Enhanced Community Care Conference

07 September 2023

ECC in Action: Community Healthcare Networks

Integrated Care: Empowering People, Improving Experiences

Introduction,

Dr. David Hanlon,

NCAGL, Primary Care

Integrated Care: Empowering People, Improving Experiences

Enhanced
Community
Care

ECC Conference 2022

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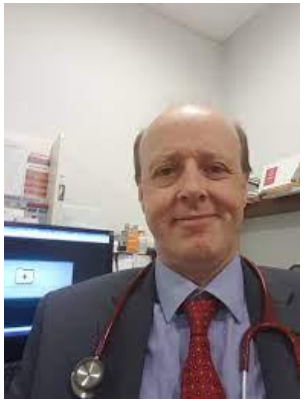
Care

Dr. David Hanlon

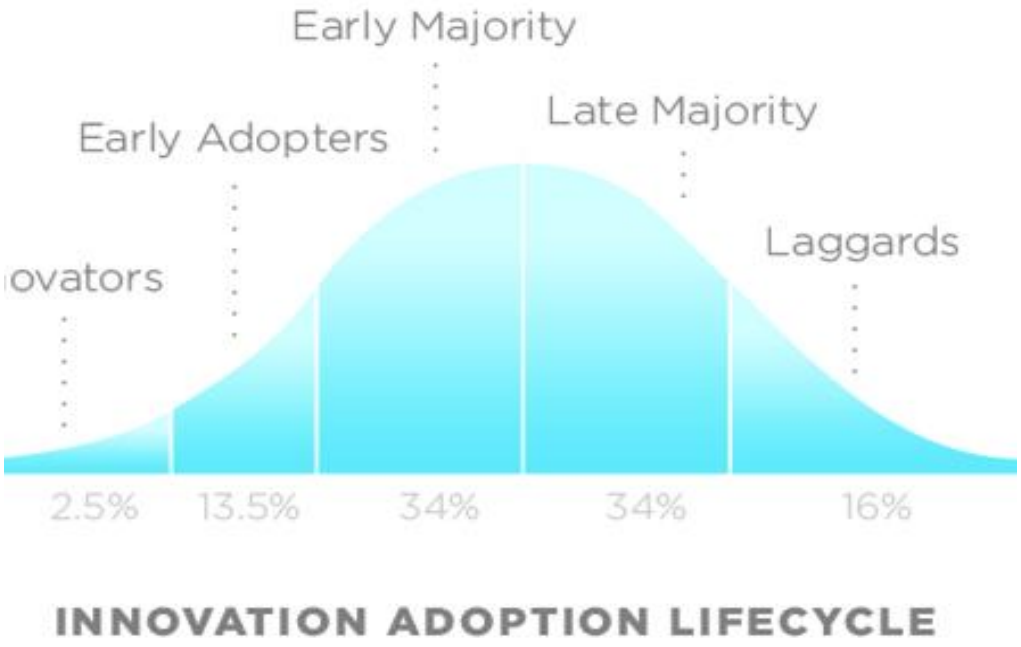
David.hanlon1@hse.ie

Declaration of Interests:



- GP in North East Kildare CHN (CHO7)
- Relatives are current service users
- Father of prospective providers
- Prospective service user
- We all have an interest in developing our health service

Change is hard!



Rogers Diffusion of Innovation

Integrated Care: Empowering People, Improving Experiences

"It is the hand that touches the patient that makes the change"

Emma Benton

“Ways of Working within the CHN”

