Enhanced Community Care Conference

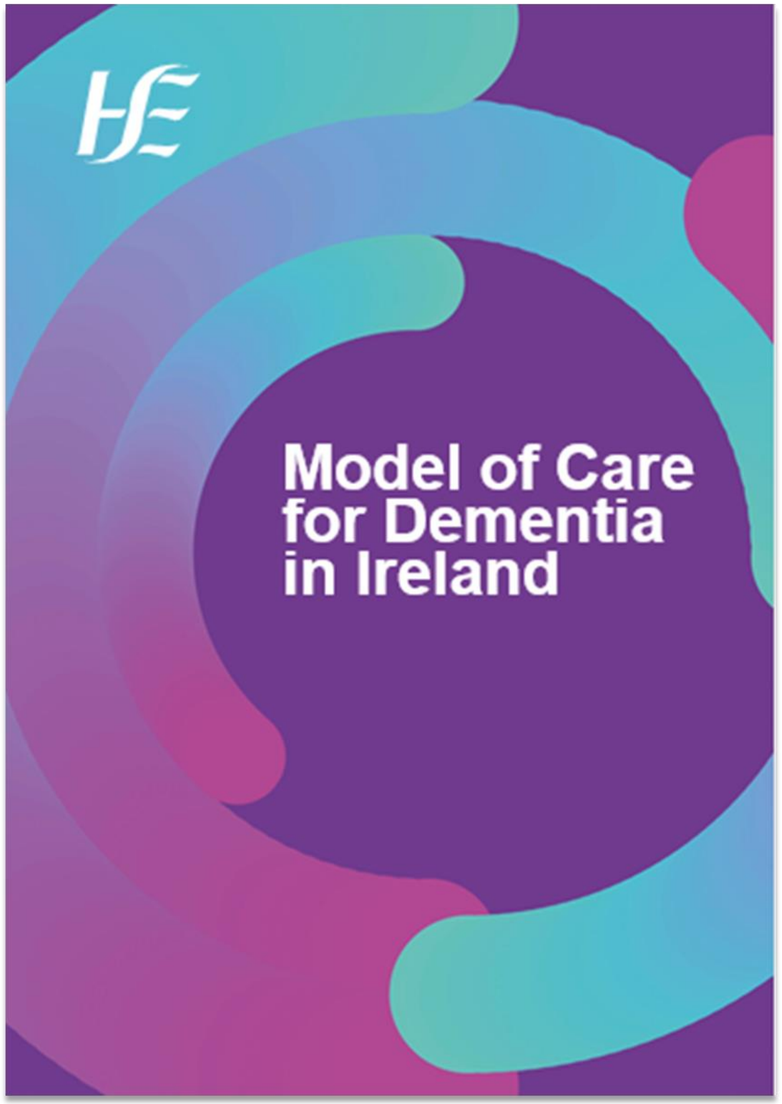
07 September 2023

Dementia Model of Care: Dr. Seán O'Dowd, Consultant Neurologist and Clinical Lead, National Dementia Office

Integrated Care: Empowering People, Improving Experiences

Background & Context

- Estimated over 64,000 people living with dementia in Ireland
- Prevalence in Ireland expected to increase to **150,000** people by 2045; pre-dementia states (“Mild cognitive impairment - MCI”): 2-3x this number
- Model of Care aims to address system shortcomings, providing **earlier recognition and intervention** for those living with dementia, as well as their support networks
- Dementia Model of Care provides an integrated framework to bring together a wide range of services into a coherent pathway for people living with dementia
- Sets out a range of **Targets and Practice Recommendations** to advance the assessment and diagnosis of pre-dementia states (MCI) and dementia, and also the treatment, care and support of people currently living with dementia in Ireland



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Background to the Dementia Model of Care

2014

National Dementia Strategy published

2017

National Dementia Office (NDO) commenced Dementia Diagnostic and Post-diagnostic Projects to address one of the Strategy's Priority Action areas: '*Timely Diagnosis and Intervention'.*

Utilising evidence from both these projects, work commenced on developing Dementia Model of Care (MoC).

MoC builds on the work of the National Dementia Strategy (2014), line with Government Policy as outlined in Sláintecare and the HSE Corporate Plan 2021 – 2024the HSE Corporate Plan 2021 - 2024

Dementia Model of Care

- Assessment process & targets for diagnostic services
- Diagnostic pathway & identifies required infrastructure - three tiers of assessment across integrated pathway
- Best practice & key steps in communicating diagnosis
- Recommendations for key elements of personalised care planning, including brain health principles for those with SCI/MCI
- Targets & recommendations - care planning & dementia post-diagnostic support pathway.

Diagnosis Model

The Model of Care provides for a three level diagnostic model of assessment:

Level 1 – GP Delivered Assessment

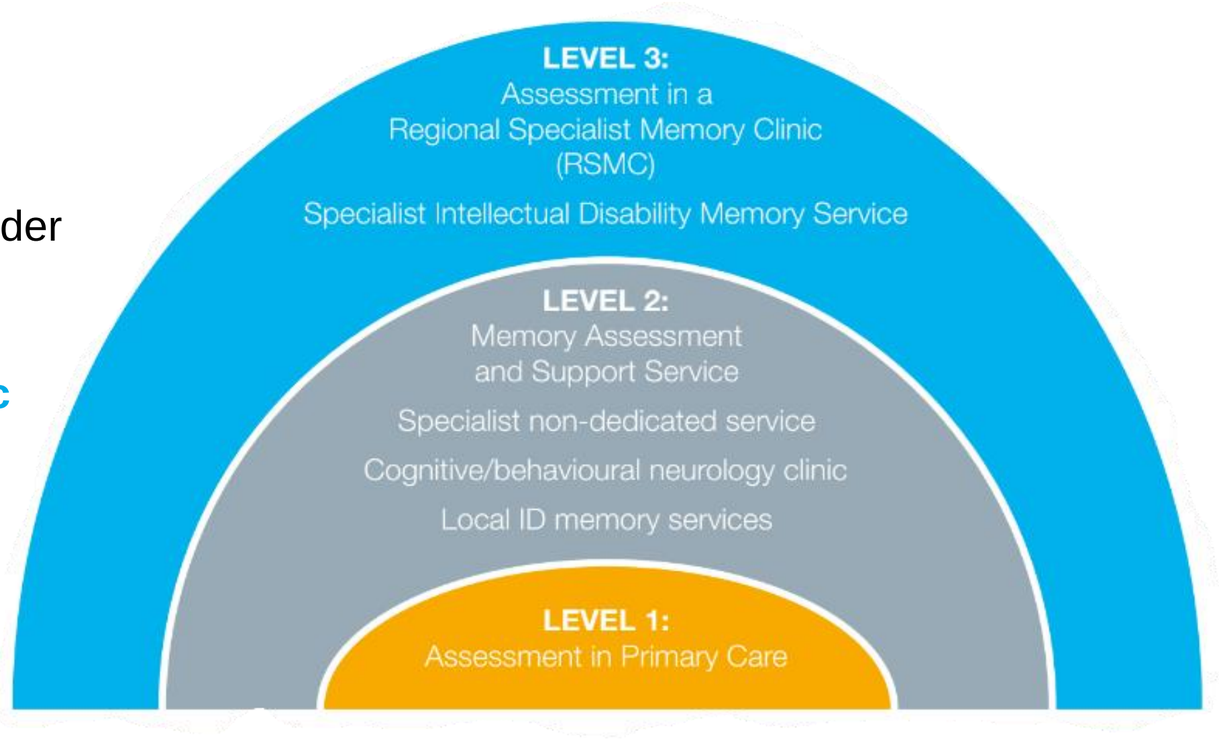
- May include **support & information** from any of the ECC Programme services
- Decision on **appropriateness of referral** to Level 2 / 3 is at the discretion of the primary care physician

