives and deal with “opportunities and threats”. There is a growing need for empowered social services due to the current policies aimed at keeping vulnerable people longer in the community than in institutional care services. However, the integration of cross-cutting services is not easy to achieve, given the complexity of cooperation between diverse organizations and sectors.

This document describes the current state of integration of services between sectors in the provision of health and social services in Albania. The models explore what happens at the sector “boundaries”, for example, the communication, coordination and collaboration that take place between different organizations and across sectors.

Model analysis also examines whether and how integration in the social and health sectors can be understood by applying similar concepts, processes and mechanisms used in the context of health care integration.

The document explores local integration practices of social and health systems fine-tuned with key elements of the Development Model for Integrated Care (DMIC). This model has been developed and validated in several areas within the health sector. Its advantage is being generic, i.e. it does not focus on a specific target group or type of support or care, but also takes into account inter-organizational and interdisciplinary processes. The DMIC has also been used in several international projects which prove that it is applicable in different contexts.

The achievement of the integrated care benefits requires strong system leadership, professional commitment, excellent management and clear consistent communication. To this end, there should be a regulatory, political and financial framework that supports



Being an individual actively integrated into social, family and community life is important for personal development.

4. CoE, (2007) “*Integrated social services in Europe: A study looking at how local public services are working together to improve people’s lives*”

integration. Information is also a key enabler; Complete and accurate information about the needs and care of a patient should be available throughout the care delivery chain for all, including the patient. Clinical and service integration is probably the most important integration process and requires multidisciplinary work among professionals who trust each other.

Being an individual actively integrated into social, family and community life is important for personal development. The opportunity to participate in social activities has a substantial impact on a person's identity, self-confidence, quality of life and ultimately their social status. People in need of specialized services⁵ face many barriers in society, they are often less likely to participate in social activities.

"Improving Municipal Social Protection Service Delivery" (IMSPSD) is a joint United Nations program focused on catalysing changes in the quantity and quality of provision of integrated social care at the local level, as part of an effective system of integrated social protection. The program builds on the vast experience of the United Nations in addressing the social inclusion and needs of marginalized groups. This program supports the implementation of the newly formed vision of the social sector in Albania, in line with the Strategic Development Goals and the country's aspirations towards European integration.

The program aims to translate policy goals into appropriate local actions so that men, women, girls and boys living in poverty or vulnerable situations have access to integrated, quality social care services based on the overall vision of an all-inclusive Albania. This report includes six selected LGUs, which are: Tirana, Kamza, Puka, Rogozhina, Pogradec and Devoll.

The model will present some definitions and explanations of the concepts that assist the selected municipalities in implementing their interventions of integrated social and health care for vulnerable groups fine-tuned with their social plans.

Although specific interventions have been developed for each of the 6 pilot municipalities, based on the community needs and their specific context, these reflect a common approach (DMIC model). This approach, at its core, is based on the individual and the family. It reflects the importance of the family and the emphasis on the community as an integral part of identity, especially within the vulnerable groups population. Adopting a family-based approach means that the whole family becomes a focus for planning and intervention. More generally, within Albania, the transition to a family-based approach with support and services provided through or in the community reflects an in-country trend towards early intervention and localized services which are provided in an integrated and holistic manner.

5. Paragraph 6 of Article 3 of the Law 121/2016 "On social care services" defines that: "Specialized services" are services provided by the professionals of various specialisations. These services are provided at regional and municipal level to children with pervasive disorder of development, mental illness, communication disorder, children in need of physical recovery, sexually abused children, children in conflict with the law as well as abused, violated or trafficked women and girls as well as all the other categories in need of these services.

1.1. Concepts and definitions

Social protection focuses on preventing, managing and overcoming situations that adversely affect people's well-being. Social protection consists of policies and programs designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to manage economic and social risks, such as unemployment, exclusion, sickness, disability, and old age. (United Nations Research Institute for Social Development)

Social care services means an integrated and organized system of benefits and facilities, which are provided by professionals in the relevant fields of public or non-public entities, in order to ensure the well-being, independence and social inclusion of individuals and families in need of social care.⁶

Pre-social services are services which include informing beneficiaries of the social care services by service providers, assisting beneficiaries in determining their needs, making the initial assessment, supporting and assisting for the choice that corresponds to the needs of the beneficiary in the social service system. These services are provided through counselling, early interventions, online counselling.

Community services are services provided to all the categories of beneficiaries of the social care services in local community centres or other premises, including day care services or temporary replacement of the guardian. These include home care, alternative, multifunctional services, day care and half day care services, as well as 72-hour emergency and sheltered housing services for homeless people.

Residential services are 24/7 and long-term specialized services of care provided to individuals in need (children and adults), in public and non-public residential centres.⁷

Homecare services are social care services provided at the home of categories in need which are unable to receive community, day and residential services.

Specialized services are services provided by the professionals of various specialisations. These services are provided at regional and municipal level to children with pervasive disorder of development, mental illness, communication disorder, children in need of physical recovery, sexually abused children, children in conflict with the law as well as abused, violated or trafficked women and girls as well as all the other categories in need of these services.

Telephone or online counselling services is a service provided through the 24/7 telephone line for the support, counselling in time of crisis and referral of cases of domestic violence and protection of children, according to the prepared and approved protocols.

Beneficiary of social care services is the subject, individual or family that fulfils the conditions to avail of the rights related to social services.

The basket of social care services contains a variety of services, which include: pre-social services, homecare services, community services, residential services and specialized services.

6. Law No. 121/2016 "On social care services in the Republic of Albania".

7. DCM No. 518 dated 04/09/2018 "On community and residential social care services, criteria, procedures to benefit and the amount of personal expenses for the beneficiaries of organized service".

De-institutionalization refers to the dissolution of residential institutions and the transfer of care and services from closed, relatively long-run institutions to community-based services, which have lower costs and are closer to the citizens' needs.

Decentralization means the transfer of rights, duties and responsibilities as close as possible to the local government, as a way to bring services closer to the citizens.

Diversification refers to the promotion of new models of integrated social services provision by governmental and non-governmental providers.⁸

The Needs Assessment and Referral Unit in the Municipality means a structure responsible for: identifying needs for social services; needs assessment based on the vulnerability mapping; drafting a costed local social plan; planning the basic social services basket; contracting social care service providers through procurement procedures, in accordance with the applicable public procurement legislation; collecting and compiling information, statistics and maintaining the register of beneficiaries and collecting information on public and non-public service networks operating within the jurisdiction of the municipality.

The Social Fund means the financial mechanism through which financial support is provided to the local government units, in order to improve the standards and delivery of existing services of social care, to plan new non-existing services, as well as to develop social policies at central and local level.

The LGU social worker means the professional, according to the relevant applicable legislation, in the needs assessment and case referral units (NARU), who will be responsible for identifying needs, referring, managing and following up cases.

The social administrator means the civil servant of the local government bodies, who evaluates, verifies and administers the process and documentation of the application for cash assistance, disability allowance benefit and provision of social services to individuals in need, via the national electronic register.

The National Electronic Register of Social Care Services means the electronic database of beneficiaries, providers, responsible institutions, type and duration of social care services.

Bio-psycho-social assessment for people with disabilities is a new multidisciplinary model based on WHO standards for the overall assessment of the needs of the individual, adult or child, with disabilities and not focusing solely on their diagnoses. The new approach includes a complete integrated package for PWD from early identification, diagnosis, needs assessment, comprehensive case management, counselling, rehabilitation through specialized social and health services, and, as appropriate, integration for employment and education or vocational qualifications.⁹

8. MSWY, *Social Inclusion Policy Paper, 2015-2020*.

9. Law no.93, dated 24/07/2014 "On the inclusion and accessibility of persons with disabilities".

1.2. Definition of integrated social and health services

Integration and integrated care

Integration means the combination of processes, methods and tools that facilitate integrated care. Integrated care means the result of the combination of these processes to the direct benefit of communities, patients or service users taking into account the “*patient-centred*” and “*population-centred*” approaches. Integrated care is deemed successful if it contributes to good care experiences and improved care outcomes and is cost-effective. Unless there is integration at the different levels of the health systems, all aspects of health care performance can suffer.

Who is integrated care for?

Integrated care is an approach for any individual where gaps in care, or poor care coordination, lead to a negative impact on care experiences and care outcomes. Integrated care is best suited for the frail elderly, for those living with chronic and long-term mental illnesses and those with complex medical needs or seeking urgent care. Integrated care is most effective when it is people-based and takes into account the diverse needs of patients/beneficiaries by:

- ▶ Providing adequate social support for women, expectant mothers and young families;
- ▶ Providing a good life for children by ensuring access to high quality education and a smooth and safe transition from education to employment;
- ▶ Providing paid parental leave of appropriate duration to enable adequate bonding, breastfeeding and postpartum care without the risk of loss of income;
- ▶ Increasing access to child care and affordable housing;
- ▶ Preventing income insecurity through protection from unemployment;
- ▶ Preventing working poverty by ensuring a minimum income;
- ▶ Promoting safe working conditions through strong occupational health schemes and paid medical leave;
- ▶ Ensuring adequate social protection for people with disabilities.

There are many definitions of *service integration*. They often refer to the structural reorganization and improved governance; for example, having a single agency responsible for such services; others mean improving cooperation between professionals from different sectors working with the same client, but in the specific context we would select the definition “*Where two or more organisations, across two or more sectors, work together to deliver health and social care well-being services; e.g. health care sector; social care sector or third sector (including community groups)*” (Hendersen *et al.*, 2020).¹⁰

They also often refer to the integration of financial resources by pooling budgets or creating specific integrated funds to support specific groups with complex needs.

Other approaches to service integration may include “*case management that evaluates, plans and coordinates the provision of services to an individual*”; “*One-stop-shops*”

¹⁰ Louise Henderson , Heather Bain , Elaine Allan, Catriona Kennedy: *Integrated health and social care in the community: A critical integrative review of the experiences and well-being needs of service users and their families*



There is already a clear consensus in the world that successful integrated care is primarily concerned with the patient experience, keeping in mind the importance of quality and cost-effectiveness in care delivery.

where services are provided from a single point of contact; various forms of partnership arrangements when two or more organizations cooperate or multidisciplinary teams, to provide the most efficient services to the citizens.¹¹

Significant obstacles to achieving integration can be encountered in terms of efforts to integrate social and health care services. Some of these examples are the following:

- ▶ Inadequate public funding for services: can lead to restrictions in the provision of services by creating waiting lists, which affect referrals and service delivery, and make it difficult to implement an appropriate integrated system;
- ▶ System complexity: stakeholders can have different roles, interests, and powers. Factors that make integration difficult are: different legislation and funding, different procedures and structures at different system levels;
- ▶ Lack of responsibility: in many systems, no one bears full responsibility for the integration of care and services, nor for the results. This is a barrier to decision-making;
- ▶ Provider-driven systems: regardless of the ideology of needs and customer-driven service systems, day-to-day practice is determined by the interests of the provider;
- ▶ Human resources: integrated services require new types of professions (e.g. case manager) and multidisciplinary teams. Staff shortages and delays in necessary training may impede the implementation of integrated care;
- ▶ Integration can become an end in itself: integration will have support as long as it yields better results to users, but will be hindered if it turns into a way to solve other system problems.

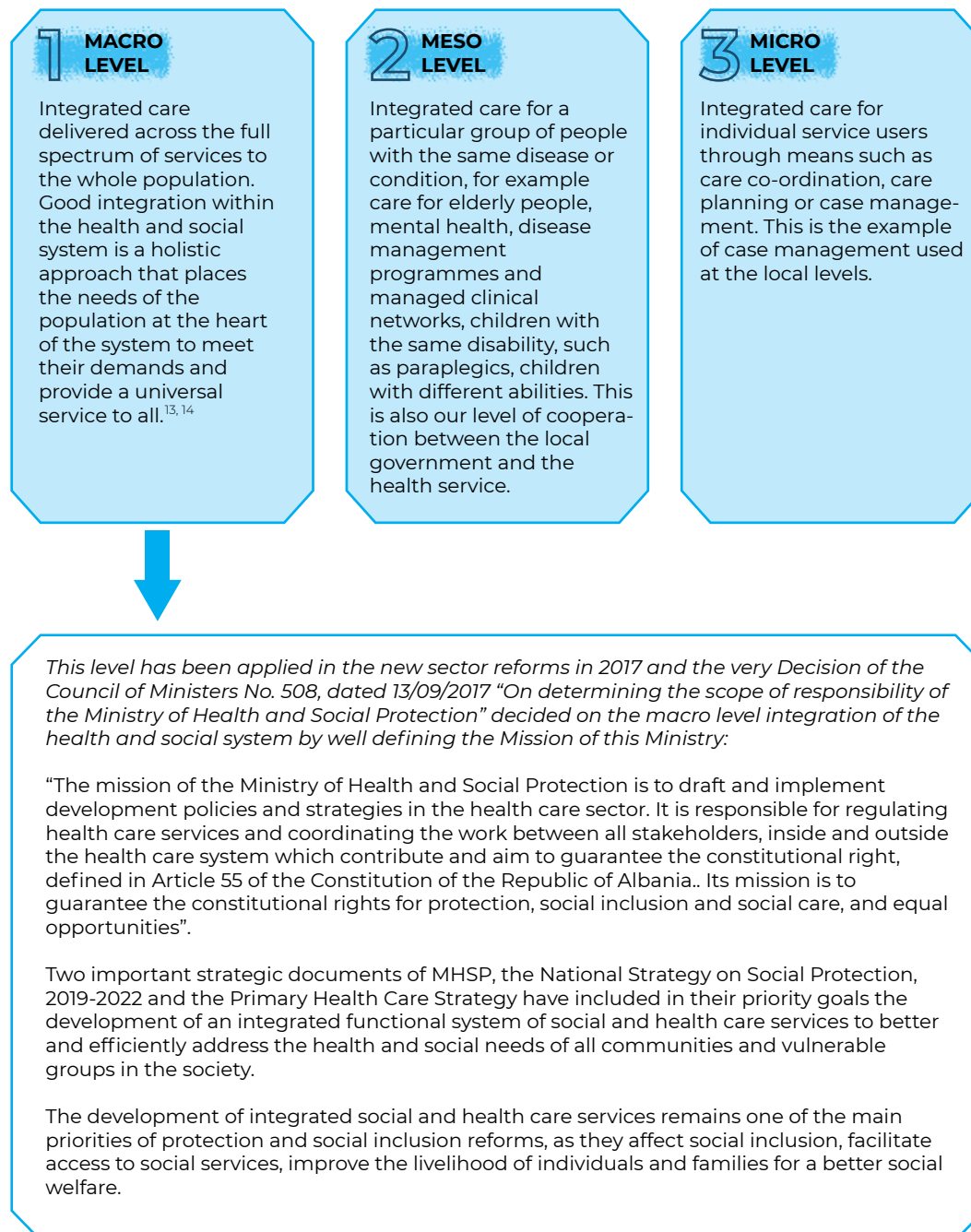
There is already a clear consensus in the world that successful integrated care is primarily concerned with the patient experience, keeping in mind the importance of quality and cost-effectiveness in care delivery. In this context, the following three dimensions of integrated care have been identified:¹²

- ▶ Integrated care seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well co-ordinated around their needs.
- ▶ Integrated care is necessary, regardless of its cost, for anyone affected by a lack of care coordination that leads to an adverse impact on their well-being and health.
- ▶ The principle of a better organization of service providers focusing on the perspective of the patient or service beneficiary is at the core of such care.

¹¹. *Integrated social services in Europe: A study looking at how local public services are working together to improve people's lives.* https://www.esn-eu.org/sites/default/files/publications/IntegratedServicesReport_FINAL.pdf

¹². *Brigid Pike, Deirdre Mongan: Health Research Board: The integration of health and social care services, February 2014*

According to global researchers, these services are organized on three major levels.



13. Kodner DL. All together now: a conceptual exploration of integrated care. *Healthcare Quarterly* 2009 Oct;13. Spec No: 6-15.

14. Suter E, Oelke ND, Adair CE, Armitage GD. Ten key principles for successful health systems integration. *Healthcare Quarterly* 2009 Oct;13. Spec No: 16-23.

CHAPTER 2

Methodology



The model of the integrated social and health care system was carried out between December 2020 - January 2021 and was guided by the principles presented by the Integrated Social and Health Services and its approach to transform the provision of social services. The biggest gap in service delivery in Albania lies in community-based services, which would enable those in need to live an independent life in their communities while avoiding institutionalization and separation from their families, based on equal rights to access to quality health and social care similar with the rest of the population and to free rehabilitation programs in their community.

The focus of the model was research on European integrated models of social and health services in order to achieve a model tailored to the Albanian context, fine-tuned with the national legal and institutional framework.

The model analysis was performed in the framework of data collection through four sources:

- ▶ A review of foreign literature to see examples of models in the European context that can be adapted within the framework of social services in Albania. The review of foreign literature has helped to approach an appropriate model of integrated social and health services at the local level.
- ▶ A review of existing legal and strategic documents related to the social care delivery and social and health care services in Albania. The purpose of the review was to collect data on existing policies and regulations for the implementation of social and health care services in Albania, as well as to identify the existing links between the two systems and services. By reviewing the documents, the types of social services were identified and a questionnaire was developed to collect the opinions, situation and challenges of stakeholders.
- ▶ Semi-structured interviews with LGU representatives in 6 municipalities (Tirana, Kamza, Rrogozhina, Devoll, Puka, Pogradec). These municipalities have different demographic and geographical characteristics. The interviews were conducted to understand the perceptions of social service structures on the access to integrated health and social care services, and to recognize existing experiences and human and institutional capacities for their provision. The interviews included managers and persons responsible for social service structures and those for project development coordination.
- ▶ Meetings and direct consultations with managers and specialists of key national institutions: Ministry of Health and Social Protection - the main policy-making institution in both, the sectors responsible for health and social policies.

Based on the above methods, the consultants worked together with the local group of municipalities selected in the project consisting of the Economic Assistance Directorate, the Social Services Directorate, and the Project Coordination Directorate in each Municipality regarding the conception, design and implementation of interventions based on the DMIC guideline.

CHAPTER 3

Integration and integrated health and social services



There is growing evidence that the integration of different public services is becoming a key policy priority in many European countries, such as new legislation, research projects, websites, conferences and publications. The main focus is on social and health services, and less on other public services such as education and employment. As the following examples illustrate, the degree of integration can be complete or partial; for example, some child services in social and educational services can be integrated leaving out other aspects.

The main arguments in favour of integrating social services with one or more public services relate to benefits for service users, specific benefits from various forms of integration, social exclusion and integration, and cost-effectiveness of integration. There is growing evidence from research and user groups that health services and social services separately are not in the best interest of service users. Selected integration of services can yield better results for users, especially for those with complex and long-term needs, such as the elderly. Another factor highlighting the need for integration is the increasing range and complexity of services in many countries. As users become more secure and empowered, their experiences and integration requirements have an increasing impact. The European Union and the Council of Europe highly prioritize the promotion of social inclusion and citizens' rights, especially for the most disadvantaged and marginalized groups in the European society. The fight against social exclusion at the local and national levels usually requires policies and integration of services to have an effective impact on multifaceted social problems.

Globalization and strong international economic competition raise important issues for countries on the cost-effectiveness of sharing major public services at the local and national levels. In this context, countries expect significant cost-effective benefits from the integration of key public services. Evidence for such expectation is still lacking. The cost-effectiveness argument is backed by the view that by having more integrated social and health services, they will have more influence at the political level to prioritize the provision of limited financial resources. On the other hand, a good integration of social and health services lowers the costs of the burden of diseases and reduces the costs of expensive specialized hospital services.



The fight against social exclusion at the local and national levels usually requires policies and integration of services to have an effective impact on multifaceted social problems.