Margaret Costello
Head of Service, Primary Care, Mid West Community Healthcare

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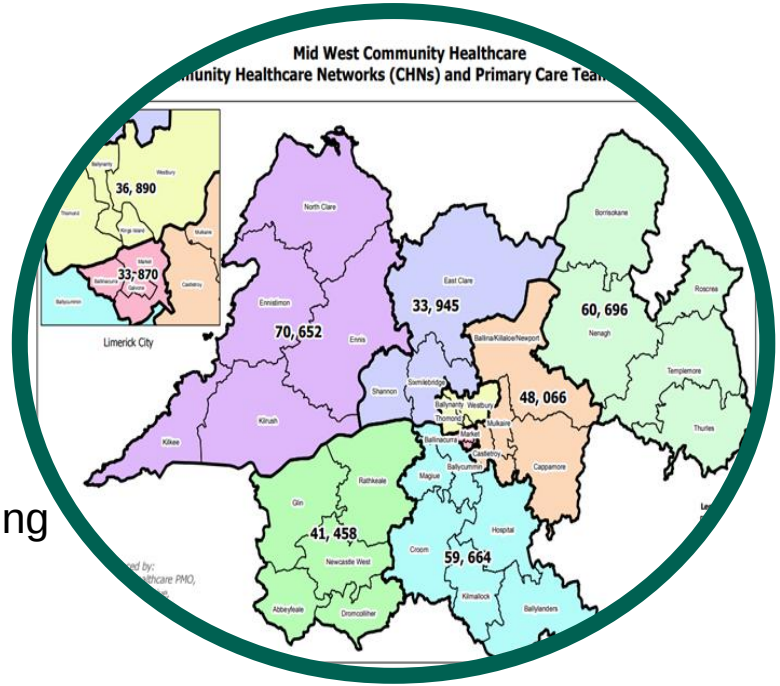
Community Healthcare Networks

- Structure to date
- Effective Population Health Approach – How We Are Doing This?
- How We Are Working Differently to Improve outcomes?
- Impact on Patients Waiting to Access Our Services
- Demonstrating Our Impact
- Opportunity for Research

Mid West Structural Changes to Date

Serving the Population of the Midwest 400,000

- 8 CHNs - *7 CHNs live*
- 35 Primary Care Teams
- 8 CHN Managers
- 40% Clinical Coordinators in post
- 3 ICPOP Teams aligned to CHNs
- 2 CDM Teams (1 Enhanced Team) aligned to CHNs
- 8 Assistant Directors Public Health Nursing
- 79% of ECC Roles filled



VALUE: CHN providing a strong foundation to deliver an effective population health approach driven by local and regional teams

WORKING TOWARDS AN EFFECTIVE POPULATION HEALTH APPROACH

– HOW?

- Strategic Health needs analysis in conjunction with Public Health Dept. at CHN level
- Know your population - Demographics, Age profile, Frailty, Deprivation, Ethnic groups etc.
- Deepen understanding with focus groups with service users & referrers

- Identification of service gaps e.g. counselling in primary care
- *Community Healthcare Network* Management Team – expanding the focus to bigger picture

How are we working differently to Improve Outcomes?

- Clinical team meetings facilitate **care coordination and care continuity** – focus on outcomes important to people and communities
- **GP Lead role** has strengthened clinical leadership, informing service planning, delivery and strong link with CHN based GPs
- **MDT prioritisation** for high risk population – move away from unidisciplinary prioritisation. Operationalised by PPPG for CTMs
- **Single point of referral** at CHN level from Acute and PCTs
- Broad principles of Primary Care **supported by specialist teams** – at table with a purpose i.e. building relationships and capacity, supporting patients, integrating care
- In reach to Model 4 Hospital through **Community Discharge Co-Ordinators** linked to CHN & PCT's.

Impact of additional Resources in Community Healthcare Network 3

New Service Developments	Improved Access
Adult SLT including FEES	Locally accessible Adult SLT service
Dietitian	Waiting Times reduced by **44%** for **<65 yrs** diabetic patients (within 3month of additional Dietitian in post) Weight Management Groups Dietetic service for children at CHN level
OT	OT waiting times reduced by **58%** within **6** months
Home First Approach	Early supported discharge Timely MDT intervention
Nursing	Enhanced Community Nursing Service
Diagnostic Specialist Teams ICPOP & CDM	Community diagnostics: Ennis Primary Care Centre (X-ray) ***YTD 2023: 10,764*** *scans, Total* ***for 2022: 9,556*** *scans* Mobile diagnostics for Nursing Home Residents GP access to diagnostics Direct GP referral pathway to ICPOP and CDM Teams.