Level 2 – Memory Assessment & Support Service (MASS) or Other Specialist Service

- **Diagnostic assessment** in a MASS will generally focus on older persons with a typical and clear presentation

Level 3 – Assessment in a Regional Specialist Memory Clinic (RSMC)

- Based in **tertiary care, diagnostic assessment** in an RSMC is generally for younger, atypical or unclear presentations requiring a more detailed assessment



Care Planning & Post Diagnostic Supports

Personalised care planning- including pharmacological interventions & broader post-diagnostic and psycho-social supports

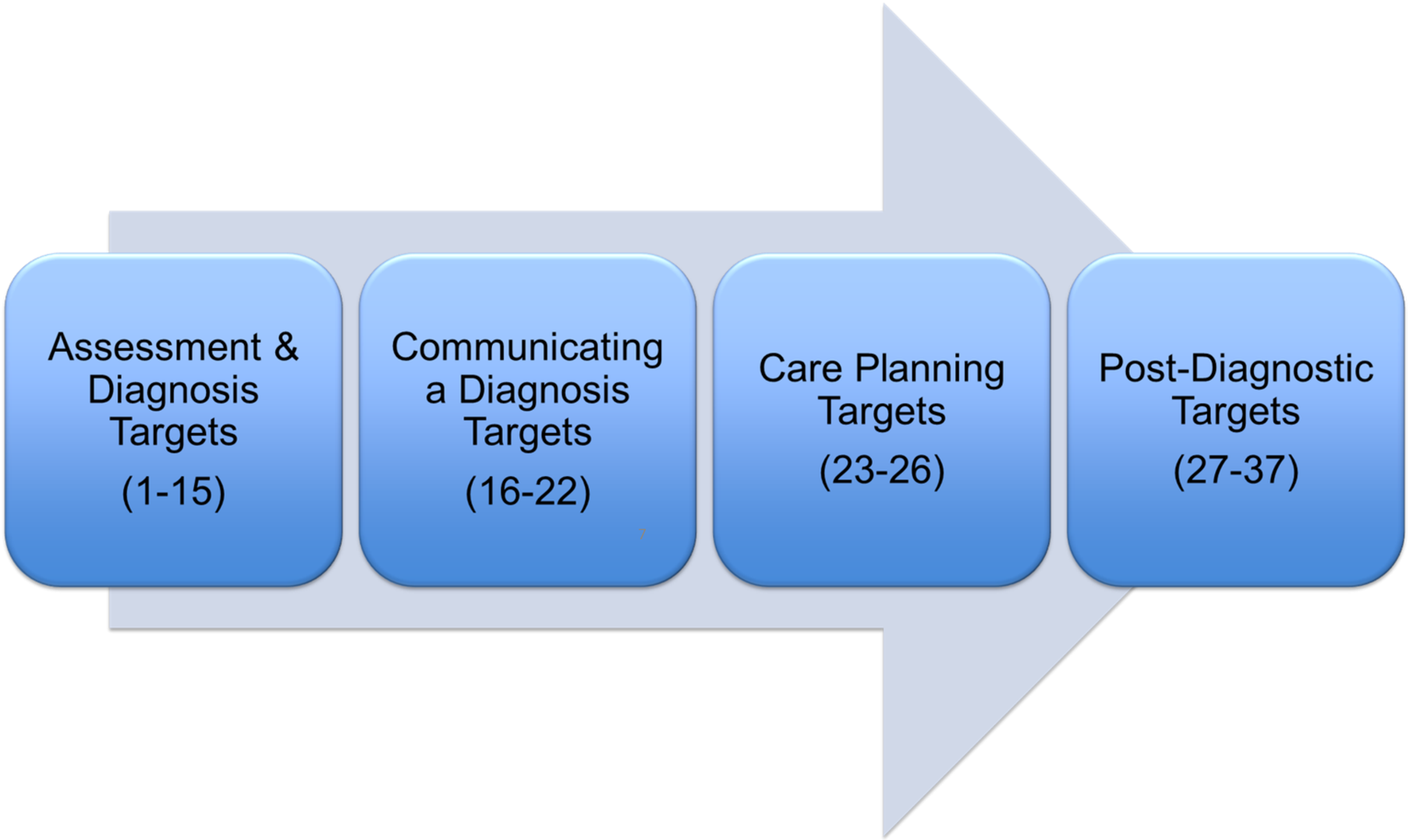
Timely follow-up post-diagnosis & provision of a named point of contact

5 Key strands of Post Diagnostic Support: Understanding and Planning; Staying Connected; Staying Healthy; Supporting Cognition; Supporting Emotional Wellbeing

People diagnosed with **Mild Cognitive Impairment** will be offered specific **interventions and supports** in a timely manner including brain health interventions

People diagnosed with **dementia, and those diagnosed with mild cognitive impairment** and their supporters will be offered **signposting to research participation**

Target Categories



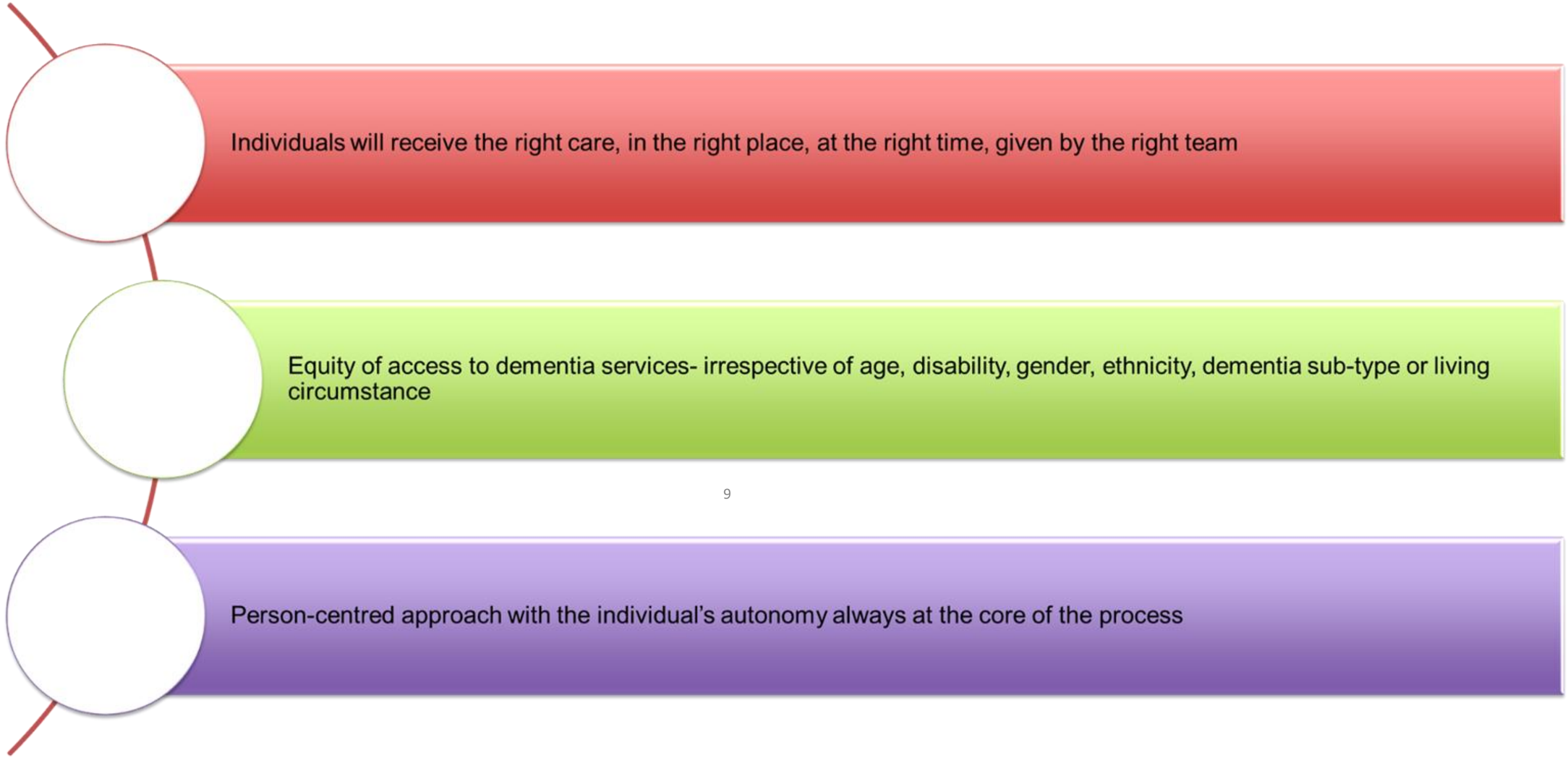
What does the MoC mean for the Healthcare System?