3.1. An overview of international experiences with integrated social and health services

The term “*integration*” should be perceived as the implementation of a set of approaches and methods to have higher coordination and efficiency between different services, in order to achieve better results for service users. **These approaches include: service coordination, cooperation, partnership, collaboration, joint or cross-professional work, and more.** Therefore, “integration” is conceived as a continuum or degree of integration, with methods chosen to suit the specific needs, circumstances and opportunities to provide care to service users. Experience clearly shows that there **is no** “one model suits for all” related to integration.

Integrated services are a set of services available to a certain group of the population in a given geographical area, or to the population of a given geographical area, by a company or organization alone, under a single decision-making authority

There are different definitions of the term “integration”: *Integration, in its complete meaning, means the planning and/or provision of a single system of services, jointly managed by partners, who remain legally independent. A single system for a given service, for example, would integrate the mission, culture, management, budgets, accommodation, administration, and registers, and would be implemented at all levels of integration (team, service, or organization).*

The European Union Procure Project (2004) defines integrated care as: “A conception of the provision of care services in which individual units operate in a coordinated manner and aim at achieving cost-effectiveness, quality improvement and increased satisfaction of users and care providers. The tools to achieve this goal include increasing the efficiency of service delivery within systems, improving care continuity, personalized services in the care delivery process, and empowering service users”. (Leichsenring K, Alaszewski, 2004, p 15)

Within the same project, the French National Report suggests that: “*Integrated services are a set of services available to a certain group of the population in a given geographical area, or to the population of a given geographical area, by a company or organization alone, under a single decision-making authority*”.

The above definitions state the goals and components of well-integrated care services. The extent to which they currently exist is a different story. Integration, as implied by these definitions, is stronger than in other terms such as “joint work”, “partnership”, “cooperation” and “network”. These terms and their practices can probably be understood as important tools in achieving service integration, but these alone are far less than what is required.

3.1.1. Horizontal and vertical integration

According to the literature, there are two main effective forms of integration in social and health care systems in order to meet the needs of the citizens and the community. These forms are: horizontal integration and vertical integration.

In social care, **vertical integration** at the macro level refers to measures to achieve greater coordination policy at different levels of government - national, regional and local; and, at the micro level, in residential, community and home services for different groups of local users - all within social services alone. For example, in 1971 in the United



The vaccination program and vaccination campaigns are vertical programs that help prevent infectious diseases and are services provided in cooperation with the primary health care service covered by family medicine, and women and child counselling services.

Kingdom, a new law placed social services, which were previously separate for children and different groups of adults, under the same authority. But social services were separated from health and education services at the local authorities.

In health services, vertical integration unites the hospital, clinical and community health services. “The highly technical” interdisciplinary health care is increasingly in demand as the patient moves in and out of different settings, implying that patient care will be more vertically oriented (see Delnoij et al, 2002). The same article notes how the integration of services at the micro level is influenced by the characteristics of health systems at the macro level (for example, funding mechanisms); and how “fragmentation and lack of coherence, and the inability or unwillingness to engage in interdisciplinary cooperation are serious problems in many health care systems in Europe”.

Vertical integration brings together the organizations at different levels of the hierarchical structure, for example, the primary with secondary care, or general practice with community care.

A good example of vertical integration in our health care system are vertical public health programs, such as the early breast cancer screening program, the cervical screening program, which integrate primary care and hospital services through these patient-centred programs which focus on the prevention and early detection of diseases.

The vaccination program and vaccination campaigns are vertical programs that help prevent infectious diseases and are services provided in cooperation with the primary health care service covered by family medicine, and women and child counselling services.

Their prevention leads to lower costs of hospital services, increases the quality of the patients’ lives, who no longer visit more complex services which would affect their mental health through increased stress and their social lives.

Horizontal integration is quite different. It refers to movements to merge separate public services to the benefit of service users, for example health and social services. This type of integration is the main but not exclusive focus for many European initiatives. The main services that social services can integrate with at varying degrees are health, education, employment, financial assistance, and criminal justice services. Successful horizontal integration is needed at all levels, starting with the integration of separate ministries at the national level.

An example of horizontal integration of integrated services in the country is one of *the most important reform initiatives and that is moving from the medical definition of disability to the bio-psycho-social model*, which includes the revision of the criteria for assessment and definition of disability, the introduction of a multidisciplinary approach, the establishment of the necessary structures, the reform of benefits and the right to benefit from schemes without the contribution of the employee, as well as the establishment of an information and communication system.

To date, many rehabilitation centres have focused mainly on health issues and rehabilitation activities, ignoring the social needs of people with disabilities. Approaches to cultural, sport, and recreational activities require a broader focus on rehabilitating vulnerable groups.

3.2. Needs, challenges and obstacles of integrated care - different examples

The need for integrated care

The idea of integrated care is not new. The concern about the lack of integrated care dates back to the beginnings of health care. This concern relates to the system and service fragmentation, which cause individuals to “fall into care gaps” – e.g. primary/secondary care, social/health care, mental/physical health care,

Integrated care, on the other hand, focuses on the needs of users. It means different treatments/services for different people, focusing on the patient perspective. Achieving integrated care requires that those involved in planning and service delivery be based on the patient perspective, as the organizing principle of service delivery (Shaw et al 2011, after Lloyd and Wait 2005)

Full structural integration of health and social care is rare and there is little supporting evidence. Structural integration is necessary and sufficient to achieve successful care integration and partnership by working. Different forms of integration are suitable in different settings and contexts. Some argue that the network approach, based on partnership sustainability, is more appropriate in addressing complex policy challenges. Partnerships and other forms of integration need to function within the organization and governance structures, so it is essential that organizations choose the model of integration that is most appropriate for their local needs. Possible organizational barriers to integration include initial service configuration, access, and eligibility.

Financial integration mechanisms include complex legal and financial frameworks, for example partners contributing to unified budgets need to agree on financial contributions, resource issues, partnership agreements and human resources.

Why is integrated care an important challenge?

Integrated care is a complex approach in cases where gaps or poor coordination in care delivery have a negative impact on its experience and outcome. Integrated care is more suitable for the frail elderly, for those living with chronic illnesses or long-term mental health illnesses, and for those with complex medical needs or seeking urgent care. It is most effective when it is people-based and takes into account the overall patient needs. Disease-based approaches lead to fragmentation of care.

Integrated care does not develop naturally in response to new needs in any care system, whether planned or market-driven. Strong leadership, professional commitment, and good management turn out to deliver genuine benefits from integrated care. Systemic barriers to integrated care need to be addressed if we want to make this happen. (Ham et al. 2011).

Among the main challenges for the integration of health and social care we can mention:

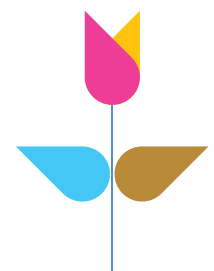
- ▶ The extent and speed of social change in society may threaten local achievement for integrated care;
- ▶ Commitment of clinical service providers to integrated care;
- ▶ The power of health and welfare boards to foster integration and exercise influence/leadership;

Limited financial resources which will or will not encourage the planning and use of integrated services.

Key organizational and managerial barriers to integrated social and health care (The Case of Scotland)¹⁵

Significant risks need to be addressed if a major health and social care reform aims to radically change the way services are delivered and improve outcomes for the people who use them. Integrating health and social care services is a key policy for the Scottish Government, focused on meeting the challenges of Scotland's ageing population by shifting resources to community care and preventative care at home, or at a home setting. The Audit Committee reviews the progress made in establishing new integration authorities which will be responsible for planning joint health and social care services and managing budgets.

The report published from the Scottish Committee found that significant risks need to be addressed if integration provides the fundamental changes needed for health and social care. These risks include difficulties with budgets, complex governance adjustments, and workforce planning.



Integrated care does not develop naturally in response to new needs in any care system, whether planned or market-driven.

15. Brigid Pike and Deirdre Mongan, (2014), *The integration of health and social care services*

Collecting health information for different groups across the organization's borders offers many opportunities to improve the health of the population. The development and implementation of integrated electronic systems is complex, costly and time consuming.

The case study of Local Health Care Cooperatives (LHCCs) in Scotland brings efforts to promote horizontal integration of primary care and related services, and vertical integration with secondary services through "intermediate care" and "managed clinical networks".

The local health care cooperative is a local integration organization that combines community health services with a range of specialized services (for the mentally ill, the elderly and people with learning disabilities) whose focus is increasingly on care given in or near people's homes'.

The transfer of management and financial responsibility to primary care practitioners encourages the transfer of decision-making and complements professional incentives with economic influence.

Service users and providers: LHCC represents a "new hierarchy of care", consisting of seven levels:

- ▶ Community health and well being – A non-medical emphasis on the control of local health hazards, and the promotion of positive health through public health programmes linked to community plans.
- ▶ Self care – Enabling people to look after themselves with the assistance of carefully designed information and educational materials, including advice offered through services delivered on line or through digital TV.
- ▶ NHS 24 – A nurse-led triage system to direct patients unable to care for themselves to the most appropriate member of the extended primary care team or in emergency to the ambulance service or hospital.
- ▶ Extended primary care – Stronger teams of primary care professionals including doctors, nurses, midwives, pharmacists, social workers etc., able to meet the vast majority of patients care needs.
- ▶ Intermediate care – Focuses on community hospitals, nursing, residential care and the patient's own home, using the skills of "intermediate care physicians", nurses, therapists and social workers. IC offers locally provided "step -up, step-down" services including investigation, rehabilitation, and respite, principally but not exclusively for the elderly.
- ▶ Secondary care – Linked through managed clinical networks, and supporting the work of the levels below.
- ▶ Tertiary care – Linked through managed clinical networks, as centres of highly specialised advice and care.

Normative integrative processes: While policy might be said to give primacy to organisational restructuring as a lever for reform, there is evidence that change in organisational and professional cultures does not necessarily occur spontaneously when organisational architecture is redesigned. A substantial literature exists on the factors that need to be addressed to achieve the shifts in professional and organisational cultures that enable a progression along this spectrum. Amongst the main messages for professional collaboration are the importance of sharing of knowledge, respecting the autonomy of different professional groups, and having a shared set of values about how to respond to shared definitions of need.



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CHAPTER 4

Integrated social and health care services in Albania



4.1. Legal framework

The current administrative and territorial reforms undertaken by the Albanian Government aim at enhancing the local government units (LGUs) cost-effectiveness, thus enabling them to provide better services and ensure that all citizens have access to them. Furthermore, these social services started in early 2013, together with the development and adoption of the National Strategy on Social Protection and the Social Inclusion Policy Paper, and the new Law on Social Services (entered into force on 24 November 2016), the proposed draft law on the Rights and Protection of Children to create a policy and legal framework for the development of community-based social services, which by their nature should be more accessible than centrally administered provisions. Providing integrated health and social services for vulnerable groups has always been a challenge. However, there is supporting legislation and policy documents in place which promote and support integrated services.

Law No. 139/2015 “On local self-governance” has charged local government units with a number of new and important responsibilities in the field of social care services, since, because of its proximity to the community, the local level is considered the most suitable for providing social services to the beneficiaries. These services include the provision of community social services, review and decision-making regarding custody procedures, and, in certain cases, the management of residential services.

Law no.121, dated 21/11/2016 “On social care services in the Republic of Albania” and the related by-laws regulate the functioning of the social care services system and in particular the process of providing services by local public bodies charged according to the Law. Article 36 of this Law obliges the Municipality to provide and administer social care services within its territory by: identifying needs; assessing needs based on the vulnerability mapping; drafting the local social plan; programming local budgets; planning basic social services basket; outsourcing the social care service delivery through procurement procedures, in accordance with applicable public procurement legislation; coordinating the necessary social care services with the State Social Service.

Decision of the Council of Ministers No. 518, dated 04/09/2018 “On community and residential social care services, criteria, procedures to benefit and the amount of personal expenses for the beneficiaries of organized service”, has defined the forms of social care services, the basket of social care services¹⁶.

Decision of the Council of Ministers No. 864, dated 24/12/2019 “On the adoption of the national policy document on ageing, 2020–2024, and the action plan for its implementation” where one of the general goals is to ensure the creation and strengthening of the social and health care system in all of the municipalities of the country, based upon the principles of the healthy ageing, by guaranteeing the utilization of qualitative services for all of the elderly that require care”.

¹⁶. Annex 3 provides details on the social care services included in this DCM

Decision of the Council of Ministers No. 405, dated 20/05/2020 “Primary health care strategy” emphasizes the importance of integrated services: health and social care services for individuals/patients. Furthermore, it highlights the cooperation with the local government to develop these integrated services by taking advantage of the social fund and various donors in order to enhance the well-being of citizens and their families.

Decision of the Council of Ministers 866, dated 24/12/2019 “On the approval of the National Strategy on Social Protection, 2020–2023, and the action plan for its implementation”, where one of its specific objectives is: the establishment of a system of integrated social and health services at the local level for family, children and individuals in need.

Mainly, the Albanian government is committed to the integration of social and health care services. The recent National Strategy on Social Protection 2019-2023 set clear objectives about the integration of social care services and health care services at the national and local levels (Table 1).

Table 1. National Strategy on Social Protection 2019-2023

NATIONAL STRATEGY ON SOCIAL PROTECTION 2020-2023

One specific objective is to create an integrated system of social and health services at the local level for families, children and individuals in need. The link between “health services” and “social services” allows for multidisciplinary handling of the individual and their family.

Functional integrated systems of social care and health services will be deployed in local government units. In each local government unit, structures/units for needs assessment and referral to social services at the local level will be established, as a central part of the social protection directorates, which have the legal obligation to draft local social plans.

- ▶ Based on the national literature review, some strategic and technical documents related to the primary health care aspects of social care services were identified and evaluated. The most important ones include:
 - Health Strategy 2016 - 2020;
 - National Strategy for Drug Control, 2020 - 2022.
 - Reproductive Health Strategy
 - Social Inclusion Strategy (2016-2020)
 - Policy Paper and Action Plan for the development of Mental Health Services 2013 - 2022;
 - The Policy Paper of the Strategy for the Prevention and Reduction of Alcohol-Related Damages in Albania, 2017 - 2021, and its Action Plan.
- ▶ Some of the main laws related to financing health care services:
 - Law No.10383, dated 24/02/2011 “On compulsory health care insurance in the Republic of Albania”, as amended;
 - Law No.9936, dated 26/06/2008 “On the management of the budget system in the Republic of Albania”, as amended
- ▶ The general legal framework, on the basis of which the protection, care and social integration is organized and delivered consists of:
 - Law No. 57/2019 “On social assistance in the Republic of Albania”;
 - DCM No. 111/2018, “On the establishment and functioning of the Social Fund”

- DCM No. 150/2019 “ On the methodology for calculating the social care services funding”
- Law No.10107/2009, “On health care in the Republic of Albania”.

However, there is little information in the literature on the specific steps that need to be taken to achieve this integration or on the evaluation of these systems integrated into LGUs. Currently, the legal framework has a well-defined vertical model of integration of social and health care services, while the horizontal model of integration needs an institutional will and coordination of inter-institutional work. The local authorities’ role in assessing health needs and in mobilizing the health system efforts to address the priority health needs of the population needs to be better defined.

On the other hand, the new Primary Health Care Services Development Strategy 2020-2025 has defined “integration of health and social services to respond to the individual needs of vulnerable individuals and groups” as one of its four main goals.

While the integration of health care and social support has already been achieved at the central level of health management, integration is expected to extend to primary health care services, in particular, given that the government’s priority is universal health coverage to ensure the vulnerable population has a basic package of services. Traditional primary health care services should include more social protection components.

A new model of integrated organization of social and health services for the groups in need is being piloted in six municipalities. This model is expected to bring such services to citizens as: long-term care, home care, palliative care, community mental health care, psychological, social and legal counselling, self-care and nutrition, rehabilitation services, parenting services and improvement of community management of non-chronic diseases¹⁷.



Integrated care is an approach for each individual, where gaps in care or poor care coordination lead to a situational impact of care experiences and outcomes.

4.1.1. Target groups of integrated care

Integrated care is an approach for each individual, where gaps in care or poor care coordination lead to a situational impact of care experiences and outcomes. From the international experience, integrated care is found most suitable for the frail elderly, for those living with chronic illnesses and long-term mental illnesses and for those with complex medical needs or seeking urgent care. Integrated care is most effective when it is situation-based and takes into account the holistic needs of patients. Disease-based approaches eventually lead to new care opportunities.

17. Primary Health Care Services Development Strategy 2020-2025

Table 2. Definitions of vulnerable groups

<p>A person with a disability is an individual, child or adult, with long-term physical, mental, intellectual or sensory impairments, which in interaction with various circumstances may hamper his full and effective participation in society in the same way as the rest of society.</p>
<p>Persons in the economic assistance scheme</p> <p>Beneficiaries of the economic assistance scheme are:</p> <ul style="list-style-type: none">a) families in need, who do not have income or have insufficient income;b) orphans who are not in social care institutions;c) parents with more than 2 children born at the same time, belonging to families in need;ç) victims of trafficking, after leaving the social care institutions, until the moment of their employment;d) victims of domestic violence, for the period of validity of the protection order or immediate protection order, who are not treated in social care institutions.
<p>Children with autism, with complex and multifaceted neurobiological disorder.</p> <p>It is such a wide-ranging situation that individuals with advanced IQs or even mental retardation may be involved.</p> <p>Autism spectrum disorders are characterized by different levels:</p> <ul style="list-style-type: none">▶ impairment of verbal communication▶ impairment of skills and social integration▶ stereotypical or repetitive behaviours, interests, and activities
<p>Victim of trafficking means any natural person who is a victim of trafficking in human beings, according to the definition of letter "e", Article 4, of Law No. 9642, dated 20/11/2006, "On the ratification of the Council of Europe Convention on Action against Trafficking in Human Beings".</p>
<p>Victims of domestic violence are all individuals, groups of individuals or families who are victims and/or potential victims of violence, including domestic violence or abuse, according to the applicable law.</p>
<p>The elderly in need - there is no definition in the Albanian law</p> <p>Lonely seniors, seniors without income, seniors without support - the category that benefits from social services.</p>
<p>Children in street situation are under the age of 18 and have some connection to the street, usually live and/or work on the street even on a seasonal or transitory basis.</p>
<p>Individuals addicted to drugs and alcohol are individuals with mental and physical disabilities, respectively the inability to stop consuming alcohol, narcotics and other psychoactive substances, regardless of the psychophysical and social harm they may cause.</p>
<p>A child in need of protection is any person under the age of 18, regardless of one's ability to act, according to the legislation in force, who may be a victim of abuse, neglect, exploitation, discrimination, violence or a criminal activity, as well as any individual under the age of criminal liability, who is suspected of having committed or is accused of having committed a criminal offence, as well as children in conflict with the law.</p>
<p>LGBTI is an acronym for lesbian, gay, bisexual, transgender and intersex people. These terms are used to describe a person's sexual orientation or gender identity. LGBTI people face discrimination of various forms such as sexual harassment and in various areas such as job recruitment and legal and health services, so their human rights need effective protection and services.</p>

4.2. Health services in Albania and the referral system

The health system in Albania is mainly public. The state provides most of the services to the population in the field of promotion, prevention, diagnosis, treatment and rehabilitation. The private sector covers most of the pharmaceutical service, dental service and some specialized diagnostic clinics and hospitals, mainly concentrated in Tirana.

The diagnostic and curative health service is organized in three levels:

- ▶ Primary health care service,
- ▶ Secondary and tertiary health care service and other national centres
- ▶ Public health service
- ▶ National Emergency Centre

The main purpose of health services is universal coverage. In recent years the health system has undergone phases of reform and significant legal changes related to improving the quality of health service delivery.

