A NOVEL APPROACH TO SETTING UP OF A RURAL INTEGRATED CARE TEAM

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Enhanced Community Care

INTRODUCTION

The avoidance of unnecessary admissions and supporting safe hospital discharges are key principles in the Enhanced Community Care Programme in Ireland. The National Clinical Programme for Older Persons aims to promote high quality and holistic care, provided in the right place at the right time for the older adult. In simple terms, this means bringing care closer to where the older person lives, and some cases, into their homes. The national development of Integrated Care Teams for Older Persons based in local communities has been a key factor in provision of care aimed at supporting the older person's safety and independence to enable them to live in their own home for as long as possible. One such team was developed in County Leitrim, which, according to a 2020 TILDA report (O'Halloran et al), has the highest prevalence of frailty in the country (29.76% in 55+ and 48.36% in 70+).

METHODOLOGY

The team was established in March 2022 and comprised of the following MDT members: Consultant Geriatrician, Clinical Nurse Specialist (Gerontology), Occupational Therapist, Physiotherapist & Therapy Assistant. The team also had input from a Case Manager, Dementia Clinical Nurse Specialist, Clinical Nurse Specialist in Mental Health and Advanced Nurse Practitioner from a more established team in a neighbouring county.

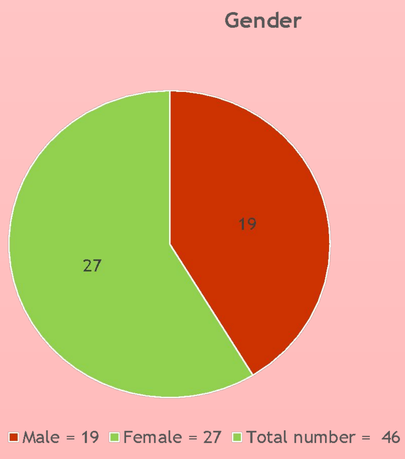
As a newly established service, quantitative data and subjective feedback was gathered from April to September 2022 from 46 patients to identify:

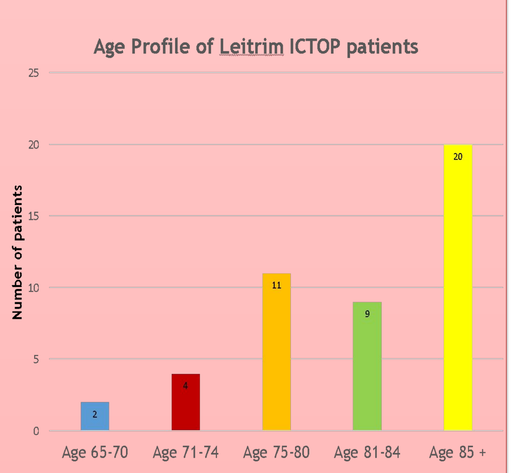
1) Referral demographic trends
2) Frailty levels and MDT needs of service-users
3) a) Service-user reported outcomes b) objective outcomes and c) likelihood of admission avoidance using a team-developed Likert scale.

Additionally we hope to use this information to identify future-planning needs for service development.