Sets out the **blueprint for optimum care** and support pathways for people living with dementia, from the point of concern when first reporting symptoms to home care in the community

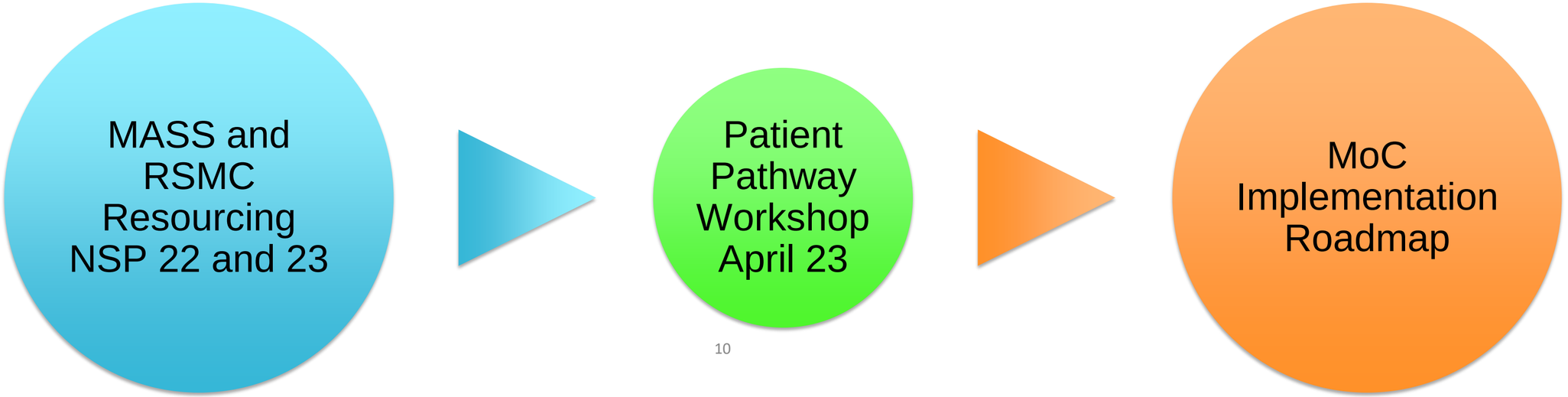
Memory services will be enhanced across Ireland **allowing quicker access and expert opinion** for primary care and acute healthcare workers who may wish to refer their patients.

Supports working in a more integrated way with primary care and acute services to deliver end-to-end care, reducing the need for hospital-based care and embracing a 'home first' approach.

What does the MoC mean for the Person with Dementia?



Implementation- Progress to Date



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07 September 2023

Digitally Enabling Systems

Dr. David Hanlon NCAGL & Mari O'Donovan, General Manager ECC

Integrated Care: Empowering People, Improving Experiences

ECC Healthlink Referral Rollout

Benefits of Healthlink

- **Simplify and streamline** the referral of all service users across CHOs and improve access to locally delivered services
- Digitalise the current referral process, providing **efficiency, privacy and security**
- **Improved communication** between the GPs and ECC Clinical teams
- Referrals that are comprehensive, legible and contain **sufficient information** for triage and decision making
- **Increased transparency**, visibility of pathways from beginning to end

Progress to Date

CHN

Rollout is underway in 6 of the 9 CHOs. Breakdown of status of 96 CHNs is as follows:

CHNs Live	**44**
CHNs Preparing for Go Live	**14**
CHNs working to meet Criteria	**38**

ICPOP

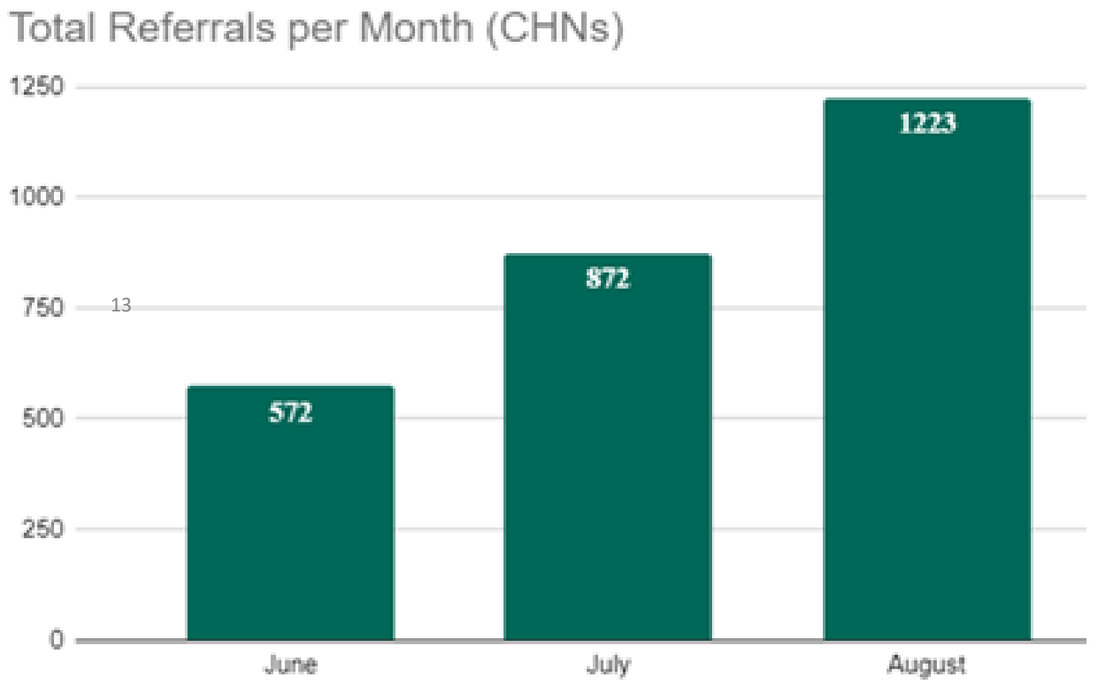
- Live in 6 of 9 CHOs (CHOs 1 - 6)
- Engagement underway with CHO 7,8,9

ICPCD

- ICPCD Healthlink Pilot is ongoing in CHO 2 (28 Aug - 8 Sept)
- Operational readiness assessment completed across all CHOs
- CHOs will go live on a weekly basis, commencing 18 September.