- ▶ Primary health care service is provided through a network of health professionals and institutions, based on the principles of family health care. This network consists of 413 health centres, which have been reorganized based on the implementation of the administrative and territorial reform. Primary health care is organized in such a way that every person living within the territory of the Republic of Albania, has the opportunity to use primary health care providers, enjoy the right to choose a primary health care contact and to register with the selected contact of the primary health care provider. Primary health care is provided without any restrictions from illness, age, gender, economic status or patient categories. Primary health care meets the needs for basic medical treatment, nursing care, prevention and rehabilitation, when these do not require treatment and examination techniques provided by other levels of health care.
- ▶ Secondary and tertiary or hospital health care service is a care provided to citizens in need of diagnosis, examination, and/or hospital-centred treatment that cannot be provided by primary health care, in line with the referral system and consists of 43 regional (or municipal) hospitals and 5 tertiary university health service centres that are situated only in Tirana, which provide specialized services.
- ▶ The Public Health Service with the Institute of Public Health as a reference and technical institution, and 36 Local Health Care Units which cover:
- ▶ Public health services that operate to solve the health problems and needs of the population.
- ▶ The National Emergency Centre includes clinical and pre-hospital care, in situations where the life of a citizen is in danger. The need for emergency medical service ends with the stabilization of the patient's health condition or their admission to the hospital.

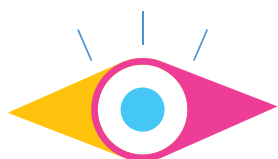
An important institutional reform saw the establishment of the **Health Care Services Provider** (HCSP) with its four regional directorates, which are part of the Public Health Service Program that are taking over a series of health care planning and administration functions in the field of primary and secondary health care services, based on the DCM No. 419 dated 04/07/2019, "On the establishment, organization and functioning of the Health Care Services Provider".

Health services in primary care and hospital care are purchased from the Compulsory Health care Insurance Fund, while investments, and part of the services covering non-

contributory categories are covered by MHSP funds because they are owned by MHSP. The Public Health Program, including the HCSP, and the emergency centre are funded vertically by MHSP resources.

Referral system

The patients' transfer within the system is regulated by the referral system. Referrals are usually forwarded by the PHC to secondary/tertiary care in the form of a request for specific consultation/examination/diagnosis on a case where the diagnosis has not yet been made or confirmed. This referral system is regulated by Order No. 493 dated 02/07/2019 "On the referral system and public health service fees" where for the first time the electronic system was applied, through which the patient is followed from the Family Doctor that is the first point of contact up to specialized services according to the patient needs.



Public social care services

account for a small percentage (less than 6.4%) of the total social protection expenditures.

4.4. Social services in Albania and the referral system

Social care services during the '90s were limited and mainly provided by non-governmental organizations or agencies; except some national residential services (for the orphans or the elderly). They were fragmented and created to respond to only one need without a long-term plan. In the meantime, the need for social services is growing. The reform of social care services, which started back in 2008, with the decentralization of some services provided at the national level, has been a slow and unstable process, because a credible formula for financing social care services has not been applied. Currently, public social care services account for a small percentage (less than 6.4%) of the total social protection expenditures.

Social service programs provided in public and non-public social care institutions aim at social protection; life insurance; health insurance; integration into social life; support for the families of children through various projects implemented in institutions; alternative services. Social care services target the most vulnerable categories, aiming at covering them with services to provide progressive coverage of the population.

The social services system includes:

- ▶ Individual home services for the elderly and vulnerable PWDs, victims of trafficking and potential victims of trafficking. These services provide supervision of physical, emotional, social functions, home assistance, personal care, psychological, social and legal counselling, as appropriate.
- ▶ Daily and community services for all vulnerable categories. These services provide psychological, social and legal counselling, specialized multidisciplinary services, personal care and food, rehabilitation services, parenting services, etc.
- ▶ Multidisciplinary services for vulnerable children, emergency services, specialized services.
- ▶ Alternative services, temporary care for vulnerable children and children with disabilities. These services are provided according to the applicable law.
- ▶ Emergency services for all vulnerable categories, which consist of case evaluation within 72 hours and case referral to other services.
- ▶ Services for young mothers and their children - temporary stay in shelters or

apartments until their final accommodation.

- ▶ Long-term residential services for the elderly, young mothers, abused women, trafficked women, alcoholics and drug users, people with disabilities. These services provide stay, accommodation, food, education, information, health services, legal, psychological and social counselling.

Social care services are provided at three levels: local, regional and national, although in 21 municipalities, social services have not been provided yet. Most social care services are provided by NGOs funded on a voluntary basis or by development partners. Services are mainly located in the largest urban areas (90% are in urban areas), and 75% are in the western and central areas of the country. Social services provided through the non-public sector, mainly funded by international development partners, international NGOs and local charities, have sought to fill in gaps in the public service delivery.

Regarding their form of financing, social services are divided into public and non-public, the latter are provided by NGOs but also by for-profit private entities.

Services funded by public funds are provided free of charge. For the first time the establishment or improvement of existing social care services is being supported both by funds allocated from the Central State Budget (Social Fund - 91307AH Item Code of the Budget Program "Social Inclusion) and by the local budget and/or donors.

Law 121/2016, "On social care services in the Republic of Albania", in Articles 36 and 37 has defined not only the role of the municipality in terms of social care services, but also its structures that must be established and operate thereof, in order to make a local community system of these services operational. Within the scope of the law, the municipality should have structures set up at two levels:

- ▶ The structure responsible for social care services in the municipality;
- ▶ Needs assessment and referral unit, established at the level of administrative units.

The roles and functions of both structures, which should be set up at two different levels of municipal organization, should be fundamentally different. The responsible structure at the municipal level should have roles and functions related to strategic management, service planning, monitoring, procurement, support of NARU structures with capacities, and operate as a bridge between the latter and the municipal decision-making leadership, in terms of social care services (Municipal Council or Mayor).

The NARU should be the implementing structure of local and national social policies, providing direct services to individuals in need.

Specifically, the tasks of the structure responsible for social care services, established within the municipality, should be: a) Identification of social care service needs in the territory under the municipality jurisdiction. b) Social care service needs assessment according to the vulnerability mapping. c) Drafting of the local Social Draft-plan, costing the necessary identified services, as well as preparation of the respective annual and medium-term budget programs, for approval by the Municipal Council. ç) Planning of the annual distribution calendar and ensuring the annual provision of the basic package of social care services. d) Provision of social services by: i) outsourcing the services to the private sector; ii) setting up and using public services. dh) Establishment and implementation of the service performance management system, based on local

standards and national minimum standards, which are approved by Instruction of the minister responsible for social affairs. e) Development and implementation of a system of performance measurement indicators, which also includes gender indicators. ë) Establishment of a service supervision system within the municipality. f) Proposal of the beneficiaries of social care services for approval by the Municipal Council.

This structure also performs functions related to: a) Administration of cash economic assistance and cash allowance for disability, in accordance with Law No. 9355 (as amended) for economic assistance. b) Child protection, in accordance with the Law "On the rights and protection of children". c) Measures for protection from domestic violence, in accordance with Law No. 9669, dated 18/12/2006, "On measures against violence in family relations", as amended.

Referral system

In each administrative unit depending on the municipality, except of municipalities with fewer than 6 thousand inhabitants, the Needs Assessment and Referral Unit is established, which, in terms of social care services and referral system should have the following main tasks:

- ▶ Identification of cases of individuals and families in need.
- ▶ Initial needs and risk assessment for individuals in need.
- ▶ Informing and counselling the public on the rights and opportunities for care and treatment, counselling on possible health and education services at the local level, counselling on employment, informing on social payments in cash.
- ▶ Drafting an individual care and support plan.
- ▶ Coordination of support for individuals and families in need, as well as referral to social care services at local, regional and central levels, according to the area of responsibility and the opportunity to provide the necessary service.
- ▶ Preparation of the necessary documentation for each individual to benefit from community services or residential service that meets the needs of the individual.
- ▶ Ongoing monitoring of the progress of cases, as well as assessment of the adequacy of the service provided.
- ▶ Entering the relevant data in the National Electronic Register for the administrative unit depending on the municipality, according to the definition of Article 29, paragraph 2 of Law 121/2016.
- ▶ Application for cash assistance scheme and disability allowance.

To perform the defined functions, the Needs Assessment and Referral Unit must have at least:

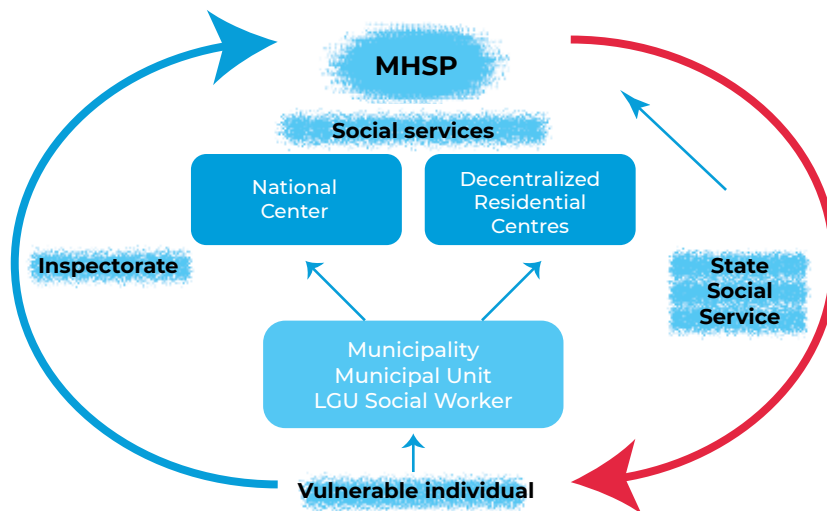
- ▶ a social worker of case assessment and referral for every 6,000 to 10,000 inhabitants;
- ▶ one child protection officer for every 3,000 children;
- ▶ a social administrator.

Each employee of this unit has specific duties, stemming from the law and by-laws which regulate the specific area they cover. Their duties are clearly specified in the Guidelines prepared for each of the employees of this unit¹⁸.

¹⁸ ESA consulting & UNICEF, Udhërrëfyes për bashkitë për planifikimin dhe administrimin e shërbimeve të përkujdesit shoqëror.

In practice, the absence of social workers at the administrative unit level has made it impossible to fulfil the legal obligations at this level, therefore, it is usually the municipal structures responsible for social services that get directly engaged in the management of various social cases. Not only does this lead to staff burnout - who do not have case management within their tasks - but it is neither to the interest of individuals in need who have to travel from their place of residence to the municipality and thus avoid the administrative unit.

Figure 2. Organizational chart of social services delivery



4.5 Financial administration at the local level for integrated social services

The financial resources and financial flow for social services is closely related to the reforms undertaken in recent years, namely the reform of social care services, mainly referred to the one since 2008, with the decentralization of some services provided at the national level. This has been a process which has had its impacts on the financing of these services and their financial flow. Of course there is no fixed formula for financing social care services.

The main financial resources of social care services are regulated by law 121/2016, “On social care services in the Republic of Albania”, and are defined as follows:

- ▶ funds allocated from the State Budget, including the social fund;
- ▶ funds from local government units budgets;
- ▶ certain revenues from assets and other activities of the municipality;
- ▶ fees for services for the beneficiaries of social care services

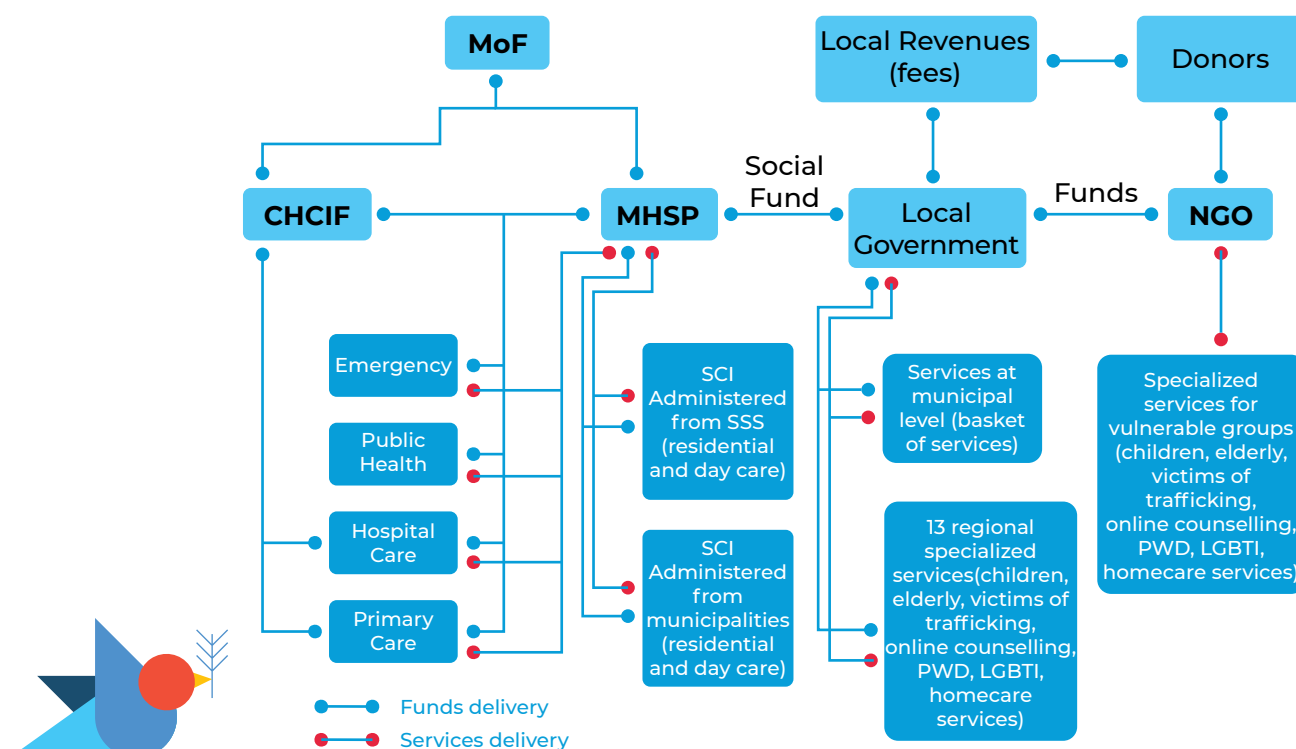
Currently, their financing consists of two forms, which is clearly shown in the following organizational chart:

There is centralization of the financing for all residential services provided by Social Care programs in MHSP and administered by SSS and SCI. Financing of families, caregivers

etc., PWD and NE payments is assessed and calculated by MHSP, but allocation is performed by the local level.

There is decentralization of the financing for all those services provided at the local level based on Law No. 139/2015 “ON LOCAL SELF-GOVERNANCE”; and Article 24 well defines the functions of municipalities in the field of social services, where municipalities up to the commune level have the responsibility for the establishment and management of local social care services; the construction and administration of social care centres and social housing; and also defines the responsibility to establish a “social fund for the financing of social services”, in cooperation with the Ministry responsible for social affairs.

Figure 3. Scheme related to health and social services funding and delivery



The Health System is financed by the State Budget through the Ministry of Finance to cover the provision of services in Public Health Programs, Emergencies and part of services and investments at the primary and secondary levels.

Financing of social and health services at the central level

Resources at the central level which are managed by the Ministry of Finance and transferred to MHSP under the program of “Social Care”. *State Social Service* which administers social care services provided in residential and day care centres. *Public SCI* which are administered by municipalities and at the regional level.

Financing of PWD and NE payments that MHSP transfers to the local government at the municipal level through SSS. They are assessed based on the assessment systems for groups in need by MHSP via the scoring systems.

The Health System is financed by the State Budget through the Ministry of Finance to cover the provision of services in Public Health Programs, Emergencies and part of



MHSP provides in its budget funds for financing social care services, which are transferred to the local government units where these social care services are delivered.

services and investments at the primary and secondary levels. (As explained in Fig2) The second source, as explained above, is the Compulsory Health Insurance Funds, which purchases services at the primary and hospital levels through payments of active contributors, which are integrated with the MHSP funds to provide services to categories in need and that are uninsured by health insurance. *This is a good example of financial integration from various sources in order to reach the categories that are not covered by health insurance to achieve universal coverage of the population.*

Financing of social services at the local level

Resources at the local level

Social care service financing may include funds from the central state budget, funds planned from local taxes and fees, property revenues and other municipal activities, donations, sponsorships and other funding from national and international partners, organizations, natural or legal persons or individuals.

- ▶ Financial resources from the Ministry of Health and Social Protection in the form of conditional transfers in the amount of 6%, which can be used by the local level for persons who they themselves identify as part of the cash assistance scheme
- ▶ Resources from the municipality's own revenues that can also be used to provide services in multidisciplinary centres and other social services such as case management, and other social activities.
- ▶ Resources from NGOs, which are funds from various donors that organize and provide social services at the municipal level entirely on their own funds or in co-financing with municipal funds for those social services that the municipality finds difficult to provide.

The Social Fund is an innovation which started its application in its broadest sense in 2019. MHSP provides in its budget funds for financing social care services, which are transferred to the local government units where these social care services are delivered. It transfers at the beginning of the year to the budget of the LGU taking into account the criteria of the highest needs and priorities of each unit in providing these services. The Social Fund operates based on the relevant legislation: Law 121/2016 "On social care services in the

Republic of Albania” which states in *Chapter II, Article 30; Article 31 - paragraph e) that “the Ministry responsible for social affairs shall allocate as a separate item in the budget the funds for financing social care services, which are then delegated to municipalities as a transfer to the social fund”; -paragraph g) states that it “shall draft and submit for approval the needs for financing from the State Budget of the social care service activities”; Article 33; Article 37; Heading III of this Law, Article 47; 48; DCM No. 111, dated 23/02/2018 “On the establishment and functioning of the Social Fund”. DCM No. 150, dated 20/03/2019 “On the methodology for calculating the social care services funding”; Ministerial Order No. 466, dated 14/06/2019 “On the establishment of a working group to assess the requests for funding opportunities for the provision of social care services”.*

The establishment of a financial mechanism such as the social fund, are integrated financial forms which allow for the implementation of decentralization policies in support of the Social Protection Strategy which transfers the rights, duties and responsibilities closer to the local government, as a way to bringing services closer to the citizens, thus **providing them with financial opportunities**.

It is recommended that this social fund received from MHSP be merged with funds for social purposes developed by the municipality or other donor funds by creating a “pooling fund”, or a better financial integration in order to better manage their provision of services and avoid fragmentation that would lead to fragmented services.

4.6. Social plans and findings from experiences with integrated services at local level



Social plans

The responsibilities, budgets and services provided to individuals in need are the sole responsibility of local government. Social plans enable the establishment and distribution of the basket of services at the local level based on local needs.

As underlined above, pursuant to the Law “On social care services” and in order to benefit funds from the state budget, municipalities shall draft a local three-year social plan, based on the identified needs for social care services. The plan should be costed for each service. All decisions on the planning, distribution and provision of social services are made at the local level, by the municipal councils where social needs arise and where the beneficiaries live. The responsibilities, budgets and services provided to individuals in need are the sole responsibility of local government. Social plans enable the establishment and distribution of the basket of services at the local level based on local needs.

Currently, only 29 municipalities have produced their local social plans. All social plans have been drafted with the technical and financial support of UN agencies (UNICEF, UNDP, UNFPA, UN Women) within various development programs. The plans are based on the preliminary needs assessment of the groups identified as vulnerable /at risk based on the municipal official data and after the consultation with the structures responsible for EA and social services, public and non-public service providers.

They have been developed for different groups and areas such as child protection, Roma community, gender equality, social service plans, etc., depending on the donor support. Generally, they are not backed by the necessary financial resources for their implementation. It is necessary to back them with the necessary funds to enable their

successful implementation¹⁹. Annex 2 summarizes the social plans of the selected municipalities in piloting integrated social and health services.