Primary Care Impact on UEC

GP OOH	Community Diagnostics	Patient Flow Pathways (Discharge Hub)	CIT/MDCIT	ICPOP
Shannon Doc out of hours service will support hospital avoidance through the delivery of GP out of hours service. Limerick Doc will provide out of hours services for GPs linked to this private co-op	Access to diagnostics in Primary Care is a fundamental element to delivery of enhanced community care in line with the Slaintecare vision	The Discharge Hub triage referrals over the weekend and those requiring clinical input on Saturday, Sunday or Monday will be seen by Community Intervention Team.	CIT will operate a 7/7 from 8am - 8pm on Sat., Sun. and bank holiday periods to support hospital discharges from all wards and from ED. CIT will accept self referrals and referrals from GP OOH by way of hospital avoidance	
Impact: **YTD 2023 Total contacts:** 67,093 **YTD 2022 Total contacts:** 72,066	**Impact:** **YTD 2023 Total scans:** 10,764 **2022 Total scans:** 9,556	**Impact:** **YTD 2023 referrals received:** 12,925	**Impact:** *CIT referrals:* **YTD 2023:** 6,047 **YTD 2022:** 5,845 *MDCIT referrals:* **YTD 2023:** 400	**Impact:** **YTD 2023:** 978 referrals Limerick: 358, Clare: 367 North Tipp: 253 **GP referrals:** 795

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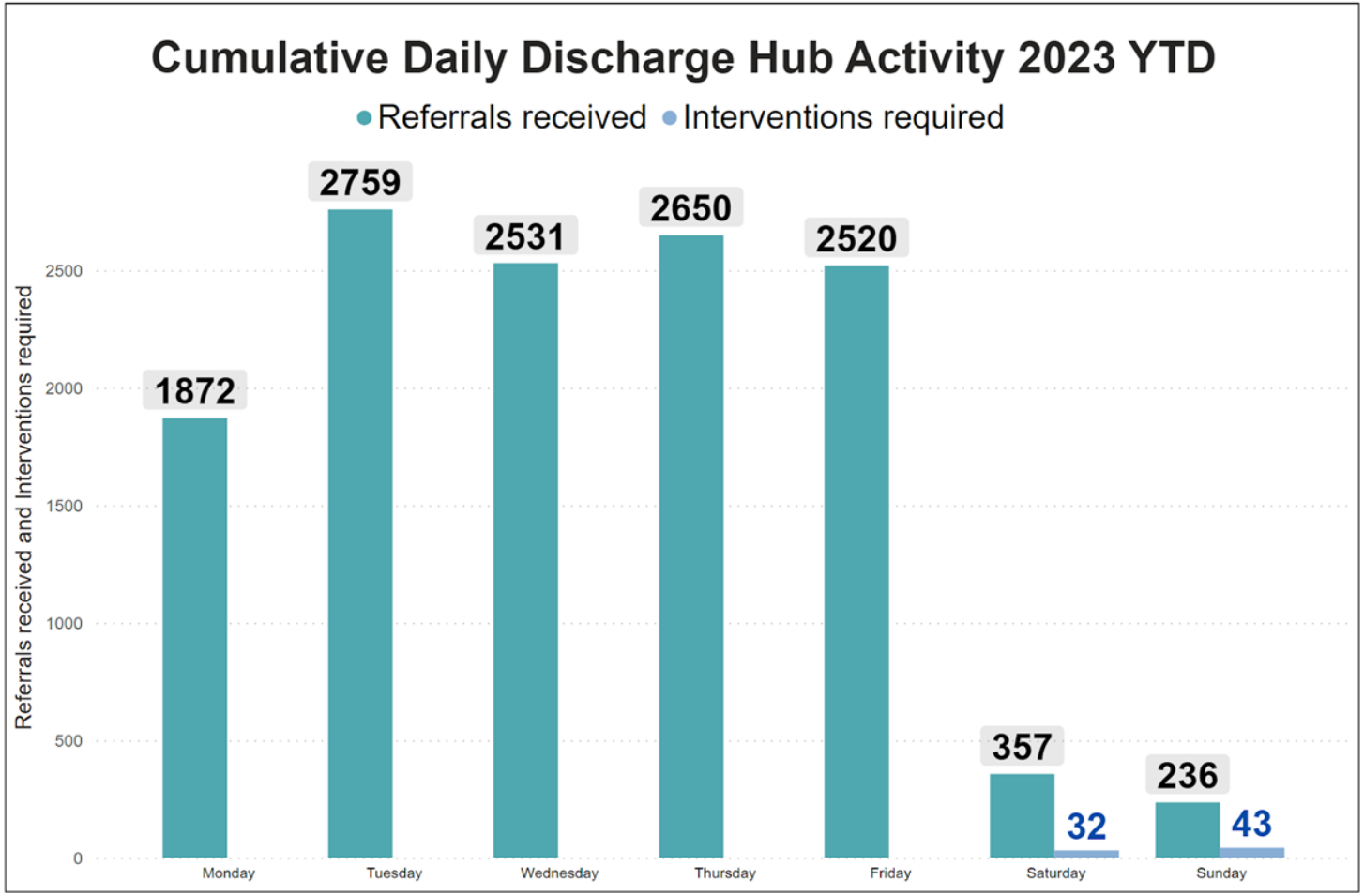
2023 YTD