Healthlink - CHN

- Form for CHN referrals developed and deployed in Cork
- In the process of deployment across all CHNs now
- Form will be updated in response to learning once established
- Now live in most CHNs



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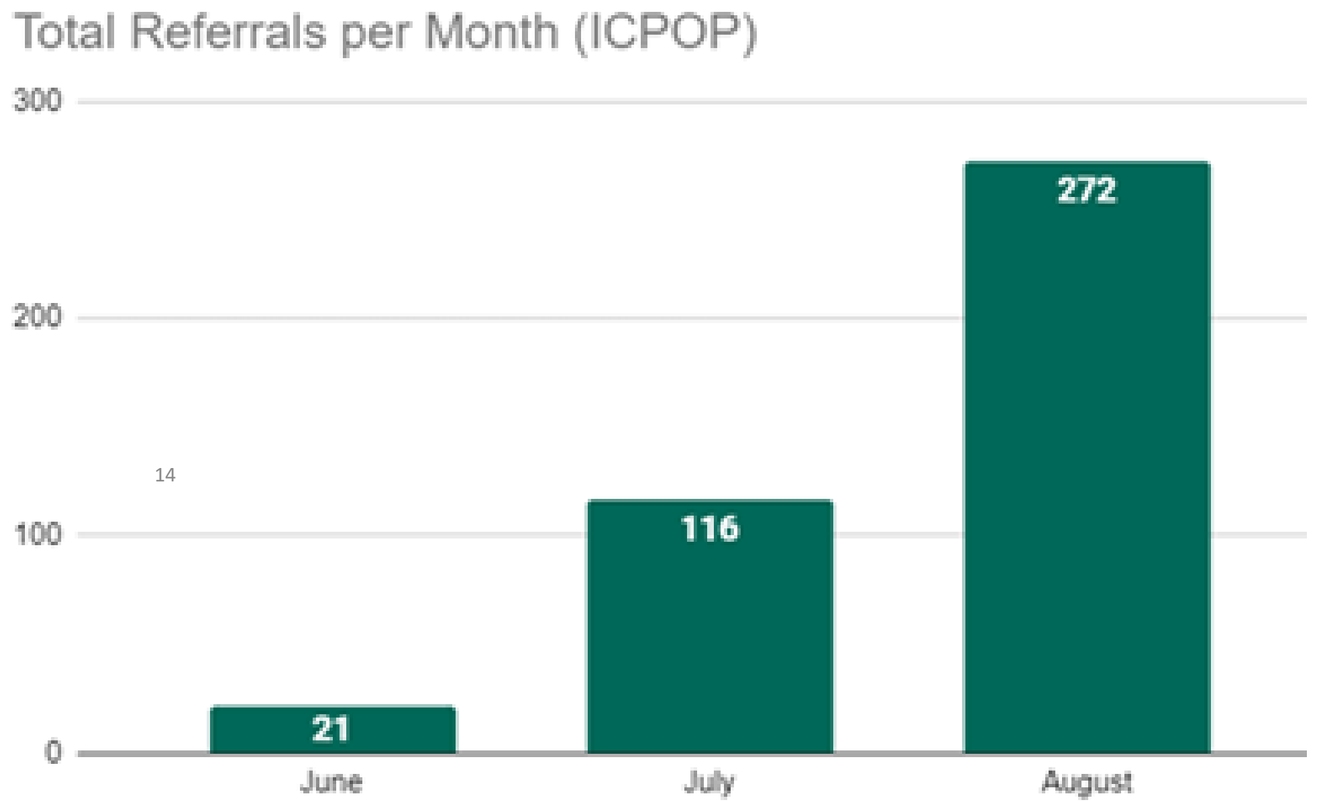
Healthlink - CST

- Form for CST OP being deployed
- Form for CST CD in test



HSE Area Finder

- Problem:
  - With all the changes, how do sources of referral know where to send community referrals?
  - How does a discharge co-ordinator know what CHN a person lives in and how to contact the CHN or CST?

- **Solution:**
  https://hseareafinder.ie

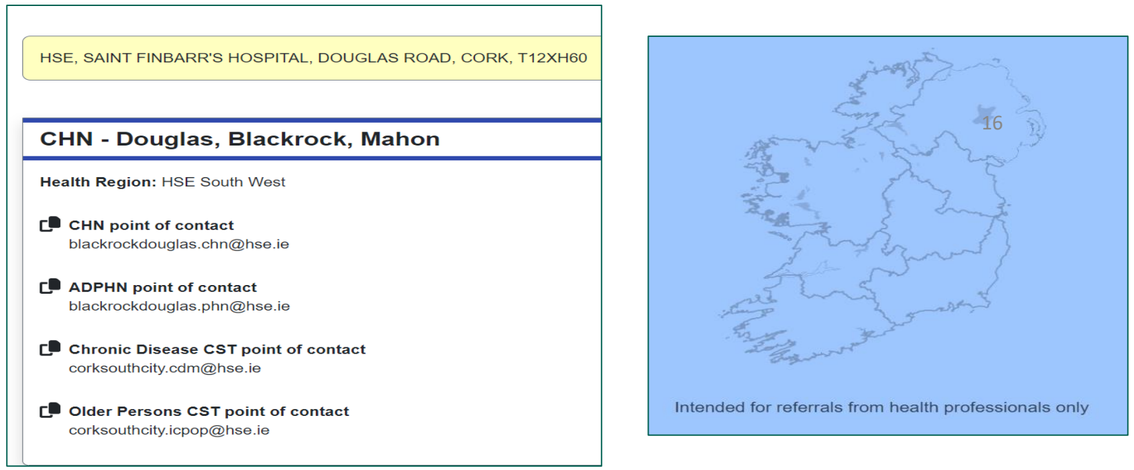
- Collaboration between Primary Care and HSE Health Intelligence Unit

HSE Area Finder

AIM

The aim of the HSE Area Finder Map is to assist in identifying the available services and appropriate point of contact for community services based on a service users address. This will promote integration and enhance knowledge of community services. On input of a patients postcode or address the map will signpost to the correct:

- Community Healthcare Network (CHN)
- Assistant Director of Public Health Nursing (ADPHN)
- Older Person Community Specialist Service (ICPOP)
- Chronic Disease Community Specialist Teams (ICPCD)



DEVELOPMENT OF HSE AREA FINDER MAP

1. Collaboration between CKCH, The National Health Intelligence Team and The National Primary Care and Strategy Team
2. Gathering contact details for all CHN, ADPHN, ICPOP and ICPCD Hubs
3. Design and development of a pilot HSE Area Finder Map URL for testing phase
4. One week pilot of map across CKCH and GP's with issues logged in August 2023. Monkey survey to evaluate users feedback following pilot
5. Development and finalising HSE Area Finder Map for National roll out and promotion at ECC conference on 7th September 2023.

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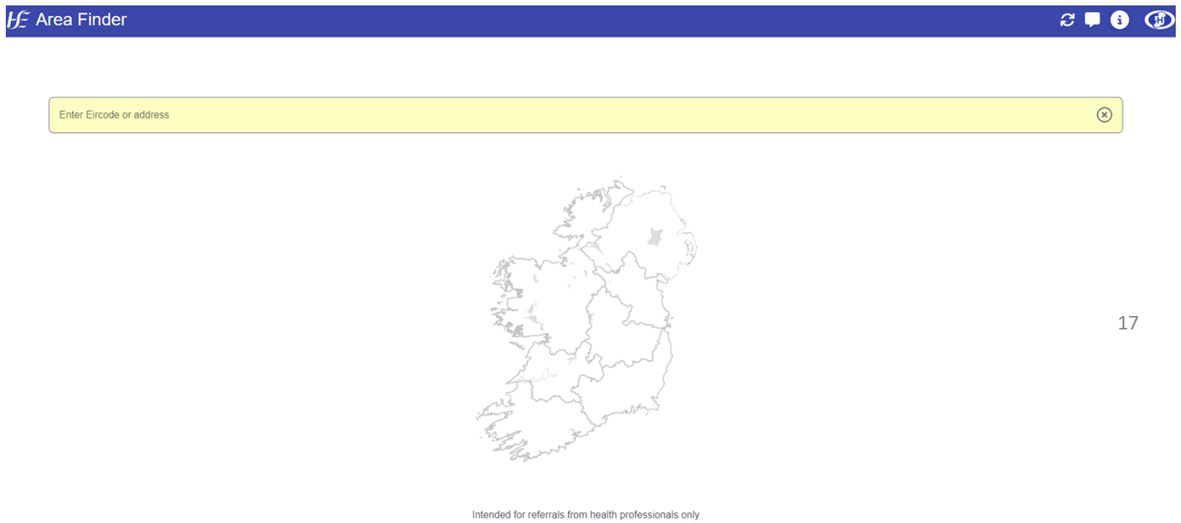
HSEAREAFINDER.IE

- Test to destruction:
  Can we break it?