Based on the existing services and groups in need prevailing in each municipality, an integrated model of health service is proposed to be applied. Preliminary findings show that:

- ▶ None of the local government units provides direct health services to vulnerable groups.
- ▶ However, in some of the municipalities there were experiences of health interventions during the social care provision.
 - Such as the provision of some medications for children in street situation, or mediation and referral to the hospital or the family doctor, in the case of field groups in the Municipality of Tirana in cooperation with ARSIS. Also, in the Municipality of Tirana in the Community Centres, the provision of home services for the lonely seniors is being piloted, including prescribed medications and referral to the family doctor. The Directorate of Health and Education Policies in the Municipality of Tirana had a constant cooperation with UHCT and NGO in organizing awareness raising campaigns on various health issues.
 - In the Municipality of Pogradec there was an effective cooperation with the city hospital within the cooperation agreement in the Inter-sectoral Technical Group assisting emergencies of children and victims of domestic violence, of PWD and lonely seniors.
 - In the Municipality of Kamza the first phase of piloting the home service for children with disabilities was completed under the support of World Vision, which foresaw health and psycho-social care provision for children and their families. It has been years that in the Municipality of Kamza, Global Care has set up a community centre where 20 children with disabilities benefit from various therapies such as physiotherapy, speech therapy, developmental therapy, group therapy, in addition to special education, as well as from psycho-social support for their families.
- ▶ None of the local units has a social services staff with academic and professional health background.
- ▶ Municipal social sector staff report difficulties in cooperating with MHSP due to the administrative bureaucracy of referral of cases requiring immediate services.
- ▶ Municipal social services structures/social sectors staff lack experience in preparing project proposals and applying the procurement legislation on the purchase of integrated services by third parties such as NGOs.
- ▶ Despite efforts to identify all groups in need of social care services and their needs for service, we estimate that semi-structured interviews have identified shortcomings and limitations in the field related to:
 - ▶ Lack of official data for some groups in need, that although the representatives of the institutions have described as groups in need of services, no data have been entered for them. It is impossible to obtain health records from the Health Centres about their community, especially about the elderly.
 - ▶ Lack of diversified services for all identified vulnerable groups.
 - ▶ Shortage of local government staff working on case management and high number of cases in need of services urges this staff to mainly manage emergencies, without having the time to work proactively in the field.
 - ▶ Existing services are provided thanks to the partnership between local government units with non-public providers, mainly NGOs.

19. UNDP, DPSSSH, 2019.

CHAPTER 5

Development Model for Integrated Care (DMIC)



5.1. Individual integrated care models

5.1.1. Integrated case management

People living with long-term illnesses have different needs intensity, so care must be provided according to their circumstances. The model argument is that community-based care is more cost-effective than immediate care in the acute deteriorating situations.

Case management programs can focus on specific conditions and target individuals with complex needs. The main objectives of case management are:

- ▶ to reduce hospital use,
- ▶ to improve patient care outcomes, and
- ▶ to enhance the patient experience.

Key components of integrated management include:

- ▶ identifying and selecting target individuals for whom case management is most appropriate, e.g. clients (or patients) who need coordination within and across health and social care;
- ▶ evaluation and planning individual care;
- ▶ monitoring clients/patients regularly; and
- ▶ reviewing care plans if necessary.

The main tasks of a case manager are:

- ▶ to assess the patient and caregiver needs,
- ▶ to develop an appropriate care plan,
- ▶ to organize and regulate care processes accordingly,
- ▶ to monitor the quality of care, and
- ▶ to keep contact with the patient and care provider.

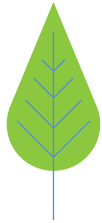
Limited-time case management targets people at high risk of emergency hospitalization. People at lower risk of hospitalization are assisted by disease management programs or rely on self-management. Both of these elements can be part of a case management program. Essential components of a case management program include:

- ▶ case finding
- ▶ evaluation
- ▶ care planning
- ▶ care coordination (usually undertaken by a case manager in a multidisciplinary team).

This may include, but is not limited to:

- ▶ drug management
- ▶ self-care support
- ▶ advocacy and mediation
- ▶ psycho-social support
- ▶ monitoring and review
- ▶ closing the case (in time-limited interventions).

The case manager usually operates within a multidisciplinary team. It is important that case managers work actively with a group of health and social care professionals involved in the program. Primary care professionals and social care staff are generally positive about the role of case managers. They particularly appreciate the role of the case manager in regularly monitoring patients as they make diagnoses and make changes to drug schemes or coordinating the overall care process. They also appreciate the role of the case manager in providing a link between primary and secondary levels and social care.



The role of health care professionals has expanded beyond providing traditional patient information and education.

Self-management support is a collaborative, patient-centred approach to caring for patient activation, education, and empowerment. In this way they seek to improve the quality of the chronic disease management centre. The role of health care professionals has expanded beyond providing traditional patient information and education. It is focused on providing help to patients so that they build confidence and make choices that lead to better outcomes and improved self-management. This approach includes:

- ▶ patient education,
- ▶ use of a wide range of behaviour change techniques to foster lifestyle change,
- ▶ adoption of health promotion behaviours, and
- ▶ skills development in a range of chronic conditions.

Patients are trained in problem solving, goal setting and the use of standardized evidence-based interventions in chronic conditions such as diabetes, heart problems, hypertension, etc.

Collaborative care planning is an important way in which individual providers can support self-management. A collaborative care plan not only focuses on the medical condition management, but also facilitates role management, negotiating necessary behavioural change from the chronic illness, and managing the emotional impact of living with a chronic illness.

5.1.2. Integrated personal health budgets

Based on the assumption that care coordination can best be performed by patients, integrated personal health budgets are an integrated care model that gives patients more autonomy over their care. Over the past two decades, personal health budget models have been piloted in the US and the UK in the areas of long-term home-based and community-based services and are now being implemented in Austria, Germany, the Netherlands and Norway. Cash payments or virtual budgets can be used not only to purchase services, but also to support family members as caregivers.

In Albania, this model is valid only for persons with disabilities and caregivers. Based on DCM No. 182, date 26.2.2020 "FOR DETERMINING THE MEASURE, CRITERIA, PROCEDURES AND DOCUMENTATION FOR THE EVALUATION AND BENEFIT OF PAYMENT FOR PERSONS WITH DISABILITIES, AS WELL AS PERSONAL ASSISTANTS" the evaluation of disability is based on a bio-psycho-social model. Four superior commissions are set up at the State Social Service, which consist of 5 members for each commission and elected by the minister responsible for health and social affairs. The superior commissions of the state social service are:

- ▶ Superior Commission for General Diseases;
- ▶ Superior Commission for Mental Health Diseases;
- ▶ Superior Commission for Paraplegia and Tetraplegia;
- ▶ Superior Commission for Blindness.

The chairman and members of the superior commission are doctors with professional experience in the field of expertise and the rapporteur of the State Social Service. The fifth member of the superior commission is a lawyer by profession, experienced in the field of disability and serves as a representative of the ministry.

The benefit measure for persons with disabilities is 10 653 (ten thousand six hundred and fifty-three) ALL per month. The personal assistant of the person with disabilities also benefits from the same payment measure. Beneficiaries of disability, who are estimated to need a hygiene package, receive an additional income payment to cover the costs of the hygienic-sanitary package, to the extent determined according to the legislation in force. This model is closely linked to the biopsychosocial model of disability assessment.

In principle, the right to have a personal integrated health budget should apply to people who are:

- ▶ persons with disabilities
- ▶ adults receiving continuing healthcare (long-term health and personal care provided outside hospital)
- ▶ children receiving continuing healthcare
- ▶ people with mental health problems.

Following the cash based integrated health budget, there is developed a personalised care and support plan. The plan sets out the personal health and wellbeing needs, the health outcomes to be achieved, the amount of money in the budget and how it is going to be spent.

5.2. Community integrated care models

5.2.1. Chronic Illness Care Model

Chronic Illness Care Model (CICM) is one of the most well-known and widely implemented integrated care models. The CICM was developed in 1998 by a group of researchers from the MacColl Centre for Health Care Innovation in the U.S. CICM suggests the shift from acute, episodic, and reactive care to care that embraces community-based, integrated, preventative approaches. Developed as a result of extensive systematic literature review, the CICM model combines evidence-based factors and components that are extensively documented to have a positive impact on patient outcomes, quality of care, and cost savings.

This model emphasizes the monitoring and prevention activities of the health situation of people with chronic health problems, that also belong to vulnerable groups such as families with economic problems, the lonely seniors, PWD, etc., in order to prevent acute situations and deterioration or unnecessary hospitalizations performed mainly in community service settings, through multidisciplinary teams consisting of nurses, physiotherapists, social workers, psychologists. Meanwhile, educational and awareness activities on non-dangerous behaviours and healthy lifestyle of an individual or group can also be held close to these centres.

5.2.2. Integrated care models for the elderly or people living in mountainous and remote locations

Integrated care models for the elderly represent another specific set of community models. This set of integrated care models is distinguished due to the specificity of individual needs which require integration between health and social services.

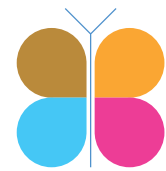
Day care for the elderly in remote locations aims to keep the vulnerable elderly in the community by avoiding or delaying institutionalization and providing comprehensive acute and long-term care services. This service is coordinated by a day care social/health centre for the adult population.

The target group may be the elderly living in the community within the geographical area of service delivery. The day care centre with vehicles for ensuring combination of mobile functioning is the main setting providing most or all of the services. In addition to providing social and recreational services, the centre also operates as an outpatient clinic with primary medical care and continuous clinical supervision and management. The centre should include a multidisciplinary team, which consists of nurses, doctors, therapists, social workers, personal care assistants, transport workers, nutritionists, etc. In case of specific case needs, the team can also make home visits.

5.2.3. Integrated services for Roma and Egyptian communities

The pilot model of Integrated Community Based Social Services (ICBSS) for Roma and Egyptian Communities, established in 2017 in Albania, introduced a new family based approach of services, meaning that the whole family becomes a focus as unit for planning and intervention. Strengthening families helps to improve the resilience of the family unit, and consequently contributes to empowering family members. The move to a family

based approach with supports and services delivered through / at the community level, will ensure early intervention and localized services which are delivered in an integrated and holistic way, targeting the most excluded communities. Strengthening families helps to improve the stability of the family unit, and consequently contributes to the empowerment of family members. The transition to a family-based approach with support and services provided at the community level will provide early intervention and localized services in an integrated and holistic manner, targeting the most excluded communities. Please read more about this model at: <https://www.al.undp.org/content/albania/en/home/library/poverty/-integrated-community-based-social-services-in-albania-to-address.html>²⁰



Strengthening families helps to improve the resilience of the family unit, and consequently contributes to empowering family members.

5.2.4. Mobile integrated care services for remote rural and disadvantaged communities

The primarily problem of rural social care and health is the extremely low density of professionals per administrative unit or surface area, resulting in large distance between people and services. To deliver services in rural areas mobile units can be used. Common forms of mobile units visiting beneficiaries or patients have been existing in Albania like:

- ▶ Family physicians making home visits accompanied with the instruments bag;
- ▶ Home emergency medical services through ambulances;
- ▶ Home visits by municipal social workers etc.

However, these services have been provided by thematic segmented teams, not in an integrated manner.

Mobile units can be set up to facilitate the fair and equitable distribution of social and primary health care services in remote and rural areas to the most vulnerable groups, such as persons with disabilities (PWD), the elderly, etc., living in social isolation due to economic reasons, residence in the outskirts or peripheral and rural areas, disability, etc. Integrated services can consist of combined medical, nursing, material, physiotherapeutic, psycho-social services through the engaged multidisciplinary teams.

20. <https://www.al.undp.org/content/albania/en/home/library/poverty/-integrated-community-based-social-services-in-albania-to-address.html>

5.3. Examples of mobile health care and social protection services for the remotest rural areas²¹

5.3.1. How to come to the aid of remote communities?

Example 1

Adelina, a 47-year-old mother of two children lives in Jollë village, within the Administrative Unit of Velçan. It is one of the remotest and poorest villages of Pogradec - one that even vehicles have trouble reaching. Only the 10 remaining families keep the village alive. Meanwhile, scarce infrastructure, which cuts off the village from the rest of the country, is over-straining the life of those few residents, many of whom living with disabilities, who remain loyal to it.

To get to the nearest village where she can access health care services, it takes her about a three hours' drive from her home. Whereas, the nearest village with a functional centre providing health care services is almost five hours away.

Adelina and her family live in deep poverty, also partly due to being cut off from the rest of the world. Such poverty has negatively impacted her health and her children's development throughout the years. As far as she knows, she suffers from thyroid glands and high blood pressure, but as days go by she fears that other silent diseases may put her at risk. On the other hand, she keeps thinking all the time about her children and their well-being.



The last time I went for a medical check-up, I spent half of the day travelling to the health centre. Imagine if one has a health emergency. Living with this fear, makes our daily lives even more difficult”

says Adelina...

21. <https://albania-undp.medium.com/shërbime-të-lëvizshme-për-kujdesin-shëndetësor-dhe-mbrojtjen-sociale-në-zonat-më-të-thella-rurale-d6e485299fda>

Example 2

Gani Sari lives in Laktesh, another Velçan village nearing complete abandonment. In addition to the family's poverty, Gani also suffers from many health issues. On top of it all, Gani's house is old and lacks running water. The lack of such a basic need forces Gani to go to the opposite side of the village and get water supply from another family.

Gani has suffered from obesity, diabetes and high blood pressure, including a condition which has left him disabled for many years. All these threatening conditions have also caused him walking difficulties. It was only after applying the diet advice on diabetes that he began to take control of his weight and move around more. Similarly to Jollë village, Laktesh also lacks a health centre, while the family mainly lives on assistance that does not exceed 6000 ALL per month. This amount is supposed to take care of Gani's health conditions, but, instead it is used to cover many other family costs first.

In order to prioritize this problem causing Adelina, Gani and other vulnerable members from the remotest mountainous areas of Pogradec, insecurities daily, a mobile health care and social services model is being piloted.

The mobile health care services not only assisted Adelina treat her current severe condition, but also discovered that she suffers from diabetes as well. The intervention team and nurse that visited her home for a medical check-up confirmed this chronic health condition after measuring her blood's glycerol level at 160 - a parameter that requires immediate intervention.

Upon receiving the necessary care, Adelina was sent to the Pogradec municipal hospital for a more specialized intervention, and she is now receiving periodical family-based medical check-ups and visits, in addition to information on how she should take care of her health in the COVID-19 context. Similarly, Gani is also receiving regular medical check-ups that include diabetes and blood pressure measuring, counselling on how to protect from COVID-19, as well as diet advice, thanks to the intervention. Apart from the obvious health improvements, Gani's mood significantly brightens with every visit from team members coming to take care of him and his family.

Thanks to mobile health care services, aid is reaching to the remotest rural areas.

CHAPTER 6

Integrated DMIC model guide



6.1. Development Model for Integrated Care and its stages

Various models have been developed in the world which focus on integrated services, in order to meet the vulnerable communities' needs. There are many examples of service integration, focusing not only on social and health integration, but also on other social factors such as education and unemployment. One such model of integrated services is the "Integrated services in the Roma and Egyptian Community", focusing on the user and the family to meet their needs.

The proposed Development Model for Integrated Care (DMIC) is generic and allows both a conceptual approach and a practical description of activities that are important for the integration of social and health services, a model developed by Minkemans et al²².

The use of this model has had positive outcomes in chronic care and it is the (Expanded) Chronic Care Model²³ that has been widely adapted internationally, and although it is a conceptual model with relatively well-defined activities, the focus is on people with chronic illnesses and on the health of the population. The purpose of this model is to integrate services - in various forms - between social and health services, by studying the employment and educational service factors.^{24, 25}

Findings from practices in particular show that the integration of services between sectors exists in various forms in a considerable number of European countries. Social services cooperate particularly with health care, but often this cooperation extends to other sectors as well. Data from practices showed more multi-sectoral integration than the literature. This finding was expected when the respondents in the study were selected according to the model. Due to the investigative nature of this study, no conclusions can be drawn regarding the distribution of cases across countries. However, it is clear that the integration of services between sectors has spread throughout Europe.

The DMIC model (Figure 1) describes the most important activities for service integration. This model has analysed numerous elements in the social, educational, health and other domains from which it has been able to create important activities for the development and implementation of integrated care²⁶. According to the DMIC, the degree of integration you can apply is correlated with the number of elements of the integrated services.



Findings from practices in particular show that the integration of services between sectors exists in various forms in a considerable number of European countries.

22. Mirella M.N. Minkman, *Developing integrated care. Towards a development model for integrated care, International Journal of Integrated Care – Volume 12, 12 October – URN:NBN:NL:UI:10-1-113824 / ijic2012-197 – <http://www.ijic.org/>*

23. Wagner, EH, Austin, BT, Davis, C, Hindmarsh, M, Schaefer, J and Bonomi, A. *improving chronic illness care: Translating evidence into action. Health Affairs. 2001; 20(6): 64–78. DOI: <https://doi.org/10.1377/hlthaff.20.6.64>*

24. Valentijn, PP, Schepman, SM, Opheij, W and Bruijnzeels, MA. *Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. International Journal of Integrated Care, 2013; 13: 1–12. DOI: <https://doi.org/10.5334/ijic.886>*

25. Barr, VJ, Robinson, S, Marin-Link, B, Underhill, L, Dotts, A, Ravensdale, D and Salivaras, S. *The Expanded Chronic Care Model: An integration of concepts and strategies from population health promotion and the Chronic Care Model. Hospital Quarterly, 2003; 7(1): 73–82. DOI: <https://doi.org/10.12927/hcq.2003.16763>*

26. Minkman, MMN. *Developing Integrated Care: Toward a Development Model for Integrated Care. Deventer: Kluwer; 2012. ISBN: 978 90 13 10026 6.*

The derived activities and this model itself have been practised in many European countries to implement efficient social and health integration models, especially in integrated services. This model is empirically validated, using cases of integrated care in people with a stroke and integrated care for the elderly population with dementia. New studies show that DMIC is also important to provide care to the population with diabetes, palliative care networks, youth care, the elderly in need, and autism care.

The components or activities that should be considered in the application of an integrated system are clustered according to importance, as follows:

Person-centred: the development of integrated services and the flow of information that suits a particular individual or a target group. Furthermore, they tailor service plans to individual requirements and in a number of cases actively involve service users in the design and implementation of service delivery at individual and group levels.

Service delivery system: the logistics flow relating to the service delivery practice. This group focuses on the mechanisms and processes that exist to modernize the health or social services delivery. One of the most developed forms is information sharing and communication via technology, which has its advantages in the provision of integrated services. On the other hand, ICT (Information and Communication Technology) can create challenges in the information flow or obligations in terms of personal data storage.

Performance management: measuring and analysing the results of the delivered service/ services and feedback to manage and improve the service delivery performance. In this activity it is very important to define what parameters should actually be measured and the measurements should be based on valid tools.