12925

Referrals received



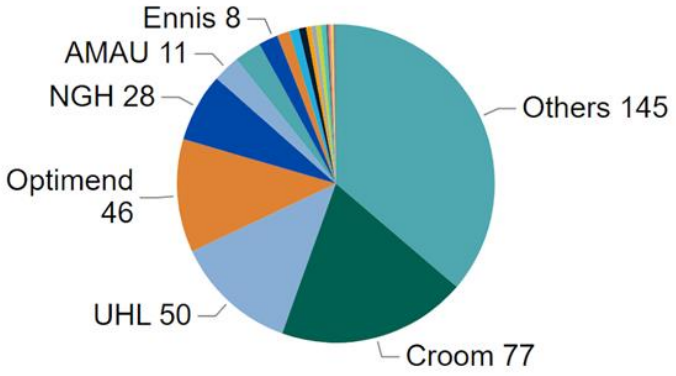
Total Number of Referrals YTD

400

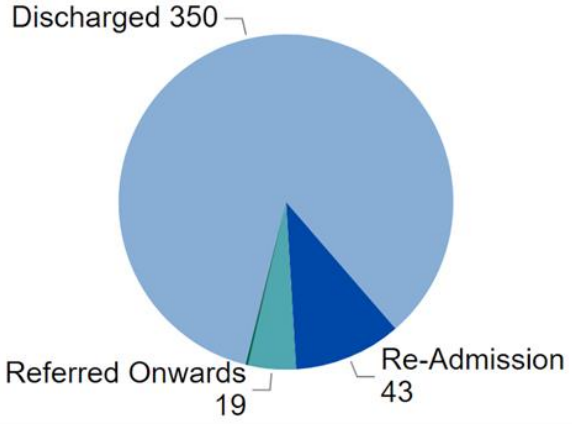
Source Referral Numbers

Source Referral Breakdown 2023 YTD

'Others' refers to wards and hospitals other than UHL



Outcome Numbers by Outcome 2023 YTD



No of Referrals by Week 2023 YTD

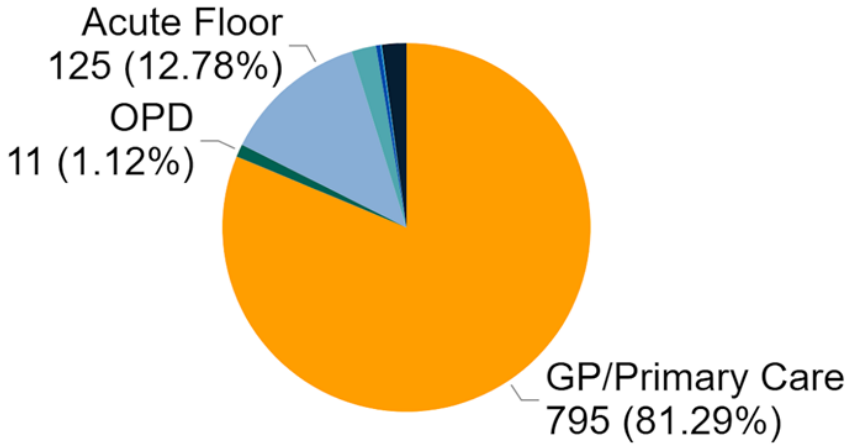
6 - ICPOP Metrics for Limerick, Clare & North Tipp YTD