Enhanced Community Care

Enhanced Community Care **Conference**

07 September 2023

Flexing the ECC Model

Pat Healy

Integrated Care: Empowering People, Improving Experiences

Flexing the ECC Model

HSE CEO Opening Statement at the Joint Committee on Health, June 2023

“I have set a specific requirement for September 2023 to flex the ECC Model to provide an interface with both public and private nursing homes to improve hospital avoidance and to support post-hospital discharge”

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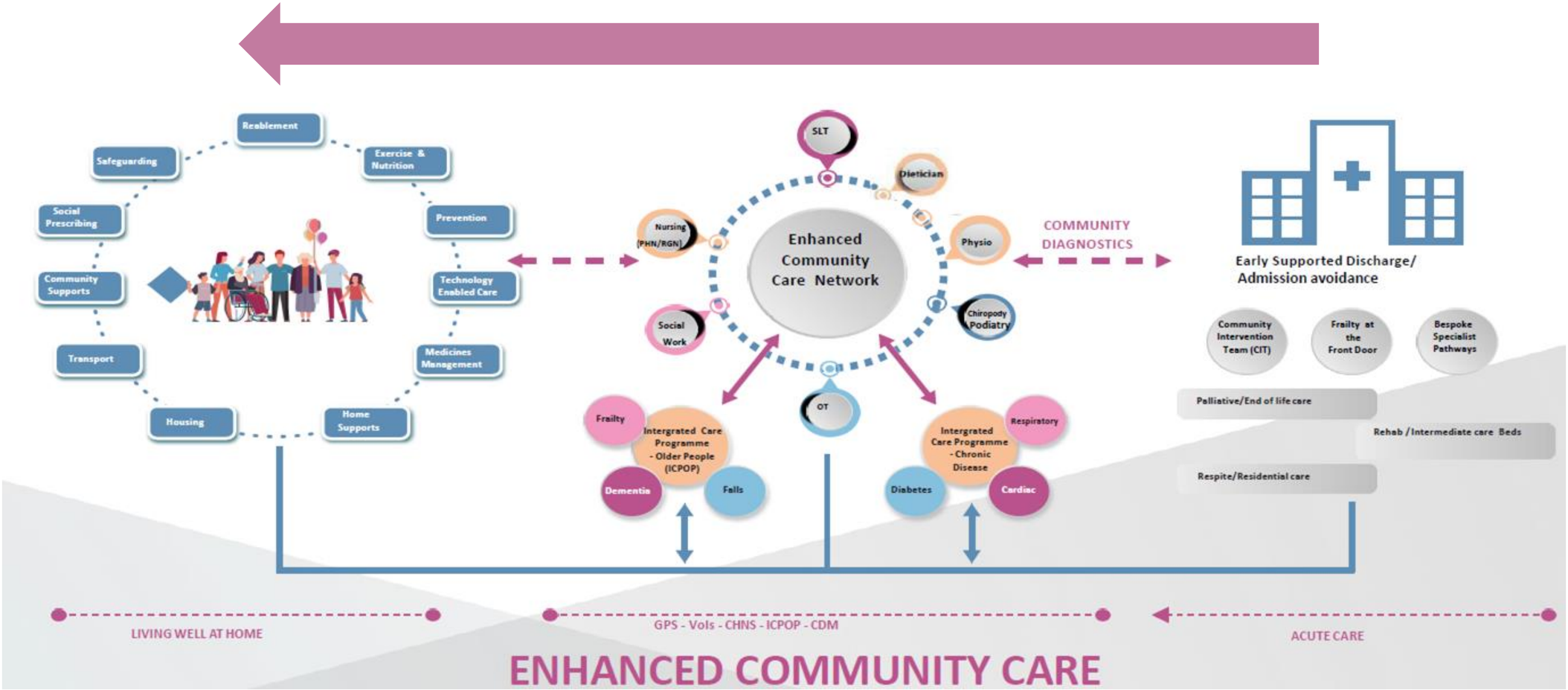
ECC Programme

Shift Left towards General Practice, Primary Care and Community-based Services



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Flexing the ECC Model

Overview

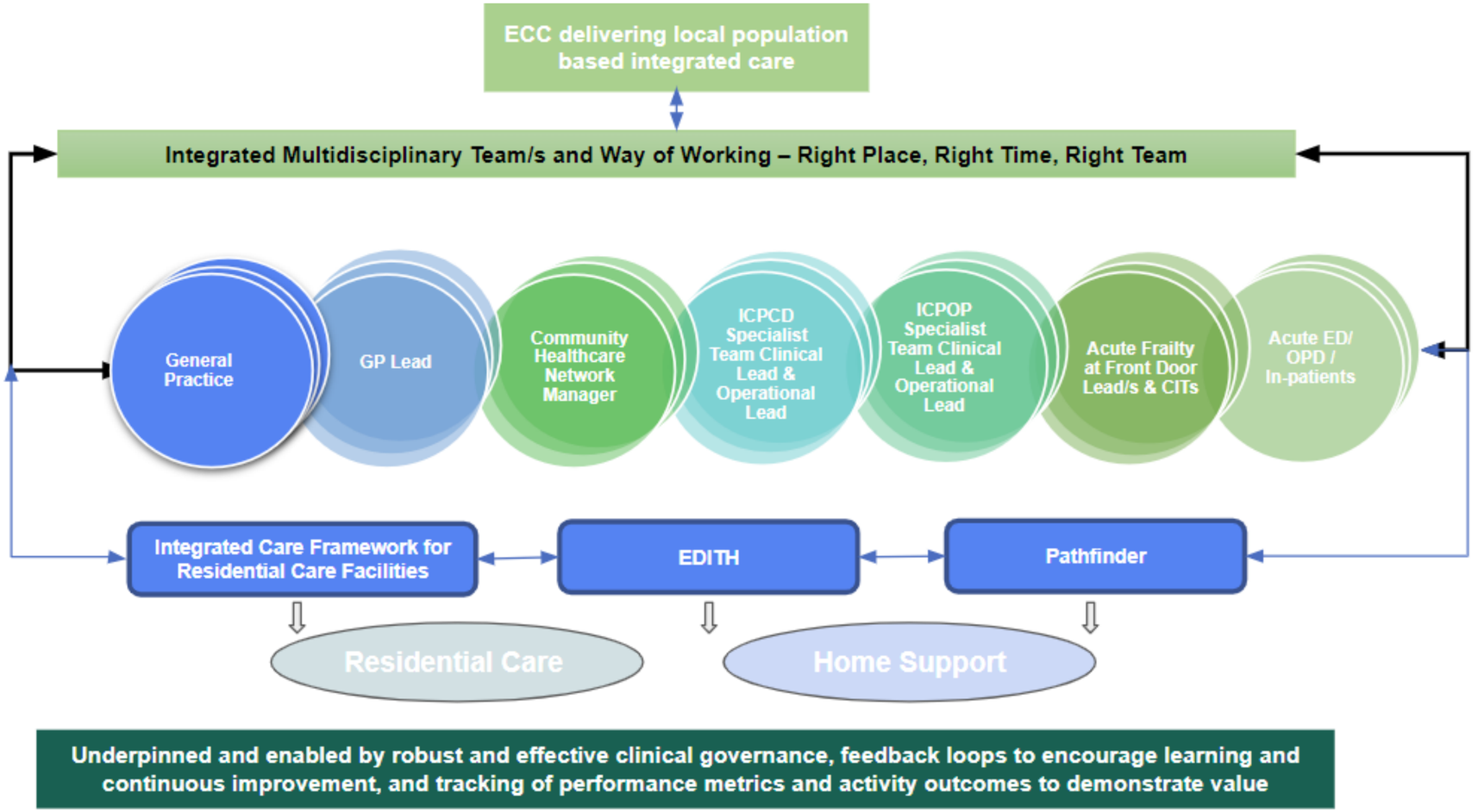
- The ECC Programme will extend the current model and maximise its reach by engaging the entire population in their geographic area, including residents in both public and private nursing homes, with the ultimate aim of improving hospital avoidance and supporting post-hospital discharge, in line with the UEC priorities
- Integrated team working across the full primary care / community service pathway is crucial to the success of the model, ensuring collaboration and coordination among teams to deliver comprehensive and responsive care
- Clear referral pathways and engagement of relevant expertise are crucial for managing caseloads and achieving optimal outcomes for service users. This includes prioritising service users who would benefit most from specialist ECC input - Clinical Care Coordinators at CHN level are essential for effective coordination across the pathways
- The CHN Manager plays a critical role in prioritising and managing the needs of their population including:
  - Waiting lists across HSCP disciplines in the CHNs
  - Building relationships with nursing homes and engaging with other specialist services as required
  - For any services for which management of demand and waiting lists is yet to transition to the CHN Manager, given its criticality, this must transition to the CHN Manager in conjunction with the development of the extended model.