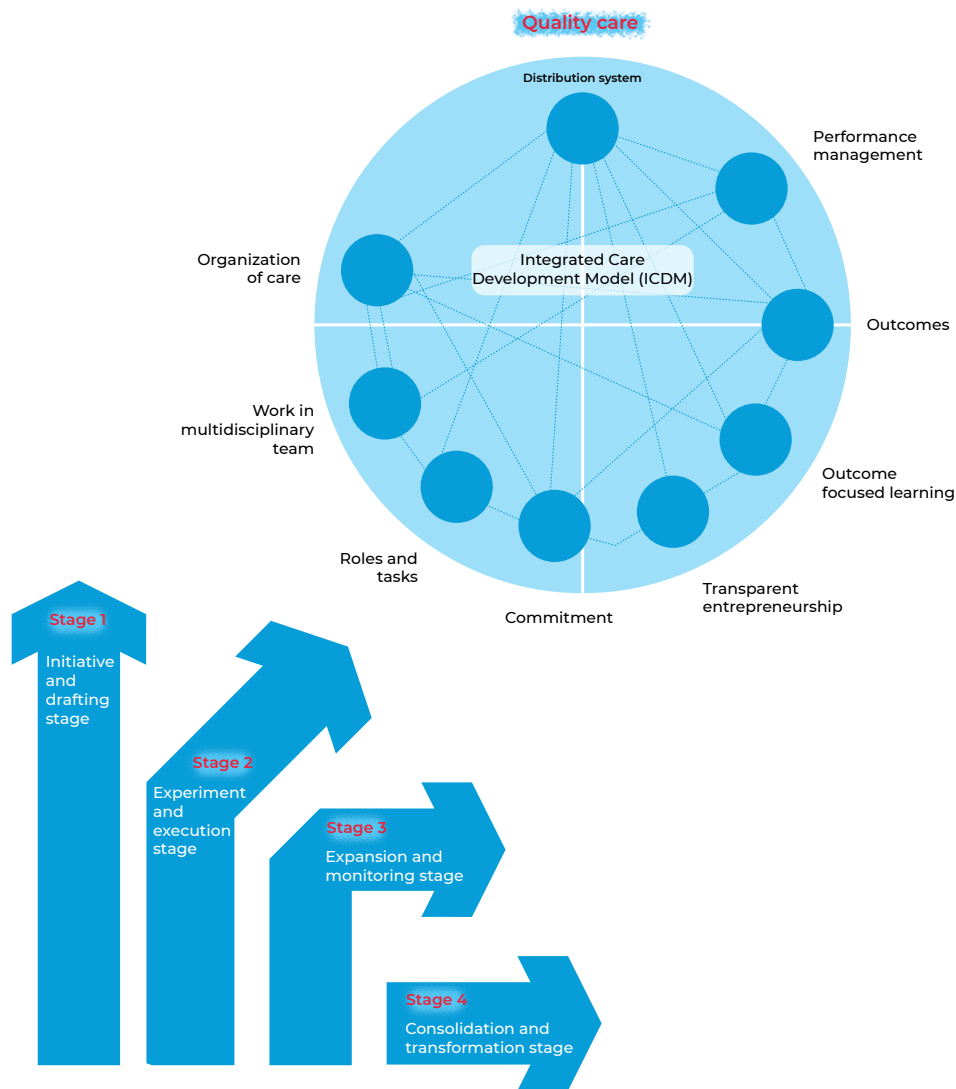
Quality care: the design quality including elements such as adherence to guideline standards, evidence-based, service users' needs and preferences. Both performance management and quality care activities have been considered as they both address measurement, standardization and evidence.

Outcome-focused learning: the presence of a practice-based learning climate, which encourages continuous improvement, as well as the development of a vision for the future.

Work in an interdisciplinary team (interprofessional teamwork): work in an interdisciplinary team for a specific target group, achieved through the cooperation of professionals working throughout the service delivery chain. This teamwork should be considered in two aspects, both vertically within the health system, and horizontally at work. Organizing cross-professional teamwork is not always a matter of developing top-down technocratic arrangements for team structuring. Instead, the focus is on creating opportunities for personal interaction. For example, literature and often practice show that even if collaborative work is imposed, it may not actually work. The literature and practices show that conflicts between professionals, for whose purposes services should take precedence, often hamper integration and collaboration. Conflict of organizational and personal interests also presents a challenge for teamwork.

Roles and tasks: This is one of the main stages with the aim of effective cooperation at all levels based on clear definitions of expertise, individual roles and tasks. Given the close

Figure 3.



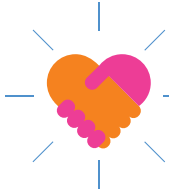
relationship between working in an interdisciplinary team and roles and tasks, we need to be careful in defining them because we are often faced with challenges regarding the division of tasks and roles within the team, often taking into account personal and professional interests.

Commitment: collaborative work practices based on clear goals and awareness of interdependencies and areas.

Transparent entrepreneurship: the ability to innovate, leadership responsibilities and financial arrangements for integrated care. Both literature and practice review show that support and guidance from different organizations are key factors in implementing an integrated service. It is important to have collaborative leadership or engagement of individuals with a multidisciplinary background by providing ongoing training to enhance their professional skills. Through the development of their capacities and skills it is important for professionals to have autonomy, to try new ways of working, to explore and challenge, to learn to understand each other in the workplace.

DMIC stages

Minkman et al. (2011) developed this conceptual model, which they named the Development Model for Integrated Care (DMIC). This model describes four stages of integrated care development which can also be applied to integrated social health services in the provision of services by local levels.



Stage 1

INITIATIVE AND DRAFTING (DESIGN) STAGE.

Collaboration between and with health care providers is important to start and amplify. The starting point is a common or occasional problem, or is based on current collaboration between care delivery professionals. There is a sense of urgency and the opportunity to work collaboratively on these challenges. At this stage, the target group of service users, the chain and process of care to be provided, as well as the needs of service users and interest groups are defined. The level of ambition, motivation and leadership are key to achieving success. An interdisciplinary team designs an experiment or project to implement the present ideas. Cooperation can be signed through an agreement between care partners. *In the context of the application of this stage within the social and health services integration at the municipal level, the approach to ensure an agreement between the local level for the provision of social services and primary health care is an important element.*

Prerequisites for projects should be considered and barriers should be limited through cooperation or agreements between social and health care providers through various organizations at the horizontal level.

Stage 2

EXPERIMENT AND EXECUTION STAGE.

New initiatives or projects need to be started and implemented in the care chain. The goals, content, roles and tasks in the care chain should be clarified and written in the care instructions and protocols. There is coordination at the care chain level, for example by appointing coordinators or holding meetings. Information is shared about groups of service users, work procedures or professional knowledge. Experiments are performed within the collaboration, the results are evaluated to learn from them and reflect on them. *Prerequisites for projects should be considered and barriers should be limited through cooperation or agreements between social and health care providers through various organizations at the horizontal level.*

Stage 3

EXPANSION AND MONITORING STAGE.

Projects have been expanded or integrated into integrated care programs. Agreements on content, tasks and roles within the care chain are clear and signed. Cooperation is no longer on an informal basis. Results should be systematically monitored and areas for improvement identified. Surveys should be carried out in target groups. More collaborative initiatives emerge, such as mutual education programs. There is a continuing commitment to the ambition of the integrated care program. Inter-organizational barriers and fragmented financial structures should be on the agenda of care partners.

Stage 4

CONSOLIDATION AND TRANSFORMATION STAGE.

The integrated care program is the regular way of working and providing care. Coordination at the care chain level is operational; information is being distributed, transferred and retrieved. A monitoring system periodically indicates whether the outcomes are consistent, what specific opportunities for improvement have been identified, and to what extent the patient's needs have been met. The program goes further based on successful results. Organizational structures are transformed or newly created around the integrated care program. Financial arrangements are made by financiers, through integral contracts that cover the entire care chain. Partners in the care chain are exploring new opportunities for collaboration with other partners in the external environment.

Questions guiding the integrated social and health care services model

- ▶ What are the goals and reasons for integrated services?
- ▶ How can integrated services be tailored to individual needs and how can service users be involved in the planning and implementation of integrated services?
- ▶ How many integrated services can be organized, provided and managed?
- ▶ How can the results of integrated services be measured?
- ▶ How can integrated services be financed?
- ▶ What are the success elements of integrated services?
- ▶ How can the transfer and sustainability of integrated services be ensured?

Practical implications

The development model can be used as a tool for evaluation and discussion in integrated social and health care practice at local and central levels. Managers and professionals can use the model to reflect on the development of their practice, to discuss which elements are present or missing, and to identify suggestions for improvement, based on current conditions where they can be applied. The relationship between the development process and the results achieved through integrated care is an important element to analyse and draw lessons for the future. The model is accompanied by an action plan regarding the intervention aspects of the model (Annex 1).

Human resource development

Multidisciplinary teams (MDTs) are defined as operational units composed of individuals with specialized vocational training who coordinate their activities/interventions to provide services to a client or group of clients. In integrated services they are promoted as a means in enabling professionals with different backgrounds in health and social care to collaborate successfully in order to improve care outcomes. Studies show that these teams can be effective in meeting some population needs, when they are based on sufficient diversity of professions and disciplines, appropriate leadership and team dynamics, as well as on supportive organizations.

Some common elements of MDT include:

- ▶ a coordinator or leader who oversees and facilitates the work of the whole team;
- ▶ regular joint meetings to share assessments and concerns about cases;
- ▶ documentation of all contacts, assessments and interventions of team members with an individual and their family, preferably through an electronic record.

Practice in MDTs shows that a number of benefits for both team members and beneficiaries have been identified:

- ▶ MDTs enable professionals and practitioners from different backgrounds to better communicate each other's roles and responsibilities.
- ▶ MDTs provide a shared identity and purpose that encourages team members to trust each other.
- ▶ MDTs bring better communication and trust between team members and more holistic, person-centred practice.
- ▶ MDTs tend to prevent unnecessary mistakes and avoid harm associated with individuals and their families.
- ▶ MDTs use resources more efficiently by reducing duplication, having higher productivity, and applying preventive care approaches.
- ▶ MDTs create the conditions for professionals and practitioners to feel less isolated and this brings encouragement among members and reduces stress.

Evidence-based studies have also shown that work at MDT enhances:

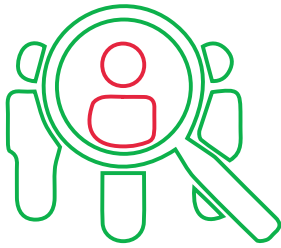
- ▶ results of working with beneficiaries
- ▶ better coordination of services
- ▶ the quality of specific treatment plans/interventions
- ▶ satisfaction of beneficiaries.²⁷

MDTs in integrated services consist of different practitioners such as social workers, psychologists, nurses, various therapists (speech therapists, physiotherapists) varying on the specific needs and services of the target groups/beneficiaries. All the above practitioners are included in the multidisciplinary team as active members by:

- ▶ sharing information with each other
- ▶ contributing to the fuller identification of user needs
- ▶ participating in drafting the treatment plan
- ▶ participating in the implementation of the treatment plan
- ▶ evaluating the results

Regardless of their professional background, all team members participate in training aimed at continuous qualification, contributing to raising the awareness of community members and preventing health and social problems.

27. Huxley et al 2011, Prades et al 2015, Cancer UK 2016, EU 2017



The NARU social worker will focus mainly on identifying needs and managing cases, following them up and coordinating with service professionals where cases will be referred as needed.

Multidisciplinary teams dynamics

Most MTDs consist of 4-9 members. These teams are guided by certain rules that are otherwise called group norms. Norms determine what is good and bad for the joint activity, what is permissible and acceptable behaviour; norms related to the members' communication and relationships in the workplace. They also deal with the team responsibilities, its functioning and purpose, sanctions for breaking the rules, decision-making, etc. The formulated rules should be flexible anyway.

With reference to the findings in six LGUs and to create the possibility of applying an integrated functional model it is necessary that either multidisciplinary teams (social and health) in NARU operate in the municipality, or the NARU social worker shall manage cases in cooperation with multidisciplinary teams that are being set up close to the multifunctional services or partner NGOs currently operating in the territory of the municipality. These multidisciplinary teams will consist of different practitioners such as social workers, psychologists, nurses, various therapists (speech therapists, physiotherapists) varying on the specific needs and services of the target groups/beneficiaries.

The NARU social worker will focus mainly on identifying needs and managing cases, following them up and coordinating with service professionals where cases will be referred as needed.

The main roles, functions and specific tasks of the various professionals who will be MDT members are provided in the terms of reference according to DCM **No. 514, dated 20/09/2017, "On the approval of the national list of occupations (nlo), revised". (Annex 4)**

6.2. Instructions on the practical implementation of DMIC at the local level

As shown in the above sessions/chapters, integrated services based on international experiences, but also those that are currently being piloted in some municipalities of the country, require the intervention and cooperation of several different stakeholders and professionals. Everyone's role and tasks and rules of cooperation should be clearly defined and recognized by all.

Herein we will try to present some procedures we suggest to follow in providing these services fine-tuned with the complex needs of the target groups, as well as procedures that are effective and in line with the mission and vision of health and social services at the local level.

As integrated health and social services represent a new approach to service delivery at the local level, and the social services system dynamics in the country, they should be based on a well-defined and unified understanding of the role of each stakeholder by referring to the necessary instructions in identifying and managing the cases of individuals and beneficiary groups. The development of guidelines and protocols for these services and the establishment of specific standards in providing different types of services tailored to the specific needs of groups in need, will be an ongoing work and continuous improvement in the future.

Procedures and guidelines for integrated services will aim at identifying the rules and procedures to be followed by all institutions, organizations and public or private agencies that work for and have responsibility over vulnerable categories/categories in need of health and social services. All the foreseen steps and procedures should be recognized and implemented by all stakeholders and professionals, which means that cases should be managed accordingly.

Continuity of care and levels of intervention

In order for integrated services to be balanced and comprehensive, they must consist of proactive and responsive elements, with an emphasis on prevention and early intervention/family support, which are needed especially in the case of children and adults with disabilities. When interventions are proactive, preventive, as well as emergency response services, they enable continuity of care. These interventions can be delivered at 3 levels:

- ▶ Primary or universal level: For all individuals and families within the population/area.
- ▶ Secondary or targeted level: For individuals and families from identified groups who may have more specific needs.
- ▶ Tertiary or individual level: Individual intervention plans designed for each abused or at-risk child.

Within this framework, integrated services can include a diverse range of interventions combined as needed, such as: cash assistance, food and clothing; health services which may include medical equipment such as wheelchairs for PWD or blood pressure monitors, medications; professional assistance such as speech therapy and physiotherapy; or care and other types of support such as parental education in the case of children with disabilities. (Annex 3)

These services can be provided based on the cooperation of several stakeholders, where the Municipality can play a central role, as in the case of services that are currently being piloted in the Municipalities of Puka, Kamza, Tirana, Rrogozhina, Pogradec and Devoll.

The main responsibility for providing these services rests with the NARU structure in each municipality, which, in cooperation with all actors and stakeholders, including health centres, psycho-social services in schools, NGOs that provide community services or specialized services, etc., must respond to the needs of individuals and families through case management and coordination of services.

In practice, this means that all stakeholders should:

- ▶ Refer cases in need of integrated services to NARU.
- ▶ Support NARU through service delivery.
- ▶ Support and cooperate with NARU by participating in case assessment and intervention planning meetings.

It is recommended that each structure or institution identify the Focal Point/Contact Point in order for communication and coordination of health and social interventions to be carried out effectively.

Roles and responsibilities

The main roles and responsibilities of the main institutions and structures in the provision of integrated health and social services can be as follows:

The responsibilities of the Municipality include:

- ▶ Setting up NARU by employing at least one social worker dedicated to integrated services, who is able to provide case management, intervention planning and coordination with the relevant stakeholders.
- ▶ Involving a health specialist (physician or nurse) in this structure.
- ▶ Setting up multidisciplinary teams with the participation of various professionals according to the needs of the beneficiaries, with a mixed composition of internal municipal staff and the involvement of specialists from institutions and NGOs that provide health or social services.
- ▶ Supporting the NARU work by facilitating communication within the municipal structures.
- ▶ Drafting and concluding cooperation agreements with public institutions or NGOs that provide specialized health and/or social services.
- ▶ Allocating sufficient budgets for NARU to operate efficiently including the provision of adequate office space and resources.
- ▶ Allocating or providing funds for the establishment of integrated services based on the target groups' needs assessment and interventions provided through social plans.
- ▶ Enabling social workers to participate in continuous training and activities and providing appropriate technical support.
- ▶ Promoting the status and role of the NARU structure and social workers inside and outside the municipal structure.

The responsibilities of the NARU social worker include:

- ▶ Leading the work of the multidisciplinary team, taking the initiative and organizing its meetings.
- ▶ Coordinating the multidisciplinary team and providing resources or referral services for individuals seeking combined health and social services as well as other necessary support;
- ▶ Serving as a liaison officer with NGOs, health services, social services, and other referral institutions/organizations, to provide information and connect beneficiaries with services and ensure continuity of care for them;
- ▶ Assisting individual or family beneficiaries, and informing and accompanying them to other services;
- ▶ Compiling a list of non-governmental organizations and professionals who provide free services (psychological, counselling, free medical, legal services, housing, etc.) and updating it regularly;
- ▶ Ensuring that the files and documentation for the beneficiaries and the services provided by MDT are completed and updated, by setting up an electronic database to store the data, as well as sharing an information overview on cases handled with all members of this team on a monthly basis.
- ▶ Organizing and monitoring case management meetings;
- ▶ Preparing periodic reports on services and their beneficiaries, to coordinate the activity of institutions at the local level, and refer cases, making sure to maintain the confidentiality of their personal data.
- ▶ Identifying institutions and organizations in the community that may eventually collaborate to provide successful services;
- ▶ Proposing to the social services structure at the Municipality and AU, the establishment of new necessary health and social services.
- ▶ The responsibilities of district health services and health staff include:
- ▶ Identifying persons in need of integrated services and refer them on due time to NARU.
- ▶ Facilitating and providing medical assistance, including necessary check-ups and tests.
- ▶ Joining MDT meetings, supporting the development and implementation of the developed individual plans.
- ▶ Cooperating with the municipal NARU structures for integrated services provision.
- ▶ *The responsibilities of NGOs and other service providers include:*
- ▶ Referring cases in need of integrated services to NARU.
- ▶ Joining MDT meetings and supporting the development and implementation of the developed individual care plans.
- ▶ Providing services to individuals and families in line with the approved care plan.
- ▶ Keeping regular links with NARU regarding the implementation of the plan, and managing any problematic situation.
- ▶ Providing services for family empowerment.

Case management process

The case management process describes the detailed steps that need to be taken after identifying a case so that individuals and families can receive the right services and support. All cases follow the same basic steps, although the details will be different during each stage.

The case management process has several stages, as follows:

- ▶ Identification/Referral;
- ▶ Initial assessment;
- ▶ Complete (comprehensive) assessment;
- ▶ Protection and care planning;
- ▶ Implementation, monitoring and follow-up of the plan;
- ▶ Case closure.

Data storage and reporting

In order to provide integrated services it is necessary to maintain two different types of data:

Individual data - information about the case and its management. The purpose of this information is to assist employees in implementing and monitoring plans for the direct individual/beneficiary and their families. This file will provide important information if the case needs to be examined or eventually plans need to change in the future. This information will be helpful in event the individual inquires later about the history of the handled problems and the care provided.

Reports - this is general information related to the presentation of the numbers and types of cases which have been managed so that municipalities, NARU, health centres and other services have the opportunity to monitor the service provision and implementation of customized plans. These data will assist municipalities in identifying trends of integrated services and assist in preparing evidence to advocate for services and funding.

To collect case evaluation data, interviews are conducted with individuals and their families, and regular home visits can also be arranged to assess the progress and effectiveness of the interventions set out in the individual case plan.

Family visits also enable the direct provision of services by the multidisciplinary team, including health and social interventions by various professionals.



Vizitat në familje
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6.3. Principles and standards of integrated services

Why are standards important?

Standards are important as they set the foundation for monitoring and measuring the DMIC effectiveness. In addition to external inspection, centres implementing DMIC should also develop a culture of self-inspection. These standards have been developed specifically for DMIC monitoring. The centre has sufficient staff and resources.

Funds to run DMIC have been identified and secured for at least one year. A Local Advisory Group is established and meets regularly. Private premises are available for a confidential conversation. A telephone line, computer and internet access are available for staff. Staff and volunteers have job descriptions and are aware of their roles and implementation.

These standards are not exhaustive, which means that other standards apply (for example in relation to food preparation, etc.). Pursuant to the law the following standards relate to the implementation of the Model.