HSE MID WEST COMMUNITY HEALTHCARE

Referrals 2023

Total new referrals	978
Referrals Limerick	358
Referrals Clare	367
Referrals North Tipp	253

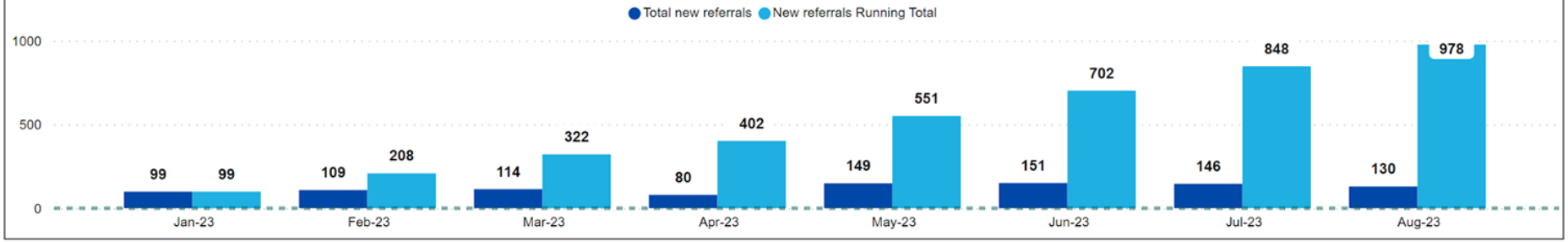
Total breakdown of referral sources



GP referrals

GP/Primary Care	795
Limerick	275
Clare	301
North Tipp	219

2023 - Number of New Referrals by Month



Mid West Chronic Disease Services

UHL prior to CDM Services, Feb 2022

- Wait time = 122 weeks
- No of clients waiting = 234
- Location University Hospital Limerick

Community Based Pul Rehabilitation Services, Limerick *(Respiratory Physician Access only)*

- Wait time = 11 weeks
- No of clients waiting = 133
- Locations GAA Halls, Hotels, Community Halls across Limerick city & county
- Virtual Pulmonary Rehabilitation available

GP Access Community Based Pul Rehabilitation Services, Co Clare & N Tipperary

- Wait time = 13 weeks
- No of clients waiting = 144
- Locations = Ennis Chronic Disease Hub, church premises Nenagh, Thurles Community Venue

Qualitative Feedback

Truthfully the programme and classes were the highlight of my day. I looked forward to going – the encouragement given kindly by the instructors was great. My gratitude goes to them.

This role has given me a better understanding of primary care teams and how they function. I have a good working relationship with the CHNM and a single point of contact for GP queries which I didn't have before. The Community Healthcare Network Management Team is providing the basis for targeted service development in the Community Healthcare Networks based on the population needs. There is great value in this partnership approach with the CHNM, ADPHN's, Clinical Coordinators and Discipline Managers"
Dr McGee

The Physio, OT and Nurse came to visit me at the same time – They worked together to support me and my family

Staff feel part of a team

When my mother was discharged from UHL the Discharge Co-ordinator was my point of contact – I felt confident that her discharge to home was planned and services we needed were in place.

Since doing the programme I can now do a lot more in the house and can walk further

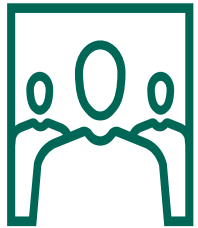
CHALLENGES AND OPPORTUNITIES

Challenges:

- Clear understanding of how success is measured
- Reluctance to change established ways of working
- Focus on Patient and Communities in design of integrated services
- Lack of robust data systems
- Recruitment of Clinical Coordinators.