Flexing the ECC Model

Integrated Ways of Working

Population management and care pathway management

- Population Health profiling
- End to end pathways of care
- Managing populations of ~50k through Community Healthcare Networks
- Managing at risk populations of ~150k through ICPCD and ICPOP specialist teams
- Care closer to home as possible
- OPD/ Inpatient Impact



Performance metrics and activity tracked across pathways

CHN
- Therapies
- Nursing
- Integrating Care

ICPOP
- Referral Activity
- Specialist Pathways Activity
- Referral Source Casemix

ICPCD
- Cardiology
- Diabetes
- Respiratory

Enhanced Community Care

Urgent and Emergency Care (UEC) Plan

Overview

Our Vision:

Improve patient experience in urgent and emergency care services
Work together across hospital, community and planning services, following the evidence to make our services better
Deliver high quality integrated care in the right place, at the right time, every time

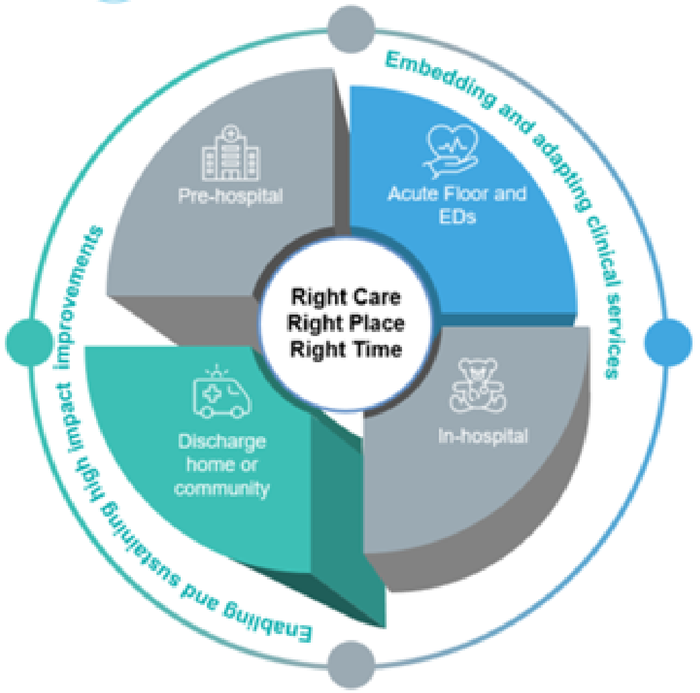
UEC Pillars

- Integrating governance and leadership
- Building capacity and capability in our teams
- Adapting and embedding clinical services
- Making and sustaining high impact improvements

UEC Enablers

- Better data for quality and better decisions
- Supported and empowered teams
- Patient-centred change
- Unlocking eHealth solutions

Our Actions to Deliver Vision



Our Promise to Patients and Families

- The Average Monthly Trolley Count at 8am not to exceed 320.
- The total number of DTOCs to be achieved by year end is 440.
- No patient aged over 75 years will wait for more than 24 hours in our EDs.
- The average LoS for those over 14 days not to exceed 28 days.

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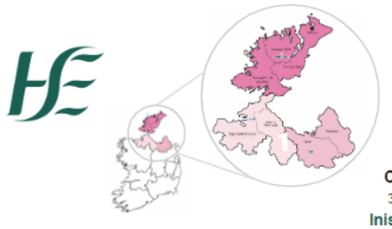
The ECC Programme has a critical role to play in supporting the UEC Plan, particularly in relation to hospital avoidance and discharge operations.

Flexing the ECC Model

Profiling of CHOs

In order to support the ECC Model's working in an integrated way, profiling of CHOs, which outlines the operational status of the teams, along with the key leadership roles has been undertaken. These profiles help support the engagement required in order to deliver integrated care effectively. The figures below are an example of the profiling completed for CHO 1 and outlines the operational status of the CHNs and CSTs, along with the names of those in key leadership roles.



Confidential - Not for circulation

CHO 1 (1/2)

Population: 391,281

✓ Team operational
✖ Team not operational

CHN 1	CHN 2	CHN 3	CHN 4
33,875	46,874	35,177	36,087
Inishowen (Learning Site)	Donegal North	Donegal East	Donegal South and West
Network Manager	**Network Manager**	**Network Manager**	**Network Manager**
Geraldine Canning	Rory Kavanagh	Darren Doyle	Samantha Ibbs
GP Lead	**GP Lead**	**GP Lead**	**GP Lead**
Dr Katherine Murray	Dr Paul Stewart	Dr Ciaran O'Fearraigh	Being Recruited
ADPHN	**ADPHN**	**ADPHN**	**ADPHN**
Kathleen Harkin	Lorraine McBrearty	Maureen Long	Patrick Browne
Team operational?	**Team operational?**	**Team operational?**	**Team operational?**
✓	✓	✓	✓

CST 1	
ICPOP	ICPCD
Operational Lead	**Operational Lead**
Clare McAleer	Claire McRory
Consultant	**Consultant**
Campaign Underway	Dr Marketa (Interim Consultant Endocrinology) Campaign Underway (Respiratory 1.0)
Team operational?	**Team operational?**
✓	✓

Letterkenny University Hospital

ALONE

Alone Coordinator: Frances Browne

Other key roles:

- CIT Lead
- Discharge Coordinator
- Clinical Leads for ICPOP and ICPCD
- Local NAS paramedics

Enhanced Community Care

*CHO 1 is being used for illustrative purposes but this information is available for all CHOs