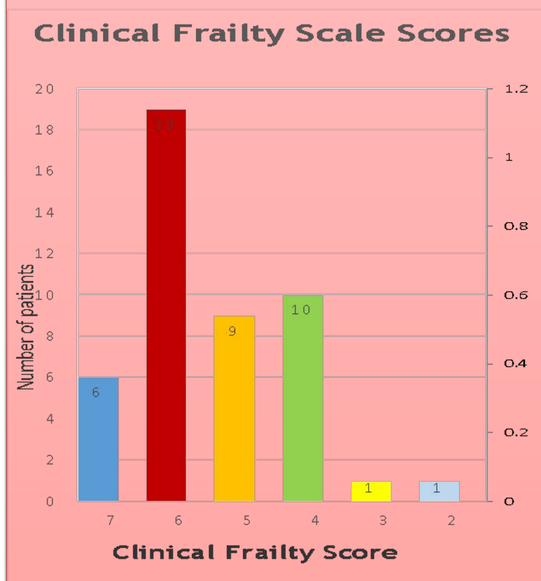
RESULTS

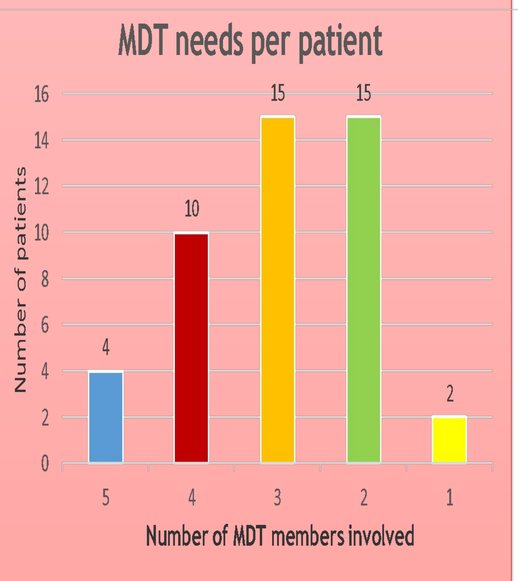
1.Referral demographic trends





2. Frailty levels and MDT needs of service-users





Frailty levels
The above graph demonstrates the range of frailty levels for the 46 patients referred to the Leitrim ICTOP service, with Clinical Frailty Scales ranging from 2 to 7.

MDT needs of service-users
The above graph demonstrates the complexity of the referred patients, as 95% of patients required 2 or more members of the MDT as part of their episodes of hospital at home care.

RESULTS

3. Outcomes and Admission Avoidance

a) Service-user reported outcomes

"I don't know what we would have done without your team" "We will miss you all"

"Only for you, I would definitely have ended up back in hospital"

"We felt it is an amazing service provided in our home"

b) Service-user objective outcomes

- Timed Up and Go tests showed an average improvement of 9 seconds post 6 week exercise intervention. This represents an improvement of 37.5% in function with correlates to balance, mobility and fall risk.
- 5 times Sit to Stand test also demonstrated a clinically important difference of 7 seconds post 6 week exercise intervention, which represents a 32% reduction in falls risk and increased functional lower limb strength.
- Cognitive assessment and intervention was required with 61% of service-users. Of this 61%, 43% had newly identified cognitive concern and were referred for either cognitive monitoring via their GP or Geriatrician follow-up. The remaining 18% of this cohort had an established dementia diagnosis and were generally under regular follow-up.
- 51% of service-users had identified needs which required onward referrals to additional health & social care teams, to support their well-being at home.

c) Admission Avoidance

- The team used a self-developed 5-point Likert scale to ascertain likelihood of admission without MDT input. Results indicated the team had supported imminent hospital/ crisis avoidance in approximately 55% of cases.

CONCLUSION

- A high proportion of service-users had a CFS of 6/7, were in the 85yo+ bracket, and over 50% required either onward referral due to cognitive concern or to additional health and social care services. 95% required 2 or more MDT members input. This suggests that the caseload presented with significant complexities in relation to frailty and social care needs. The team developed extensive links with local community services to support the longer-term needs of service-users post-discharge from our service.
- Given this is a newly established team, further identification of appropriate outcome measures to reflect patient complexity and benefits of the service is necessary.
- Initial results and patient feedback are favourable to suggest that a home integrated team has a strong role in admission avoidance and supporting service-users well-being at home.

REFERENCES

O'Halloran, A., McGarrigle, C., Scarlett, S., Roe, L., Romero-Ortuno, R. & Kenny, (2020) 'TILDA Report on Population Estimates of Physical Frailty in Ireland to Inform Demographics for Over 50s in Ireland during the COVID-19 Pandemic' (TILDA). Available at: Report_Covid19Frailty.pdf (tcd.ie) (accessed on 19 September 2022).