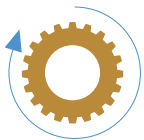
The implementation of standards affects the growth of social capital. Social capital in practical terms is concerned with the development of networks of cooperation and social resources, which include institutions, relationships and norms that shape the quantity and quality of social interactions. This will lead to the development of cooperation networks and human resources, a situation that requires the establishment of standards, as a reference point in all types of social services, aimed at all groups in need such as: children, women, people with disabilities, young people in need, the elderly, etc., to better meet their needs.

What are the standards?

“Standards” is used as a collective term to describe results and descriptive statements, which set the standard of care that a person can expect. The results are:

- ▶ I experience high quality appropriate care and support.
- ▶ I am fully involved in all decision-making about my care and support.
- ▶ I trust the people who support and care for me.
- ▶ I trust the organization that provides me with care and support.
- ▶ I experience a high quality environment if the organization provides the premises.

Descriptive statements, presented after each heading result, explain what the result looks like in practice. Not every descriptor will apply for every service. Standards are upheld by five principles: **dignity and respect, compassion, inclusion, responsible care and support, and well-being**. The principles themselves are not standards or results but reflect the way how everyone expects to be treated.



Who are the standards for?

The standards can be applied to a diverse range of services, from childcare and day care for children in their early years, to housing support and home care for adults, to hospitals, clinics and care homes.

Standards are for everyone. Regardless of age or ability, we are all entitled to the same high quality care and support. The standards will be used as a guide on how to achieve high quality care. The standards can be applied to a diverse range of services, from childcare and day care for children in their early years, to housing support and home care for adults, to hospitals, clinics and care homes. The standards do not replace or abolish the need to comply with the legislation which sets out the requirements for the provision of services. Health and care services will continue to follow existing legislative requirements and guidelines for best practices that apply to their particular service or sector, in addition to implementing the standards. Standards should be used to complement relevant legislation and best practice supporting health and care services to ensure high quality care and continuous improvement. Current guidelines for best practice can be found on the websites of the Healthcare Improvement Inspectorate Scotland.

Dignity and respect

- ▶ My human rights are respected and promoted.
- ▶ I am respected and treated with dignity as an individual.
- ▶ I am treated fairly and do not experience discrimination.
- ▶ My privacy is respected.

Compassion

- ▶ I experience warm, compassionate and educational care and support.
- ▶ My care is provided by people who understand and are sensitive to my needs and wishes.

Inclusion

- ▶ I get the right information, at the right time and in a way that I understand.
- ▶ I am supported to make informed choices so that I can control my care and support.
- ▶ I am involved in broader decisions about how the service is provided, and my suggestions, feedback and concerns are taken into consideration.
- ▶ I am supported to participate fully and actively in my community.

Responsible care and support

- ▶ My health and social care needs are assessed and reviewed to ensure my right to receive timely support and care.
- ▶ My care and support get adjusted when my needs, choices, and decisions change.
- ▶ I experience consistency between who provides my care and support and how it is provided.
- ▶ If I make a complaint, it is considered.

Well-being

- ▶ I have been asked about my lifestyle preferences and aspirations and I am supported to achieve these.
- ▶ I am encouraged and helped to reach my full potential.
- ▶ I am supported to make informed choices, even if it means I can take personal risks.
- ▶ I feel safe and protected from avoidable negligence, abuse or harm.



6.3.1. Standards of social services in Albania



The “Standards of social care services”²⁸ were developed for the first time back in 2005. They are very important to measure and help improve the quality of social services. Within the development of the private sector in the field of social services, it was necessary for the state to set some necessary rules and standards for the service quality, which had to be observed by all service providers, by public institutions (at the central or local levels), non-governmental organizations (NGOs) and private providers.

The drafting of “Standards of social care services for children in residential institutions” in 2005, was another important step in addition to setting standards of social service in Albania.

The drafting of “Standards of social care services for children in residential institutions”²⁹ in 2005, was another important step in addition to setting standards of social service in Albania. In the field of child care, the “Standards of alternative care services for children in need”³⁰ approved in 2010, the “Standards of social care services for children in need in day care centres”³¹ in 2013 and the “Standards of services in child protection units”³² were subsequently developed in 2015. They serve the social workers of these institutions and the social workers of the child services who cooperate with them, to recognize and achieve the required levels of the quality indicators of these services.

In 2006, the “Standards of social care services for people with disabilities”³³ were drafted, which are based on the document of standards of social care services and refer to all beneficiaries of social services for people with disabilities in residential and day care institutions.

In the field of gender-based violence, several important standards have been adopted: “Standards of social care services, in residential centres, for trafficked persons or at risk of trafficking”³⁴ in 2007, “Standards of social care services for victims of domestic violence in public and non-public residential centres”³⁵ in 2011 and the “Standards of service for crisis management centres for cases of sexual violence”³⁶ (located close to hospital centres, one-stop-shop service, integrated, 24/7, and short-term services) in 2018.

28. http://inspektoriaipunes.gov.al/wp-content/uploads/2014/02/Vendim-i-KM_658_17.10.2005.pdf

29. http://www.sherbimisocial.gov.al/wp-content/uploads/2016/12/Vendim-i-KM_659_17.10.2005-femijet-rezidencial.pdf

30. <http://www.sherbimisocial.gov.al/wp-content/uploads/2016/12/VENDIM-Nr.752-dat%C3%AB-8.9.2010-Per-standartet-e-kujdestarise.pdf>

31. http://www.qbz.gov.al/botime/fletore_zyrtare/2013/PDF-2013/54-2013.pdf

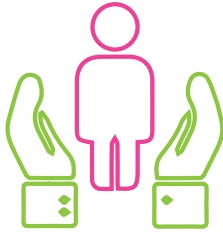
32. <http://femijet.gov.al/al/ep-content/uploads/2015/07/Vendim-Nr.-573-datë-24.6.2015-Për-miratimin-e-Standarëve-të-Shërbimeve-të-Njësisë-të-Mbrojtjes-së-Fëmijëve.pdf>

33. http://inspektoriaipunes.gov.al/wp-content/uploads/2014/02/Vendim-i-KM_822_06.12.20061.pdf

34. http://www.sherbimisocial.gov.al/wp-content/uploads/2016/12/Vendim-i-KM_195_11.04.2007-trafikimirez.pdf

35. http://www.sherbimisocial.gov.al/ep-content/uploads/2016/12/Vendim-i-KM_505_13.07.2011-dhuna-rez.pdf

36. <https://childhub.org/sq/online-biblioteka-o-djecijoj-zastiti/standardet-e-sherbimeve-ne-qendrat-komunitare-shumedisiplinore>



Within the development of the private sector in the field of social services, it was necessary for the state to set some necessary rules and standards for the service quality, which had to be observed by all service providers, by public institutions (at the central or local levels), non-governmental organizations (NGOs) and private providers.

In 2018, the “Standards of social care services in multidisciplinary community centres” were approved too.³⁷ They aim at ensuring the quality of services of these centres and their most efficient operation. The standards are designed based on the Operational Model of Multidisciplinary Community Centres and are the means which ensure the evaluation of the Model implementation. These standards are also applicable by MDCC in measuring its progress in relation to compliance with the Centres’ Model. They serve the social workers of these centres and the social workers of other services who cooperate with them, to recognize and achieve the required levels of the quality indicators of these services.

³⁷ <https://childhub.org/sq/online-biblioteka-o-djecijoj-zastiti/standardet-e-sherbimeve-ne-qendrat-komunitare-shumedisiplinore>

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Annexes



ANNEX 1

Intervention aspects of the model – Action Plan³⁸

Best practice actions	Description	Why take this action?	Who?	How to achieve it?
1. Risk assessment	Identify the people in your area who are most likely to benefit from integrated care	To increase the effectiveness and efficiency of integrated care	Integrated care leaders, supported by public health and data analysts- (GPs, care coordinators, nurses and social care)	<p>Use local population information from health and social care databases to identify the most vulnerable people, often with multiple or complex long term conditions, and/or with high needs for care. Risk stratification categorises people according to the severity of their needs.</p> <p>Usually, these individuals will be known to multiple agencies, and can be identified through need assessments, such as for frailty, or because of their frequent use of emergency services, hospital discharge or other services. Consider offering training to ensure assessment criteria are applied reliably.</p> <p>Informal information from voluntary services can also enhance knowledge about people's needs.</p> <p>Analytics and modelling, using good quality data, also generate insights into demand or potential for early intervention services, from falls prevention to tackling social isolation.</p>
2. Access to information	Ensure individuals and their caregivers have easy and ready access to information about local and community services; and that they are supported to consider these options and to select what best meets their needs	One of the challenges in any care system is to link people to the local services that are most appropriate for them, especially in a complex and difficult system. Access to information will facilitate people's involvement in their own care planning, prevention and social care, and the personalisation of care.	Local coordinators should lead the development, working with a variety of local community partners.	<p>Establishment of good, accessible information systems which have:</p> <ul style="list-style-type: none"> ▶ a single database for local services; ▶ a comprehensive listings of all local services, from statutory to voluntary, and that offer care at home and in the community; ▶ an easily accessible “front door”, or single point of access, combining both telephone and online portals; ▶ resources for maintaining and updating the database on a regular basis. <p>“Navigators” or “Coordinators” can offer support and provide guidance for those seeking services to help them select their due care.</p> <ul style="list-style-type: none"> ▶ It is critical to think beyond statutory services and to map the full range of local community assets, from home support to prevention services offered by the voluntary and community sector.

38. *Achieving Integrated Care: 15 best practice actions* ; © Local Government Association, September 2019

<p>3. Multidisciplinary team (MDT) training:</p>	<p>Invest in the development and joint training of MDTs to transform their skills, cultures and ways of working.</p>	<p>Team members from diverse organisational and professional backgrounds need to acquire new skills, adapt their ways of working and facilitate communication. Joint training facilitates a shared culture and practice. Effective MDTs develop over time and with experience. Collaborative cultures, trusting relationships and reflective team learning are at the heart of team working.</p>	<p>Local managerial staff to arrange the training; and to participate.</p>	<p>A sustained investment in team development and joint training is essential, as it helps secure the practices and protocols of the integrated care delivery.</p> <p>Topics for joint training include:</p> <ul style="list-style-type: none"> ▶ standardised approaches for joint assessment, care planning, care coordination, care management. ▶ making the shift from reactive to proactive and preventive care. ▶ working with shared care records, and information sharing. ▶ personalisation and co-production methods, including shared decision-making. ▶ team development to improve working relationships and behaviours, joint problem-solving, shared accountability. ▶ involvement of link workers (care navigators) to support self-care and social prescribing. <p>Co-location of team members has been shown to enhance the ability of teams to communicate and collaborate.</p>
<p>4. Personalised care plans:</p>	<p>Develop personalised care plans together with the people using services, their family and caregivers.</p>	<p>Care planning that directly involves individuals and those who care for them is more likely to produce plans that build on the person's own strengths and assets, support shared decision-making, and meet the person's care goals.</p>	<p>Integrated care leaders, clinical leaders and "users by experience" (to co-develop standards and practices).</p> <ul style="list-style-type: none"> · Specialists to facilitate learning programs for MDTs. · Local system leaders to tackle barriers. 	<p>When care is personal, the focus is placed on the individual at the centre of their care because they know best what their needs are and how to meet them.</p> <p>The starting point is the person's own strengths and goals, with care planning directly involving the person. Whoever is assessing needs and developing plans must adopt this guiding principle.</p> <p>Realising the ambition of personalised care requires a cultural shift. As covered in action 3, training of multi-disciplinary teams ensures that the necessary standards and practices become adopted. Learning programs should cover:</p> <ul style="list-style-type: none"> ▶ best practices for involving people in care planning and setting care goals ▶ how to plan for prevention and self-care ▶ supporting shared decision-making, patient activation, motivational interviewing, and other techniques ▶ how to involve people's families and caregivers in the planning process. ▶ Personalised care planning is best facilitated by an effective and accessible system of shared care records, one that incorporates standardised practices. <p>A personalised care plan is more than just the technical output of an assessment – it should encompass the quality of these plans from the perspective of the person. Finding ways to receive feedback will support better care and improvements in future planning.</p> <p>Plans must be reviewed on a regular basis, since people's needs and goals will change over time, as their health conditions and personal circumstances change.</p>

<p>5. Rapid response</p>	<p>Through a single-point of access, provide access to integrated rapid response services for urgent health and social care needs.</p>	<p>Having an effective crisis response in the community helps to stabilise changing conditions, keep people at home and avoid unnecessary emergency hospital attendances and admissions.</p>	<p>Social care workers, working with local partners.</p>	<p>Setting up an effective single point of access with 24 hour coverage enables an effective rapid response system to respond to people with urgent needs:</p> <ul style="list-style-type: none"> ▶ a clear model of care and agreed protocols, including referral for handling urgent and emergency care needs that arise from the targeted population, whether they are people living at home, in care homes or elsewhere in the community. ▶ a fully integrated rapid response team, ideally available 24 hours, delivered by a range of health and social care professionals. ▶ a single point of access – usually telephone triage in a hub – from which to coordinate the rapid response, and which is linked to a shared care record system. <p>The community-based urgent care system is suitable for any person at high risk of entering a crisis. This includes anyone receiving integrated care at home or in the community, care home residents, those who frequently attend hospital emergency care, or people recently discharged from hospital.</p>
<p>6. Operational framework</p>	<p>Create an integrated care operational framework that is right for the local area, and which highlights benefits for local people.</p>	<p>Moving from a shared vision for the new local system to real change requires collaborating with service providers to have a shared operational framework and goals.</p>	<p>Joint specialists/coordinators and integrated care leaders, working with local providers.</p>	<p>Operational frameworks translate system leaders' vision and strategy for integrated care. An operational framework will be unique to each local area; it is not a "one size fits all" approach.</p> <p>Aiming to meet the needs of local people, and staying people-centred in focus, the framework should describe: how care will be organised and provided; how outcomes will be achieved, the range of services available; and how prevention and early intervention are incorporated into the offer.</p> <p>The framework should be co-produced by local providers, front-line staff and local people, so as to ensure:</p> <ul style="list-style-type: none"> ▶ the framework maximises the potential and capacity of local assets and resources, including the voluntary and community sector. ▶ prevention and early intervention services are incorporated into the plan. ▶ engagement with front-line staff and local people maintains a focus on the development and innovation of local services. ▶ that there is support for new ways of working, and that any structural or behavioural changes are understood. ▶ front-line staff will have the autonomy and freedom to work together.

<p>7. Shared records</p>	<p>Identify and tackle barriers to sharing digital care records to ensure care providers and practitioners have ready access to the information they need.</p>	<p>Information sharing supports care planning, care coordination, proactive and urgent care management, as well as the personalisation of care, and workforce and service planning. What gets in the way are behaviours and assumptions about how to share data legally and functionally.</p>	<p>System leaders.</p>	<p>Access to shared care records is an important aspect of integrated care. A focus on eliminating the barriers to data access and data sharing will accelerate local progress. To do this well, it requires:</p> <ul style="list-style-type: none"> ▶ committed leadership, supporting culture change, openness and collaboration to perceive work processes, professional interactions and the engagement of service users. ▶ strong information governance, including through formal information-sharing agreements and partnerships. ▶ interoperability and standardisation, ensuring IT systems are able to communicate across different settings and organisations. ▶ a focus on the relevance and quality of data. ▶ staff skills development and clear guidance to ensure consistent compliance with data protection laws and the regulatory framework. ▶ processes in place to ensure customisable data sharing, tailored to the person's consent and service needs. ▶ a user-centred design, developing the facility for people to have access to their own records ▶ analytic capacity and capability to extract insights and monitor outcomes.
<p>8. Community capacity</p>	<p>Build capacity for integrated community-based health, social care and mental health services, focusing on care closer to home.</p>	<p>To support people to maintain their independence and prevent unnecessary hospital or institutional care, it is important that there is capacity within community-based services to support prevention, early intervention and rehabilitation.</p>	<p>Coordinators, leaders from local providers, including clinical leaders, and local people.</p>	<p>An objective of integrated care is to provide services to people closer to home – or at home. This means developing a greater array of preventive, therapeutic and rehabilitative services in the community.</p> <p>This requires the redesign of care pathways and the creation of new or expanded community-based services. Some services could be designed for delivery at home, and others might be accessed at a neighbourhood “hub”, which could provide primary care, community health, mental health, social care and voluntary sector services all in one place. Access to specialist care would support the management of long term conditions and urgent care, while an expanded offer of rehabilitation would help people prevent unnecessary admission to hospital or care settings.</p> <p>Coordinators should involve local people, their families and caregivers, as well as health and social care providers, in their planning efforts, so that the resulting services are better tailored to local context and priorities.</p>

<p>9. Partnership with voluntary, community and social enterprise (VCSE) sector.</p>	<p>Foster partnerships to develop community assets that offer a wider range of services and support.</p>	<p>Actively cultivating partnerships with local voluntary services, and community organisations will broaden the range of services people are able to access to keep them independent and well, such as services that support prevention, self-care and social prescribing.</p>	<p>Coordinators working with the VCSE sector and local people.</p>	<p>An objective of integrated care is to provide services to people closer to home – or at home. Limiting these services to statutory health and care ignores the often useful “assets” of the local VCSE providers, often already serving local people.</p> <p>Think broadly about how to partner with the VCSE sector to develop community-based services, support and interventions that focus on prevention, self-care, independence and well-being.</p> <p>Coordinators, working in partnerships, can:</p> <ul style="list-style-type: none"> ▶ change the community climate – shifting the emphasis from deficits and needs, to strengths and assets, creating the right environment for community engagement. ▶ reinforce an ethos of co-production, taking a co-design approach to develop the services people want, and focusing on well-being, prevention and self-care. ▶ include voluntary-led services in local authorities services to support personalised care planning. ▶ connect people to local community resources and initiatives ▶ support and encourage the full offer of schemes and programs run by the VCSE sector.
<p>10. Common purpose</p>	<p>Agree on a common purpose and a shared vision for integration, including setting clear goals and outcomes.</p>	<p>A clear shared vision and common goals help develop integration and support the necessary behavioural changes for achieving better health and well-being outcomes.</p>	<p>System leaders, building on current local arrangements.</p>	<p>Without a common purpose and shared vision, integrated care will fail with coordinators and providers not working collaboratively towards the same goals.</p> <p>It is vital for local system leaders to re-affirm their vision for integrated care and the expected goals and outcomes. This involves:</p> <ul style="list-style-type: none"> ▶ working together to align priorities and responsibilities, including the establishment of a common language and set of objectives. ▶ co-designing and co-producing goals and solutions with the service users. ▶ building commitment, ensuring leadership is shared and rooted deeper, engaging middle managers, multidisciplinary teams and front-line staff. ▶ setting medium and long-term objectives, ensuring vision and goals are tangible, well-defined and measurable.