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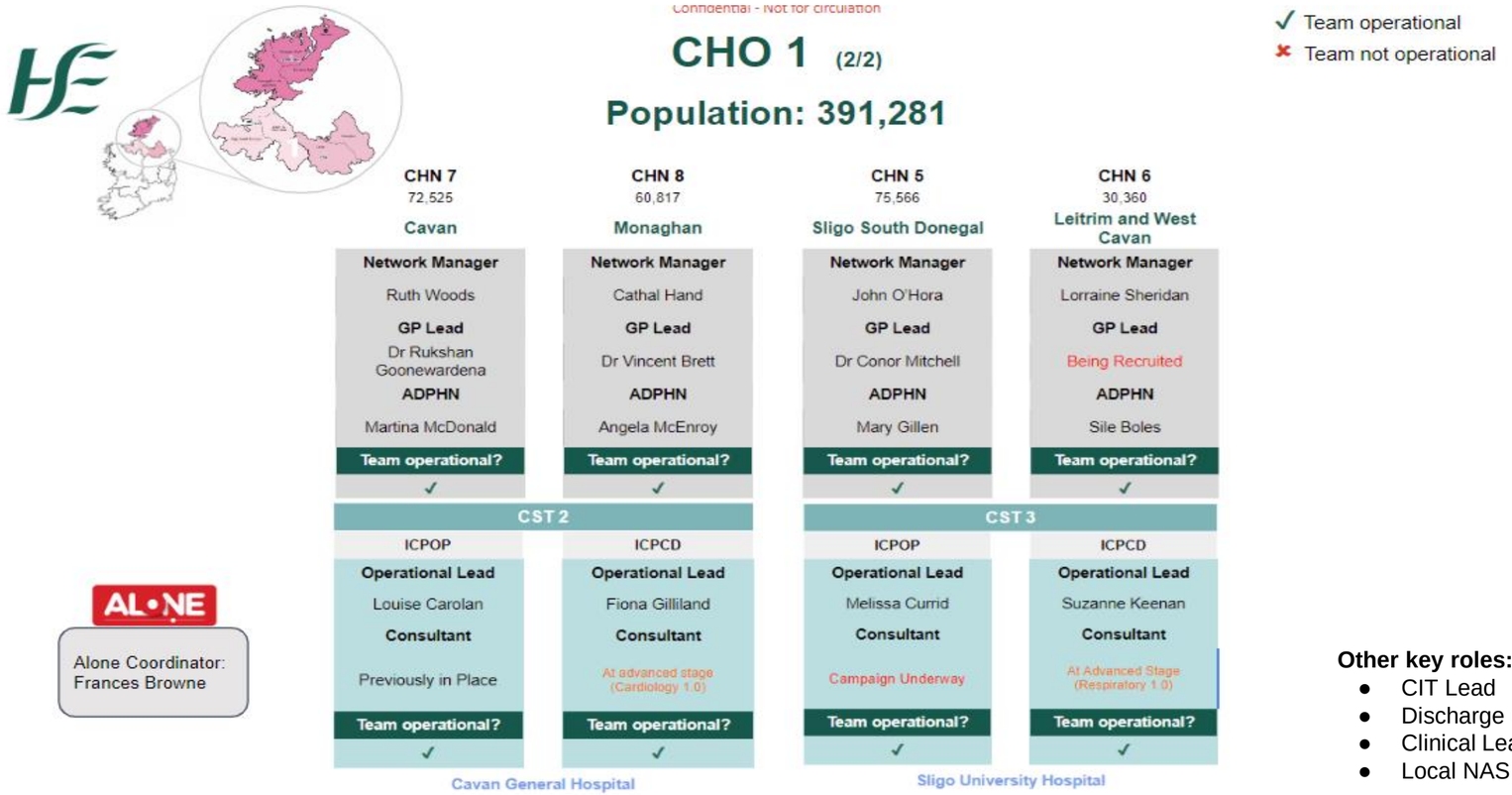

Other key roles:

- CIT Lead
- Discharge Coordinator
- Clinical Leads for ICPOP and ICPCD
- Local NAS paramedics

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Flexing the ECC Model

Profiling of Nursing Home Facilities

A profiling exercise of nursing homes has also been undertaken, which shows the public and private facilities in each CHO and their maximum occupancy, along with their aligned CHN, CST and acute hospital. This information provides a description of the quantity and type of nursing home beds across the CHO area. By looking at this data it helps to understand the spread and mix of facilities aligned against the beds per capita. The figures below provide an example of the profiling undertaken in CHO 1.

CHO 1 - Nursing Homes

Population	# Nursing Homes	Max. Occupancy	Private N. Homes	Public N. Homes	Unknown (Private/Public)
391,281	52	2,480	35	17	0

	Population	# Nursing Homes	Public Homes	Private Homes	Unknown (Private/Public)	Max Occupancy	Homes per capita	Bed per capita	N. Homes per 10k	Operational	Acute Hospital	CHN GP Lead	ICPOP Operational Lead	ICPCD Operational Lead
CHN 01	33,875	4	2	2	0	183	0.0001	0.005	1.18	CHN: Yes ICPOP CST: Yes ICPCD CST: Yes	Letterkenny University Hospital (LUH)	Dr. Katherine Murray	Clare McAleer	Claire McRory
CHN 02	46,874	8	2	6	0	300	0.0002	0.006	1.70			Dr. Paul Stewart		
CHN 03	35,177	4	1	3	0	191	0.0001	0.005	1.13			Dr Ciaran O'Fearraigh		
CHN 04	36,087	6	3	3	0	235	0.0002	0.007	1.66			At Advanced Stage		
CHN 05	75,566	11	3	8	0	568	0.0001	0.008	1.45		Sligo University Hospital	Dr. Conor Mitchell	Melissa Currid	Suzanne Keenan
CHN 06	30,360	4	3	1	0	141	0.0001	0.005	1.31			Being Recruited		
CHN 07	72,525	10	2	8	0	488	0.0001	0.007	1.37		Cavan General Hospital	Dr Rukshan Goonewardena	Louise Carolan	Fiona Gilliland
CHN 08	60,817	5	1	4	0	374	0.0001	0.006	0.82			Dr. Vincent Brett		
Total	**391,281**	**52**	**17**	**35**	**0**	**2,480**	**0.0001**	**0.006**	**1.33**					

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Flexing the ECC Model

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CHO 1 - CHN & CST Alignment

Population	# Nursing Homes	Max. Occupancy	Private N. Homes	Public N. Homes	Unknown (Private/Public)
391,281	52	2,480	35	17	0

CHN	No. Of Nursing Homes	Max Occupancy	CST	ICPOP Operational	Aligned Acute Hospital
1	4	183	Community Specialist Team Letterkenny	Yes	Letterkenny University Hospital
2	8	300			
3	4	191			
4	6	235			
Subtotal	22	909			
5	11	568	Community Specialist Team Sligo	Yes	Sligo University Hospital
6	4	141			
Subtotal	15	709			
7	10	488	Community Specialist Team Cavan	Yes	Cavan General Hospital
8	5	374			
Subtotal	15	862			
Total	52	2,480			