Opportunities:

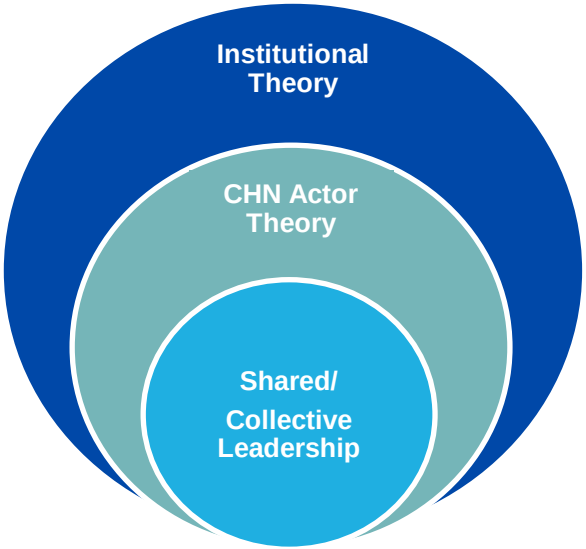
- CHN as anchor in context of development of RHA's.
- Understanding staff perception of Integrated Care – baseline in MW
- Continue to work on a Model of Care for different population segments.



HSE COMMUNITY INTEGRATION

LEADING WITH AND FOR INTER AND MULTI PROFESSIONAL COLLABORATION –A MULTI STAKEHOLDER STUDY

Overarching theories

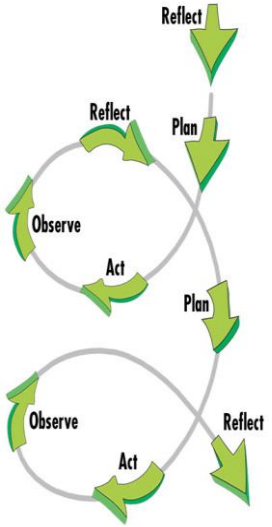


Research focus

Aim of the study: to review the concepts, advantages, enablers, barriers, and opportunities for CHNs adopting a multi-stakeholder perspective.

The study will identify a framework of factors that contribute to good practices in interprofessional and multi professional collaboration and from an individual, team, and CHN perspective.

Research Methodology Action Research



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“Act as if what you do makes a difference. It does.” —William James

Integrated Care: Empowering People, Improving Experiences

“A Journey Through our Community Healthcare Network”

- **Marian Lavin**, Community Healthcare Network Manager
- **Eileen Kelly**, Physiotherapy Manager
- **Geraldine Gormley**, Senior Physiotherapist & Clinical Coordinator

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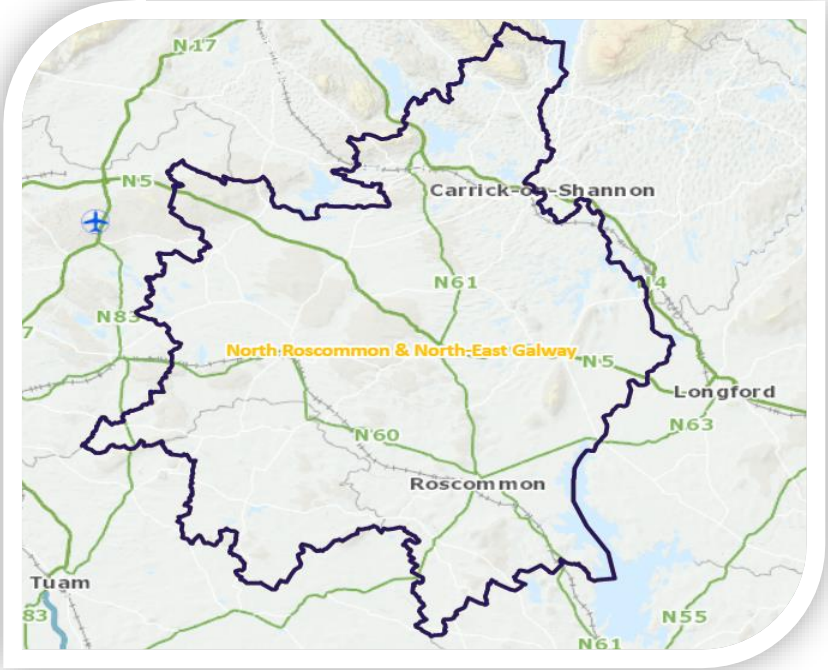
Our Community Healthcare Network



Population of **54,492** (CSO 2016)