<p>11. Collaborative culture</p>	<p>Foster a collaborative culture across health, care and wider partners.</p>	<p>Integrated care systems require people to work across diverse organisations and professions to achieve success. This requires significant culture change.</p> <p>· A development strategy that fosters collaboration at all levels is suggested.</p>	<p>System leaders.</p>	<p>Creating a joint strategy for organisational development by system leaders will set the parameters for the culture changes expected at all levels of the system. How system leaders act and behave will demonstrate these expectations in practice.</p> <p>The focus should be to develop mutual understanding and collaborative ways of working, including building capacity for tackling challenges that arise when different organisations or groups of people work together.</p> <p>System leaders have the power to address:</p> <ul style="list-style-type: none"> ▶ accountability for decision-making at the most appropriate level – system, place, neighbourhood or individual. ▶ sharing accountability for the use of joint resources ▶ facilitating opportunities for staff from different disciplines to understand each other's roles and professional identities, building trust, relationships and joint ways of working. ▶ creating opportunities for professionals from multiple settings and agencies to learn from each other and plan solutions and interventions together. ▶ developing integrated training opportunities, including offering rotational placements in different sectors. ▶ facilitating information sharing, including shared access to care records.
<p>12. Resource allocation</p>	<p>Maintain a cross-sector agreement about the resources available for delivering the model of care, including community assets.</p>	<p>Commissioning should be underpinned by firm shared agreements for how resources will be allocated in relation to outcomes, and how outcomes will be monitored. This should help to reduce or resolve competing financial incentives within the current system.</p>	<p>Systems leaders and coordinators of health and social care</p>	<p>Some of the barriers to integrated care are financial, namely how resources align with the expected model of care; how they are made available to local providers through contracts; how joined up they are in terms of outcomes and contractual incentives; and whether the lines of accountability for delivery of value and outcomes are clear.</p> <p>System leaders that actively address resource challenges and maintain cross-sector agreements will create greater scope for success. They need to:</p> <ul style="list-style-type: none"> ▶ define the shared budget available for the population groups targeted in each local unit and in line with the model of care. ▶ agree how resources will be pooled, along with the legal and governance arrangements, including cross-sector agreements. ▶ identify the types of contractual models and financial incentives that will be used for managing provider contracts. ▶ ensure the incentives within the contracts correspond with the outcomes and service changes expected.

<p>13. Accountability</p>	<p>Provide system governance and assure system accountability</p>	<p>As part of their public governance role, system leaders should regularly be monitoring progress and evaluating the outcomes and benefits of integrated care. Key is demonstrating that integrated care is making a difference to local people and that resources are being used appropriately.</p>	<p>Local system leaders.</p>	<p>Most local systems have good foundations for assuring system accountability, but the continued evolution of integrated care systems will bring new challenges – for example working over geographies larger than those for local accountability.</p> <p>Effective governance structures and processes will need to enable local priorities to be met by high-quality services and adequate resources; that decision-making is transparent and publicly accountable; that local populations have equitable access to care; and that the cultural changes associated with integrated care are fully realised.</p> <p>Local systems may need to test their current governance arrangements and introduce important changes, reviewing the following important factors:</p> <ul style="list-style-type: none"> ▶ governance arrangements that are simple, transparent and not overly burdensome or bureaucratic. ▶ clarity about where decision-making and resource allocation powers lie within the system, and how different decision-makers will be held accountable – and to whom ▶ an accountability framework that focuses on monitoring progress, assuring quality and delivering better outcomes. ▶ agreed ways of working for tackling barriers to integration, solving joint problems such as workforce planning, and sharing resources. ▶ clarity about local people's influence and involvement in governance and decision-making.
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<p>14. Human resources planning</p>	<p>Lead system-wide human resources planning to support delivery of integrated care.</p>	<p>A system-wide human resources strategy will ensure there is appropriate capacity and capability across all local settings to meet the ambition and goals of the local integrated care system.</p>	<p>System leaders, local providers from the public, independent and voluntary sectors.</p>	<p>System leaders should undertake workforce planning in partnership, and not in isolation, working with local health and care provider organisations.</p> <p>Local workforce strategies should be cross-sector in nature, covering the public, independent and voluntary sectors. They should address:</p> <ul style="list-style-type: none"> ▶ existing and future recruitment needs and retention challenges; ▶ the state of the local labour market; ▶ the skills and training required to work in new settings and in new ways; ▶ the advent and roll-out of new roles, such as link workers or care navigators; ▶ the availability of local resources for workforce development and training. <p>Using a whole-system approach to workforce planning will ensure local providers are working in partnership to address workforce shortages, such as developing innovative and shared opportunities for recruitment and retention – and avoiding competition for staff.</p> <p>Including the independent sector in social care is of particular importance to the growth of home-based and community care and rehabilitation.</p> <p>The strategy should reflect the need to develop an integrated workforce by creating opportunities for professionals from multiple settings and agencies to learn from each other and plan solutions and interventions together. This is likely to produce integrated training programs and rotational placements in different sectors.</p> <p>Involvement of local education providers in the development of the workforce strategy recognises that they too play an important part in building capacity and capability.</p>
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ANNEX 2

Social plans in the piloted municipalities

Social Plan 2021-2023, Municipality of Kamza – The Needs Assessment Report for Social Care Services has identified shortcomings in the capacity of social service structures in municipalities and AUs in terms of the requirements of the law, lack of social services especially community-based services, despite the numerous needs of the identified groups and has also set a series of priorities which are addressed through concrete measures provided in the Social Plan 2021-2023.

The Social Plan foresees interventions in three main directions: (i) Creating the necessary conditions for the establishment of the community social care services system, through the allocation of human resources, infrastructure and necessary funding, as well as intensifying the coordinating role of the Municipality to maximize the effectiveness of the stakeholders' interventions in addressing the needs of vulnerable groups; (ii) Establishing an integrated and organized social care services system to enable the well-being, independence and social inclusion of individuals and families in need of these services; (iii) Involving the community in decision-making and ensuring quality and adequacy standards of the provided services.

It is worth underlining that 2 of the plan objectives in the framework of establishing an integrated and organized system of social care services are specifically focused on the development of an integrated system of community-based health and social services for persons with disabilities and the development of an integrated system of community-based health and social services for the elderly.

Social Services Plan 2020-2022, Municipality of Puka – The Social Plan of the Municipality of Puka is based on a Needs Assessment, which shows data on the existing situation of the organization, structures and capacities of the local social care staff, individuals and groups in need in the territory of the Municipality of Puka, as well as an overview of existing services in the territory. Based on this assessment, four main goals have been defined and broken down into specific objectives: (1) Strengthening the structures and capacities of the municipal social services; (2) Developing a cross-cutting approach to social case management; (3) Establishing and operating a coordinated local network of social care services; (4) Protecting and re-integrating the families in need.

Based on the consultations conducted with public and non-public stakeholders in the field of social care services, the Plan defines different types of interventions to achieve the above goals, such as the need to set up the responsible social care services structure and the NARU, staffing with social workers, improving the needs identification and case management processes, setting up new services, prioritizing the Community Centre

for Children with Disabilities and the speech therapy and physiotherapy service for PWD. The Municipality of Puka has costed each of the activities included in the social plan according to the Decision of the Municipal Council No. 31, dated 21/05/2019 "On the approval of the mid-term budget program 2020-2022" and DCM 150, dated 20/03/2019.

Social Plan 2020 - 2022, Municipality of Rrogozhina – The Social Plan 2020-2022 approved by Decision No. 75, dated 27/10/2020 has defined concrete measures and priorities for the development of social care services in its territory, in line with the needs assessment for services identified through data collected about individuals and groups

in need; the discussions with staff and other stakeholders; and the basic basket of social care services. Lack of official data for some groups in need, lack of NARU in AU limits the ability to work proactively in the territory.

However, the definition of excluded groups or at risk of exclusion accounted for in percentage (%) against the total number of individuals in need of social services and their ranking by specific weight, has enabled the setting of three main priorities and goals to be achieved by 2022: (1) Functioning of appropriate and effective social service programs in all administrative units of the municipality, ensuring the use of diverse and quality services fine-tuned with national standards for all citizens in need of services; (2) Creating an appropriate environment that supports and assists individuals and groups in critical need to integrate into the society, while preserving human dignity, regardless of their economic, social, health status or functional autonomy, through effective local policies, in full compliance with the municipality needs and opportunities; (3) Enhancing the demand for the provision and functioning of effective services, through the awareness raising of communities, other stakeholders and of the groups in need in particular, through outreach, counselling, consultation and cooperation.

In the action plan matrix the three priorities are broken down into specific objectives and measures, institutional responsibility, indicators, timelines and costing.

Social Protection Plan 2019 – 2023, Municipality of Pogradec - The Social Care Plan approved by Decision of the Municipal Council No. 96, dated 21/10/2019, is based on the approach of providing a package of services for all categories of groups in need and on the philosophy of building partnerships between different stakeholders, such as the local and regional government institutions, international, national and local organizations, and local business entities as a potential supporter in strengthening social services. It is also supported by the Action Plan (2019-2023) which is divided into four main areas:

- ▶ Coordinating and networking services (including the service mapping and basket of services, vulnerability mapping and database for beneficiaries, sharing with operators/NGOs that provide services);
- ▶ Capacity building of structures and human resources (including strengthening the structure with staff and professional training, setting up NARU in AU based on the standards provided by law, defining roles and tasks and standard case management templates);
- ▶ Developing social services in the Municipality of Pogradec (where the provision of community and multifunctional services for children, women heads of households, the Egyptian community, and mobile home services for the elderly dominate);
- ▶ Developing prevention programs (with a special focus on empowering and educating young people and families in need).
- ▶ The NARU set-up in order to stress the social worker's role as a central professional figure in these units and the increase in the number of employees providing social care services is considered a fundamental factor to effectively address the problems of the groups in need and the community.

Social Plan 2021-2024, Municipality of Devoll - Based on the needs assessment, it was found that social care services are almost missing, and there are significant shortcomings in the social services sector, both in shortage of staff and its concentration only in the municipality structure. Meanwhile, the needs of identified vulnerable groups are numerous and complex that require immediate response within the implementation of the law.

Reorganizing public structures in charge of social care at the municipality and Administrative Units levels, strengthening their capacities, increasing their capacity for case identification, management and follow-up around the territory, through the establishment of NARU, the Child Protection Unit, the Domestic Violence Unit and cooperation with social administrators are among the plan's priorities.

The development of new services for the categories in need, starting with the establishment of a Multifunctional Centre, which will provide coordinated services for the development of children and families in need, is the next priority to be implemented within this plan.

Social Plan 2018-2020, Municipality of Tirana - Based on the basket of basic services, and the assessment of service needs in its territory and through discussions with staff and partners, the Municipality of Tirana has listed the following priorities in the development of existing social care services and new ones:

Development of existing services: Reorganization of services for children and women (especially women victims of violence and domestic violence), development of sustainable services for Roma and Egyptian communities, in addition to emergency services, registration of all cases submitted to the AU to provide referral to services, provision of home visits for cases submitted to AU, development of custody service..

Development of new services: Establishment of NARU in each Administrative Unit, day care centres and shelters for the homeless, counselling service for psychologically abused children, services for children with autism spectrum disorders, development of social services for the LGBT community, establishment of substance abuse services, setting up services for the elderly (using voluntary networks, too).

In order to develop new services, the plan aims at drafting protocols and cooperation agreements such as: drafting the NARU operation protocol; drafting pre-social services components (according to their subcategories) in the NARU protocol (including couple counselling and parenting counselling); drafting and signing a cooperation agreement with MHSP for the establishment of a pilot model of home service delivery (prioritizing PWD, the elderly); conception of the pilot model of domestic service delivery, its costing and implementation.

In every municipality where the integrated model will be piloted, groups in need have been identified. (Table 3)

Table 3. Groups in need identified by municipalities³⁹

Groups in need	Tirana	Kamëz	Rrogozhina	Puka	Devoll	Pogradec
PWD	23065	1805	465	227	1355	4352
Unemployed job seekers	10031	2854	528	315	879	N/A
Families in the EA scheme	5091	525	242	N/A	1006	4021
Families with 6% fund assistance	N/A	34	N/A	N/A	89	132
Roma and Egyptian families	90	281	N/A	N/A	180	N/A
Homeless families	533	90	270	95	21	28
Children with disabilities		395	67	N/A	184	N/A
Women heads of poor households	N/A	94	N/A	N/A	189	10
Victims of domestic violence and victims of trafficking	105	156	9	4	11	92
Elderly in need	241	80	106	N/A	8	N/A
Children in street situation/in conflict with the law/abused/exploited	N/A	189	N/A	N/A	N/A	6
Individuals addicted to drugs and alcohol	N/A	N/A	N/A	N/A	N/A	N/A
Homeless LGBTI	38⁴⁰	N/A	N/A	N/A	N/A	N/A

39. Statistical data are based on the social plans of every municipality.

40. Data from the LGBT Shelter, June 2018

ANNEX 3.

Pilot Interventions in Each Municipality

The United Nations Joint Program “Improving the Delivery of Local Social Protection Services” is providing technical assistance to the municipalities of Tirana, Rrogozhina, Devoll, Kamza, Puka and Pogradec to design and administer local social plans and provide integrated social services. This program is implemented by the Government of Albania in partnership with four UN Agencies, including UNDP, UNICEF, UN Women and WHO and with the participation of UNFPA and ILO, and is funded by the Joint Development Objectives Fund (SDG Fund). The program aims to support the Government of Albania to translate the policy goal into appropriate local action so that men, women, girls and boys living in poverty, or situations in need, have access to appropriate integrated services and quality social care and supports the overall vision of an inclusive Albania.

Municipality of Rrogozhina

The intervention in the Municipality of Rrogozhina is based on one of the priorities identified in its Social Care Plan, addressing the complex challenges of the elderly, especially those in critical condition. Through this intervention, the Municipality is developing a case management system to improve the services provided to the elderly in need, living in the urban areas.

The Multidisciplinary Team consisting of the Head of the Social Services Sector, two nurses, a physiotherapist and a social worker are initially trained to provide integrated health and social services in order to improve the quality of life of the elderly, their reintegration into the social life, care at the time of COVID19 and rebuilding actions of the dignity of the elderly over 60 years.

In order to ensure impartiality in the provision of integrated services, a three-person committee is set up consisting of: the Head of the Social Services Sector and two members appointed by the Mayor who will conduct a preliminary assessment, based on prioritization criteria of the beneficiaries. After the preliminary assessment, the cases will be referred to the Multidisciplinary Team for an in-depth needs assessment, development of individualized plans, case management, coordination with services and fulfillment of needs through the Case Management Fund.

The individualized plan based on a calendar of family visits includes the provision of health and psycho-social interventions. The social worker will be responsible for the needs assessment process, development of the individual plan according to the format presented in the training, coordination of the multidisciplinary team for each Administrative Unit, coordination of resources and services to meet the needs and provide home services in cooperation with the nurse and/or physiotherapist.

In addition to planning the care package and providing multidisciplinary services, a Case Management Fund will be made available to cover basic social, health or housing needs of at-risk-elderly, such as food packages; clothing; non-reimbursable or unaffordable prescribed drugs by a physician; sphygmomanometer.

This project also is also implementing social activities and health education for the elderly that will promote their participation in community life and at the same time engage the community, young people, adults and business enterprises to create an environment that contributes to the well-being of the elderly and their active social life.

Municipality of Tirana

The intervention in the Municipality of Tirana is focused on mobile services to respond to the rural community needs. The main aspects of the intervention are:

- ▶ Mobile service reorganized and designed by integrating health care to respond better to the community needs.
- ▶ Identification of 150 children and their families in rural areas and their support through direct health and social services to ensure their overall well-being using mobile service and a case management approach.
- ▶ Information sessions on health care and how to access existing health and community services for about 100 rural community members.
- ▶ Development of positive parenting programs for the well-being, health care of mothers and children, with a special focus on anti-COVID measures, hygiene, antenatal and postnatal care of nearly 50 new parents and mothers.
- ▶ Development of professional capacities from the health and social structures to integrate and coordinate actions in the provision of health and social care in rural areas.

As costs, quality and access to social and healthcare are all affected by distance and density, reducing inequalities in quality service provision requires a place-based dimension. The municipality of Tirana is transforming its delivery model of services by integrating social and health care and by delivering care through mobile teams to increase accessibility for rural communities and improve social and health outcomes.

Municipality of Kamza

In terms of the Social Plan, the Municipality of Kamza has a high number of children with different abilities; there are 395 children that account for 0.98% of the total number of children in the municipality. The model is also based on the needs assessment of 50 children with different abilities of the Municipality of Kamza, that were previously identified during the implementation of a project in collaboration with World Vision. These children come from families in dire economic conditions, who cannot afford private specialized centers. The implementation of this model aims at addressing the problem of missing social and health services for people with disabilities and their follow-up in the Multifunctional Center for Children and Adolescents which is in the design phase.

Four multidisciplinary teams are established including nurses, speech therapists/physiotherapists, psychologists and social workers who are trained in advance to assess the children needs and share group expertise and experience, to address these needs and prepare individual plans for each children, to conduct home visits, to share information with the team and coordinate interventions. At the same time, needs assessment templates and development of individual plans for children and their families are prepared. The Municipality Social Worker in cooperation with the nurse is responsible

for assessing each case and their needs for specialized services and will then refer these needs to the multidisciplinary team to begin providing integrated services. Based on the preliminary needs assessment, the teams provides individual therapeutic home sessions in the four areas of Kamza. The social worker will take care of the coordination of services and of the economic and psycho-social needs of the family and cooperate with the school psycho-social service on the specific needs of the cases.

Municipality of Puka

The model of this municipality aims at helping children with different abilities to have equal access in health and psycho-social services.

The intervention in the municipality of Puka is focused on providing integrated home service in remote areas of Gjegjan, Rrape, Qelez and Qerret, and Puka Health Centers, in order to empower and integrate children with disabilities in both rural and urban areas. These services are mainly consisting of home physiotherapy and psycho-social services for children with disabilities.

In advance, the project built the health and psycho-social workers' capacity in terms of access to integrated services and work in multidisciplinary teams. At the same time, efforts will be made to inform the community about the new integrated service through information stands in health centers and other public settings. The multidisciplinary team supports children with physical and learning disabilities at home and in the community. The team is committed to transforming the lives of the children through:

- ▶ Support with transitioning to independent living.
- ▶ Deliver physiotherapy for children in need.
- ▶ Manage logopedic sessions for children in need.
- ▶ Personal care and medication administration.
- ▶ Companionship and help with socialising in the community.
- ▶ Supporting leisure activities.
- ▶ Care for parents or guardians.

Municipality of Pogradec

The model of the Municipality of Pogradec is about the establishment of physiotherapy service combined with the psycho-social service, as a free public service accessible to marginalized groups facing mobility issues. The service includes the health component integrated with the social component through the establishment of a multidisciplinary team consisting of a physiotherapist, a nurse and a municipal social worker, and volunteers engaged to provide their assistance.

This intervention is in line with the Municipality of Pogradec priorities, and namely with the Social Care Plan, which aims not only to improve the provision of social and health care services but also to expand new services that contribute to the vulnerable groups' quality of life. Services will be provided for vulnerable groups, and priority will be given to persons with disabilities, paraplegics and quadriplegics, and all age groups who need to receive this service.

Individual plans are prepared for the beneficiaries, based on the data of the Municipality and the Health Centers on the patients' health conditions and individual economic possibilities, which enable specialized treatment with physiotherapy and psycho-social assistance, both in the new established clinic and at home.

A physical therapist works with an individual to make sure each mobility aid is properly fitted to the right height and position. Physical therapy exercises may also be used to increase muscle strength in the arms and legs.

Municipality of Devoll

The intervention in the municipality of Devoll is focused on assistive devices and on providing integrated services to individuals with disabilities. The main aspects of the intervention are:

- ▶ Providing persons with disabilities in Devoll, who are already part of the cash based disability payment, with the necessary customized assistive equipment (mostly wheelchairs) to facilitate their daily life.
- ▶ Another component of the intervention is the integrated health and psycho-social support for people with disabilities through a multidisciplinary team consisting of physiotherapists, nurses and psycho-social staff of the Municipality of Devoll.
- ▶ This team is also providing education and training for persons with disabilities and their caregivers in Devoll on how to use the medical equipment.

Human Resources

1. Terms of reference and the role of the social worker

The main functions and specific tasks of the social worker in day care centres

- ▶ Establishes a relationship between the centre where services are provided to families and the community for the protection, development and integration of the individual
- ▶ Keeps contacts with the family and informs it about the results and needs of the individual during the services provided at the centre.
- ▶ Evaluates the socio-economic status, housing conditions and social relations inside and outside the family, and gathers information about the individual in need.
- ▶ Participates in case discussions by providing assessments of the individual and his family in the psycho-social aspect.
- ▶ Shares and discusses with the members of the multidisciplinary team the necessary information about the client.
- ▶ When working in a team, gives opinions on needs assessment in terms of education, health and recreation for the individual in need.
- ▶ In collaboration with other specialists and caregivers, plans the care plan for social, educational, and emotional services for the individual.
- ▶ Assists in writing up and maintaining the personal file of the individual by gathering the necessary information for psycho-social balance.