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Flexing the ECC Model

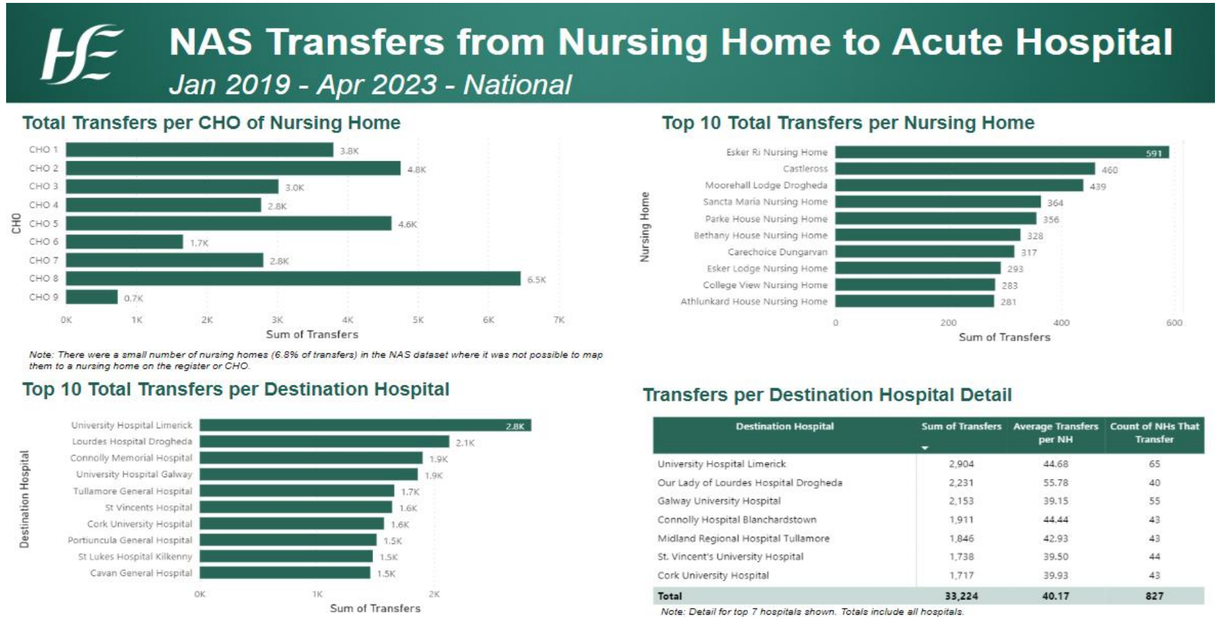
Analysis of Transfers from Nursing Homes to Acute Hospitals

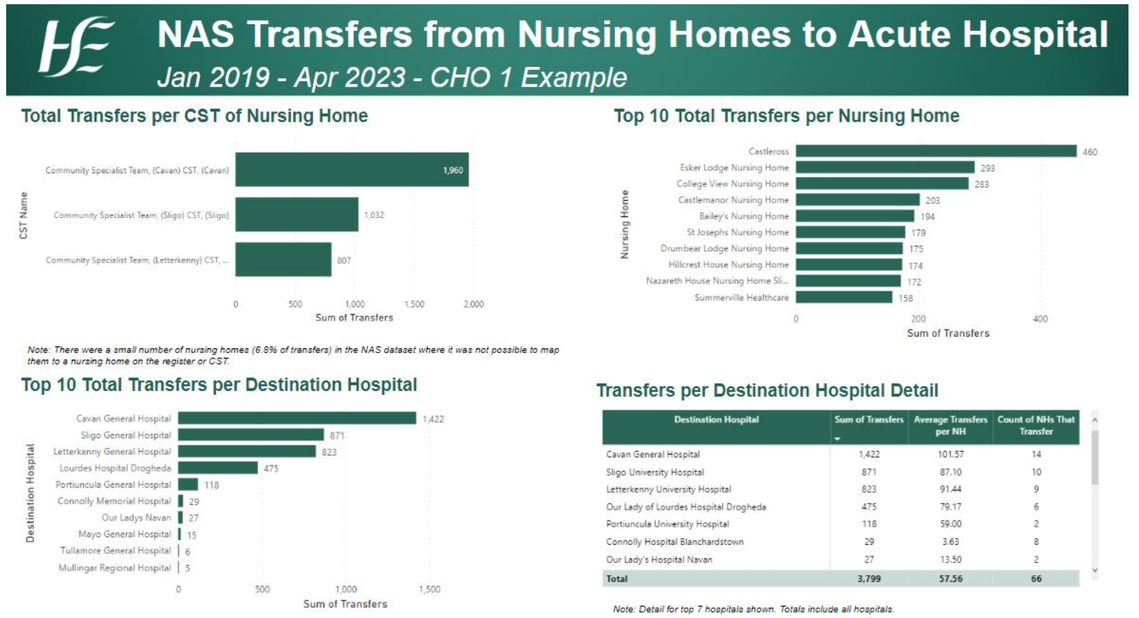
- The ECC Programme has been working to build a greater understanding of the nursing homes with the highest rates of transfer to the acute hospitals, with the intention of using this as an active management tool to allow for the targeting of services at the areas of greatest need
- A National Ambulance Service dataset has been obtained, which contains the number of transfers between nursing homes and acute hospitals from January 2019 - April 2023. The data is aggregated for the full time period i.e. it is not broken out by months
- Data analysis reveals the following:
  - 33,712 transfers were recorded in this time period, 33,224 of which were to acute hospitals aligned to ECC services
  - Transfers from 406 facilities were recorded. The data suggests that although the majority of residents from particular facilities are transferred to the same hospital, there are instances where residents from one facility may be transferred to different hospitals
  - The data suggests that transfers between nursing homes and acute hospitals are not restricted to the same CHO. In other words, residents in a nursing home in one CHO may be transferred to a hospital in a different CHO
  - The Programme is currently engaging with NAS regarding getting access to a more granular level of data on a regular basis.

Flexing the ECC Model

Analysis of Transfers from Nursing Homes to Acute Hospitals

- The figures below illustrate the following:
  - Total number of transfers from nursing homes to acute hospitals
  - Top ten nursing homes with the highest rates of transfer
  - Top hospitals receiving the highest numbers of transfers from nursing homes
- The figure on the left illustrates this at a national level, and the figure on the right provides a CHO-level view, using CHO 1 as an example.





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Flexing the ECC Model

Developing an Approach

- There are a range of services across both the acute and community settings that are supporting hospital avoidance and early supported discharge for older adults, including those in nursing homes, with a number of initiatives already demonstrating impact. These include:
  - EDITH
  - RCSI Hospital Group Integrated Care Framework for Residential Care Facilities
  - Pathfinders
  - MMUH Community Medicine for Older Person’s Nursing Home Outreach Programme
- Service delivery areas are encouraged to leverage the available services in their CHO / Health Region, enhance and join up these services and continue to foster integrated ways of working in order to support hospital avoidance and early supported discharge
- In tandem to this, the ECC Programme is focused on developing an approach that leverages ECC resources to further support residents in nursing homes, whilst also ensuring UEC priorities in relation to older people are delivered.

Flexing the ECC Model

Key Enablers and Critical Success Factors

In order to achieve the key objectives in supporting nursing homes, there are several critical success factors that need to be in place, including:

- A strong governance process
- Effective clinical leadership
- Integrated ways of working with ECC
- Collaborative working relationships between acute, community and nursing home services
- Leveraging of the full breadth of services and resources available at service delivery level
- Timely response and engagement from services
- Clear pathways and transitions of care across all relevant services in the CHOs / Hospital Groups / HSE Health Regions.

Flexing the ECC Model

Next Steps

- Proposed approach to flex the ECC model nearing completion for early implementation
- One size won’t fit all - menu of options
- Key immediate focus will be on:
  - Streamlining admission to nursing homes from acute hospitals
  - Minimising conveyances from nursing homes to acute hospitals
  - Reduce acute hospital length of stay for older people
  - Supporting achievement of zero tolerance approach to 24 hour and 6 hour PET times in acute hospitals
- The Programme will continue to develop and refine the approach and will engage with the system on an ongoing basis

  Clinical pathways and supporting documentation is being developed
- Data analysis will continue to further refine current data sets which will allow for effective prioritisation and management.