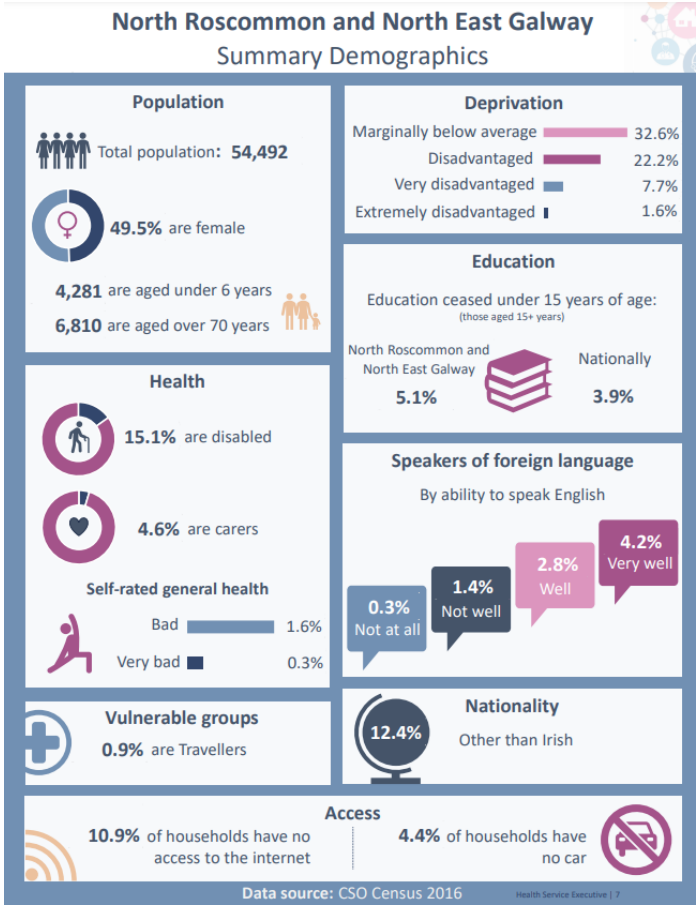
4th biggest CHN in CHO2

Socioeconomic status of marginally below average

6 Primary Care Teams

Population Profile: ageing population, frailty, reduced physical activity, chronic conditions

Our Community Healthcare Network



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Community Healthcare Network Priorities

Population Health Profile: Meeting the needs of our Population	**Ease of Access**
Working Together as an Effective Team	**Integration/Collaboration**
Holistic Approach	**Focus on Wellbeing**

Patient Persona

Annie is 80 years old

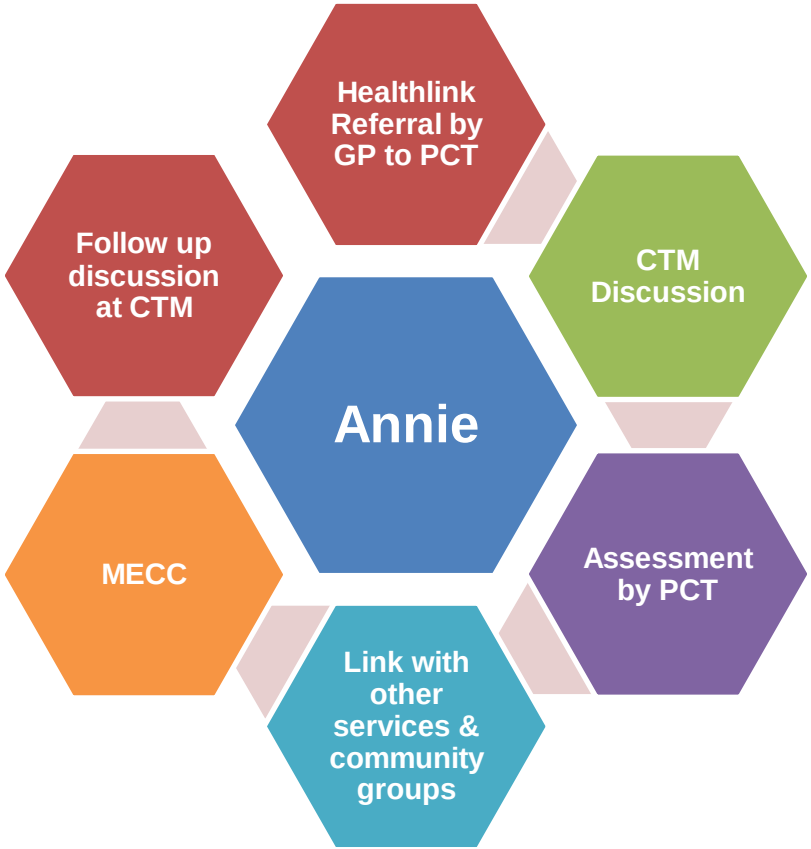
Lives alone

Was very active prior to the Covid-19 Pandemic

Lately she feels she has “slowed down and gotten old”

