

CONFERENCE ABSTRACT

1) Bridge: a piloting project of social enterprise to enhance reablement and social inclusion for people with physical disabilities

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The paper presents a piloting project aimed to set up a new service delivery model for people with physical disabilities, either acquired or inherited, named "Bridge". The service can be defined as a personalised care plan PCP placed at intermediate care level, time-limited and home based, and based on a multi-disciplinary approach and care team. Bridge's objectives are to support these frail persons by assessing their multiple needs and provide a PCP, which is conceived as complementary to the health and social care services they should already receive, and enhance their reablement and social inclusion. The project has been developed by Spazio Vita, a social enterprise aka a Community Interest Company that derives from a hospital's patient association for people with Spinal Cord Injury.

The paper provides an in-depth analysis on tools developed and results achieved for organising the service delivery model, based on the data collection from the 50 patients enrolled in the first pilot one year.

The multi-disciplinary team is made up of clinicians, psychologists, social workers, occupational therapists OT, peer-counsellor and other therapists with different specialisations delivering creative laboratories art or music therapies, informatics and computing, pet therapies, mindfulness etc..

Eligible patients could be identified either from the Spinal Unit of the adjunct hospital either from other care units of the Metropolitan area of Milan or from community services or directly from the patients' communities surrounding Spazio Vita. Eligible patients are screened by an integrated need assessment through a newly scale that joins up clinical, psychological, social, functional and individual factors to assess the beginning condition against a score from 0 to 30. The latter evaluation allows to value the patients' enrolment and assign a care level based on the severity of the condition low, mild or high and the PCP for a limited period from 6 months to 1 year.

The PCP plan is supported by a personalised case manager: based on the major needs in fact the case manager could be the psychologist or the social worker or the OT. PCP have been build

up on a different mix of three care packages: clinical and OT, psychological and social, and social inclusion. Patients enrolled vary from 0 to almost 70 years, while families and carers have been involved based on individual needs.

Results show the relevance of this service and all objectives were achieved: from avoiding clinical exacerbations at home, reducing hospitalisation, enhance reablement and self-management up to improve socialisation and individual psychological and social inclusion. Patient Report Outcome measures quality of life scale SF36 and PACIC questionnaire were completed for all cases, at the entrance and closure of any individual project. Finally, the piloting project allows to design the service delivery model in order to identify detailed tools assessing scale, evaluating criteria and scores, outcome measures, care packages, the role and intervention of each professional, and an economic evaluation and estimation of the PCP based with bundle payments relying on the severity level assigned and the mix of care packages.

Keywords: reablement; intermediate care; physical disabilities; personalised care pathways; case management