In centres for PWD, the social worker implements the following care plan programs:

- ▶ Manages unacceptable behaviours
- ▶ Enhances information capacities in various fields
- ▶ Organizes and moderates important social topics for this PWD target group that displays problems of withdrawal and active participation
- ▶ Helps PWD explore their interests, develop talent and independence, enhance self-esteem and learn how to behave with others in different situations
- ▶ Organizes and manages recreational activities that promote the physical, emotional, intellectual and social development of PWD, both inside and outside the institution.
- ▶ Manages sports activities whenever they are organized in the community.
- ▶ Works in the community to raise public awareness of the problems and needs of the individual.
- ▶ Creates a support network for the individual in the community by establishing relationships between the service centre, other counterpart centres, community kindergartens and schools, the Municipal Unit, the State Social Service, or sister organizations within and outside the country operating in the same field, etc.
- ▶ Ensures the client attends the kindergarten and school and works, by following their progress on a regular and periodic basis.
- ▶ Organizes or attends sports, cultural activities organized by the community for this category.

Key qualifications required:

- ▶ Higher education, Faculty of Social Sciences;
- ▶ Good knowledge of the legal framework on children;
- ▶ Have not less than 2 years of work experience;
- ▶ Good knowledge in computer software;
- ▶ Excellent communication, mediation and interviewing skills as well as proven teamwork skills;
- ▶ Have specific experience in case management;
- ▶ Knowledge/experience/training on Applied Behaviour Analysis, Developmental and Play Therapy (preferred).

2. Terms of reference and the role of the psychologist

The main functions of the psychologist activity

The psychologist is one of the most important members of the multidisciplinary team. He is responsible for the services provided in the centres for development and integration. Since the work of the psychologist with the individual is inseparable from the surroundings and the community, the functions and tasks of the psychologist at the centre are closely related as follows:

Field specific assessments

- ▶ Performs intelligence tests to determine the IQ
- ▶ Performs draw tests for specific users
- ▶ Performs visual-motor tests to assess educational skills
- ▶ Performs psychological tests for people with severe emotional problems

The psychologist and the teamwork for program evaluation and design

- ▶ Discusses the problems of the service user with the team
- ▶ Shares and discusses the necessary information with team members
- ▶ Discusses psycho-emotional problems, behavioural problems, and the attitude that staff should have towards them
- ▶ Discusses user skills in different areas.
- ▶ Gives his/her opinion about dealing with various emotional problems (fears, jealousies, etc.).
- ▶ Discusses the atypical behaviours of persons such as: rituals, obsessions, stereotypes or disorders of sensory integrity and attitudes towards them.
- ▶ Discusses the strengths of the service user and their stimulation.
- ▶ Defines areas of immediate intervention.
- ▶ Participates in drafting the needs assessment report.
- ▶ Participates in drafting the individual educational plan together with the multidisciplinary team.
- ▶ Participates in re-evaluations.
- ▶ Gives opinions on the intervention with the caregiver.
- ▶ Completes the individual client documentation in term of problems above and maintains it.

Provides therapeutic and psychotherapeutic treatment for service users

- ▶ Provides therapeutic treatment techniques for users based on IEP (Individual Education Plan) in the field of cognition, psycho-emotional and behavioural problems.
- ▶ Provides psychological counselling
- ▶ Provides emotional support to users who need it.
- ▶ Intervenes in extreme behaviour situations displayed by different users.
- ▶ Provides techniques and therapy to modify inappropriate behaviours.

The role of the psychologist with the service user's family

- ▶ Contacts the caregiver and other family members
- ▶ Analyses any client relationships with other family members
- ▶ Analyses members' relationships between them by analysing their impact on the user
- ▶ Evaluates other family factors (abuse, hyperprotection, neglect) that may have an impact on the problems of PWD
- ▶ Evaluates the psycho-emotional state of the caregiver
- ▶ Instructs and informs the caregiver about any significant problems of the service user
- ▶ Plans and implements psycho-educational intervention in the family
- ▶ Gives advice to the caregiver in order to lift stress, stigma, etc.
- ▶ Provides psycho-emotional support for the user by setting up support groups with parents in order to: relieve stress, share experiences, etc.

Key qualifications required:

- ▶ Higher education, Faculty of Social Sciences, Psychology track (specialized in school psychology);
- ▶ Good knowledge of the legal framework for disabilities;
- ▶ Have not less than 2 years of work experience;
- ▶ Good knowledge in computer software;
- ▶ Excellent communication, mediation and interviewing skills as well as proven teamwork skills;
- ▶ Have specific experience in case management;
- ▶ Knowledge/experience/training on Applied Behaviour Analysis, Developmental and Play Therapy (preferred).

3. Terms of reference and the role of the specialist/educator

Specific functions and tasks

- ▶ Educates the service beneficiaries and provides care services to them;
- ▶ Schedules the educational work based on the standards, while respecting the needs, interests and peculiarities;
- ▶ Coordinates the work with the social worker, psychologist, caregivers, for the rigorous implementation of the daily schedule, internal rule and activities that take place inside and outside the institution;

- ▶ Develops educational programs according to IEP in groups and with individuals.
- ▶ Follows and works to strengthen the INDIVIDUAL ties with parents or relatives who have legal responsibilities;
- ▶ Reports in writing or orally to the Director on the progress of children and various problems they encounter;
- ▶ In collaboration with the psychologist develops individual plans/activities for the integration of children with disabilities or difficult behaviour.

Key qualifications required:

- ▶ Higher education, Faculty of Social Sciences, Specialized pedagogy track;
- ▶ Good knowledge of the legal framework for disabilities;
- ▶ Have not less than 2 years of work experience;
- ▶ Good knowledge in computer software;
- ▶ Excellent communication, mediation and interviewing skills as well as proven teamwork skills;
- ▶ Knowledge/experience/training on Applied Behaviour Analysis, Developmental and Play Therapy (preferred).

4. Terms of reference and the role of the physician

General description of the “Physician” group of professions, the fourth level of competence in NLO (National List of Occupations). Physicians perform the diagnosis, treatment, and prevention of disease, harm, injury, and other types of physical or mental injury, using specialized testing, diagnostic, medical, surgical, physical, and psychiatric techniques, as well as modern medicine principles and procedures. They order various laboratory tests and other diagnostic procedures to determine and assess physical and mental health, the nature of the disorder or disease, in consultation with physicians and other medical specialists. They perform the prescription, administration, counselling and monitoring of curative treatments and preventive measures, and refer the patient to other specialized services. They can be employed in hospitals, health centres, universities, research and scientific institutions, other institutions that provide health services or be self-employed.

Key functions

Physicians perform part or all of the following functions, based on the organization of work:

- ▶ Perform a physical examination of the patient to determine the health status;
- ▶ Obtain information on the history of the disease by asking the patient and his family;
- ▶ Order various laboratory tests, X-rays and other diagnostic procedures to determine the nature of the disorder or disease;
- ▶ Consult physicians and other medical specialists to assess the patient physical and mental health;
- ▶ Perform the prescription, administration, counselling and monitoring of curative treatments and preventive measures;
- ▶ Refer the patient for other specialized services such as: surgical interventions

and other clinical procedures, rehabilitation centres or other types of health care centres;

- ▶ Advise individuals, families and communities on health, nutrition and lifestyles that help prevent or treat disorders or diseases;
- ▶ Identify, manage and provide information and care before, during and after pregnancy;
- ▶ Record the patient's medical history;
- ▶ Report births, deaths and illnesses that must be registered with state authorities by following appropriate legal and professional procedures;
- ▶ Carry out research on human health and medical services;
- ▶ Prepare articles, scientific reports and other statistical materials;
- ▶ Communicate professionally with their superiors, colleagues and others;
- ▶ Respect the internal policies and procedures drafted by the organization;
- ▶ Implement the health insurance and protection rules;
- ▶ Implement the technical safety and environmental protection rules.

Employment requirements

- ▶ A university degree is usually required.
- ▶ Completed long-term specializations in this profession, according to the relevant law on higher education;
- ▶ A license to practice the profession according to the legal framework in force for regulated professions;
- ▶ Be mentally fit.

5. Terms of reference and the role of the nurse

The specialist nurse provides treatment, support and care services to people in need of care because of the effects of ageing, injury, illness or other physical or mental injury, or potential health risks. They take responsibility for planning, managing patient care, processing and implementing nursing care, supervising other health care workers that work autonomously or in teams with physicians and others. The specialized nurse administers the medication prescribed by the physician in the delivery of health care, treatment, instructions, and plans as set by nursing medical institutions and other health professionals, and takes preventive and curative measures. They can be employed in health care companies, public and private hospitals, other health care centres or be self-employed.

Key functions

Specialized nurses perform part or all of the following functions, based on the organization of work:

- ▶ Organize and plan the work and activity for patients based on the practices and standards of the institution depending on the objectives and priorities;
- ▶ Coordinate patient care activity in consultation with other health professionals and other members of health teams by implementing nursing care protocols;
- ▶ Develop and implement care plans for the biological, social and psychological treatment of patients, for diseases and care, in cooperation with other health professionals;

- ▶ Ensure the reception, tranquillity, comfort, communication with the patient and their companions;
- ▶ Identify the patient's needs and get involved in meeting them;
- ▶ Make a clinical assessment of the patient's condition by following the care report and establishing the nursing diagnosis;
- ▶ Complete the care report and other documentation of nursing care accurately;
- ▶ Plan and provide personal care, treatments and therapies including administration of drugs and treatment response or care plan monitoring responses;
- ▶ Apply technical procedures (in inserting IV, performing transfusions, administering intramuscular, intravenous, subcutaneous injections, inserting catheters, attending to wounds, drains, etc.);
- ▶ Implement the appropriate procedures for the preparation of tables where various manipulations and examinations will be performed;
- ▶ Perform wound cleansing and apply permitted surgical services by following their treatment procedures
- ▶ Implement and respect the rules of asepsis and antisepsis;
- ▶ Monitor the patient's pain and concerns and use a variety of therapies including the use of pain relief drugs;
- ▶ Provide quality nursing care service for all patients admitted to the service/ward;
- ▶ Take measures to prevent risks and assess the risk situation to the patient and to themselves;
- ▶ Provide psychological assistance to the patient, assist the patient in the biological, psychological and social aspects related to his illness and within the nursing care;
- ▶ Apply the medication prescribed by the physician;
- ▶ Sterilize work tools used in diverse manipulations and other care procedures;
- ▶ Organize the continuity and connection of nursing care actions in cooperation with the team, ensure timely information sharing with the team;
- ▶ Participate in clinical research, organized by professionals in the field;
- ▶ Implement the safety and hygiene of care, maintenance of medical equipment and their administration;
- ▶ Analyse and evaluate the actions taken and the expected results to the patient;
- ▶ Plan and participate in health education programs, health promotion and nursing education activities in clinical and community settings;
- ▶ Respond to questions from patients and families and provide information regarding prevention or ill health, treatment and care;
- ▶ Maintain statistics and perform statistical studies on the work performance;
- ▶ Communicate professionally with their superiors, colleagues and others;
- ▶ Supervise and cooperate with the physician-nurse-janitor team
- ▶ Respect the internal policies and procedures drafted by the organization while maintaining professional confidentiality;
- ▶ Implement the health insurance and protection rules;
- ▶ Implement the technical safety and environmental protection rules;

Employment requirements

- ▶ A university degree
- ▶ A master's degree in a relevant speciality.
- ▶ Have passed the State Exam according to the Programs determined by the Ministry of Education and Ministry of Health for obtaining the License to Practice Nursing.

- ▶ Be registered with the Order of Nurses.
- ▶ Have communication skills.
- ▶ Speak at least one foreign language
- ▶ Have work experience as a nurse in the Hospital Clinical Service
- ▶ Be mentally fit.

Additional information

An individual can start the profession as an assistant. With experience and additional qualification one can pass to the level of specialist in the field. Then through further qualification and in-depth studies as a Master of Science or Doctor in Nursing, a specialized nurse can be promoted to managerial positions in the relevant Nursing Sectors of health services where they are employed or have on-the-job training.

Nurses who reach this status can also be an active part of the Pedagogical and Didactic Sector teaching young students at the Faculty of Nursing. In order to exercise their private activity (self-employment) in this field, they need to register as a natural or legal person, as appropriate.

Employees in this profession can specialize in the following areas: consulting nurse, orthopaedic nurse, medical nurse, clinical nurse, maternity nurse, anaesthesia nurse, public health nurse, specialist nurse, specialized nurse/paediatrician, gynaecology nurse, infectious disease nurse, rheumatology nurse, occupational disease nurse, palliative care nurse, chemotherapy nurse.

6. Terms of reference and role of “Hearing and speech therapy specialists”/ speech therapist

Speech therapy is the branch of medicine that deals with the prevention and rehabilitation of language and communication pathologies. Speech therapy includes rehabilitation therapies that consist of treating pathologies that affect the voice, i.e. speech and communication: pathologies that affect the written language and reading, and characteristic signs of language and speech at different age periods. It also deals with the prevention and treatment of cognitive disorders related to communication, such as those related to memory and learning.

The presence of a speech therapists plays an important role in various educational institutions, such as nurseries, kindergartens and primary schools, state and private hospital centres, state or private clinics, and residential centres. The tasks of a speech therapist are:

- ▶ Rehabilitation of speech disorders
- ▶ Rehabilitation of language disorders
- ▶ Rehabilitation of behavioural disorders
- ▶ Rehabilitation of cognitive disorders
- ▶ Rehabilitation of sound cords
- ▶ Speech rehabilitation for people with hearing loss
- ▶ Working method for individuals on the autism spectrum

Rehabilitation of swallowing disorders. The hearing and speech therapy specialist assesses, manages and treats physical disorders that affect hearing, speech, communication and swallowing. They prescribe corrective equipment or rehabilitation therapy for hearing, speech disorders, and related sensory and nervous problems, as well as counselling on hearing safety and communication performance. They can be employed in hospitals, health centres, universities, research institutions and continuous care centres, day care clinics, rehabilitation centres, educational institutions and other institutions that apply health services for hearing and speech therapy or they can be self-employed.

Key functions

Hearing and speech therapy specialists perform part or all of the following functions, based on the organization of work:

- ▶ Perform hearing or speech tests or examinations in patients to gather information on the type and extent of impairment, using electronic and specialized instruments;
- ▶ Advise clients on techniques to improve hearing or speech impairments;
- ▶ Instruct clients on communication techniques such as sign language or lip reading;
- ▶ Assess hearing and speech disorders to determine diagnoses and courses of treatment;
- ▶ Examine and clean patients' ear canals;
- ▶ Provide and adapt hearing aids or devices;
- ▶ Perform adaptation and tuning of cochlear implants;
- ▶ Record the necessary client data at all stages, including the initial assessment and completion of treatment;
- ▶ Monitor the client's progress to complete treatment when goals are achieved;
- ▶ Plan, manage treatment programs for clients' hearing or speech problems, by consulting with doctors, nurses, psychologists and other health professionals, as appropriate;
- ▶ Recommend assistive devices, according to the nature of the damage or the client's need;
- ▶ Refer clients to other medical or educational services, if needed;
- ▶ Advise educators or other medical staff on hearing or speech topics;
- ▶ Educate and supervise audiology students and health care staff;
- ▶ Instruct clients, parents, teachers or employers to avoid behaviours that lead to miscommunication;
- ▶ Participate in conferences or trainings to update or share knowledge on new methods or techniques of treating hearing or speech impairments;
- ▶ Inspect and measure noise levels in the workplace;
- ▶ Carry out acoustic protection programs in the industry, schools and communities;
- ▶ Plan and manage treatment programs to manage physical disorders affecting speech and swallowing such as: stuttering and eating disorders;
- ▶ Advise and instruct individuals with hearing or speech impairments, their families, teachers and employers;
- ▶ Conduct research on hearing or speech topics;
- ▶ Prepare scientific articles and reports to promote research results;
- ▶ Archive and store the documentation, in hardcopy and electronic format;
- ▶ Communicate professionally with their superiors, colleagues and others;

- ▶ Supervise the work of support staff and other office staff;
- ▶ Respect the internal policies and procedures drafted by the organization;
- ▶ Implement the health insurance and protection rules;
- ▶ Implement the technical safety and environmental protection rules.

Employment requirements

- ▶ Specialists in this area shall have a university degree in medicine, audiology, speech pathology and the like;
- ▶ Be registered with a Doctor's Order.
- ▶ Be mentally fit.

Additional information

An individual can start the profession as an intern/assistant. Then through further qualification and in-depth studies and on-the-job training, a hearing and speech therapy specialist may undertake several supervisory functions in the relevant field. In order to exercise their private activity (self-employment) in this field, they need to register as a natural or legal person, as appropriate. Employees in this profession can specialize in the following areas: orthopedist, orthophonist, orientation technician for people with hearing disabilities.

7. Terms of reference and the role of the physiotherapist

The physiotherapist evaluates, plans and implements rehabilitation programs that improve or restore motor functions in people, maximize mobility, relieve pain, and treat or prevent other physical problems related to harms, illnesses, or other injuries. They use a wide range of physical therapies and techniques such as: movement, heat, ultrasound, laser and other techniques. They can be employed in hospitals, clinics, the industry, sports organizations, rehabilitation centres, social service facilities, private institutions or be self-employed.

Key functions

- ▶ Physiotherapists perform part or all of the following functions, based on the organization of work:
- ▶ Administer tests of muscles, nerves and joints functional abilities to identify and assess patients' physical problems;
- ▶ Define treatment goals in collaboration with the patient;
- ▶ Design treatment programs to relieve physical pain, strengthen muscles, restore joint mobility, and improve balance;
- ▶ Develop programs to improve cardiothoracic, cardiovascular and respiratory functions;
- ▶ Perform the development, implementation and monitoring of programs and treatments, using the therapeutic properties of physical activity, the heat, the cold, massage, hydrotherapy, electrotherapy, infra-red and ultraviolet light and ultrasound for patients' treatments;
- ▶ Instruct patients and their families on the procedures to be continued outside the clinical premises;

- ▶ Record the patient's medical history;
- ▶ Consult the patient's medical history to perform further diagnosis;
- ▶ Monitor patients' responses to treatments
- ▶ Share information with other health professionals to ensure ongoing and comprehensive patient care;
- ▶ Develop and implement health promotion programs to prevent and control common diseases and physical disorders, for patients and the community;
- ▶ Conduct research in physiotherapy;
- ▶ Provide counselling and education services to the public;
- ▶ Supervise the work of assistants or other employees;
- ▶ Inform about new techniques and procedures discovered in the field of physiotherapy;
- ▶ Archive and store the documentation, in hardcopy and electronic format;
- ▶ Communicate professionally with their superiors, colleagues and others;
- ▶ Respect the internal policies and procedures drafted by the organization;
- ▶ Implement the health insurance and protection rules;
- ▶ Implement the technical safety and environmental protection rules.

Employment requirements

- ▶ Specialists in this area shall have a university degree in physiotherapy.
- ▶ Have completed a professional course;
- ▶ Be mentally fit.

Additional information

An individual can start the profession as an intern/assistant. Then through further qualification and in-depth studies and on-the-job training, they may undertake several supervisory functions in the relevant field.

In order to exercise their private activity (self-employment) in this field, they need to register as a natural or legal person, as appropriate.

Employees in this profession can specialize in the following areas: electrotherapist, occupational therapist, physiotherapist, massage.