Recent fall and a UTI

Annie's Journey



Annie's Goals

To improve her mobility

To regain her independence & confidence

How can we help Annie to achieve her goals?

"To get out and about again"

"To feel like she used to"

Healthlink

- Centralised, streamlined referral process
- Improved quality of referrals
- Improved efficiency, privacy & security
- Sustainability
- Building digital infrastructure

Clinical Team Meeting

Identify, plan and coordinate care

Respond to the needs of the person in a timely fashion

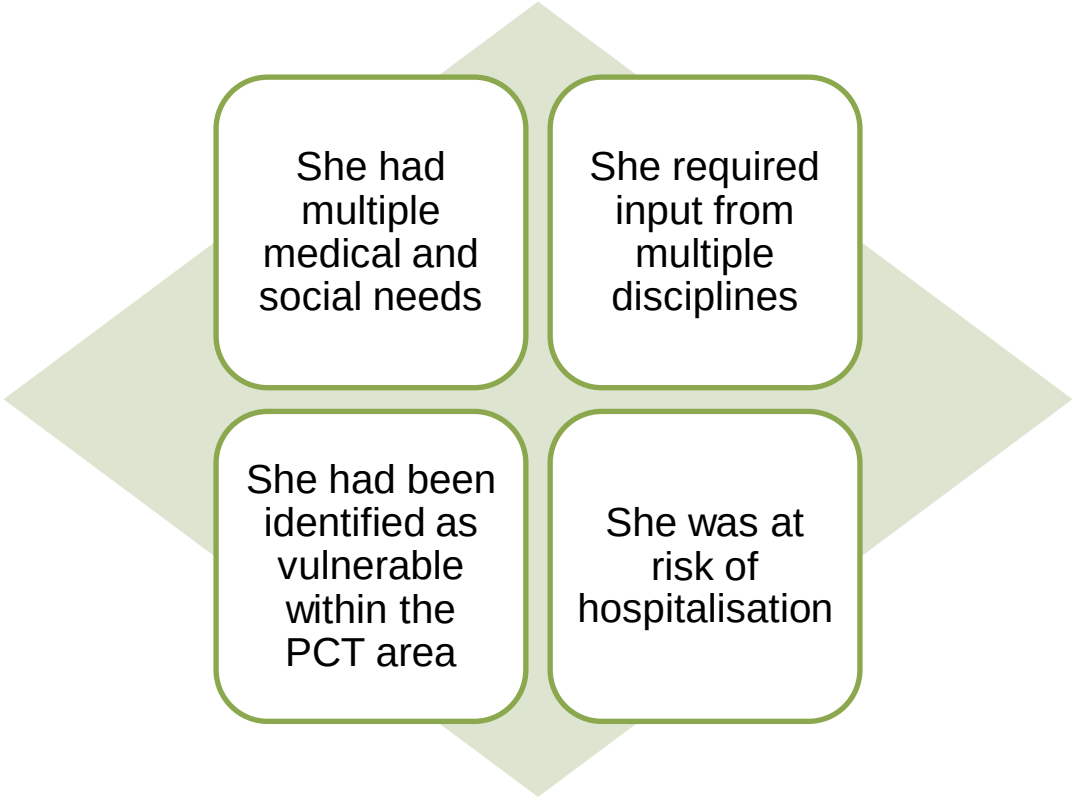
Share information for the effective management of care

Review and coordinate ongoing care

Develop, plan, implement & evaluate a multidisciplinary care plan

Share experience & learning

Annie's suitability for discussion at CTM



Clinical Coordinator Input into Annie's Care

Ensure Annie is listed for discussion and that all relevant team members are invited

Facilitate and chair the Clinical Team Meeting

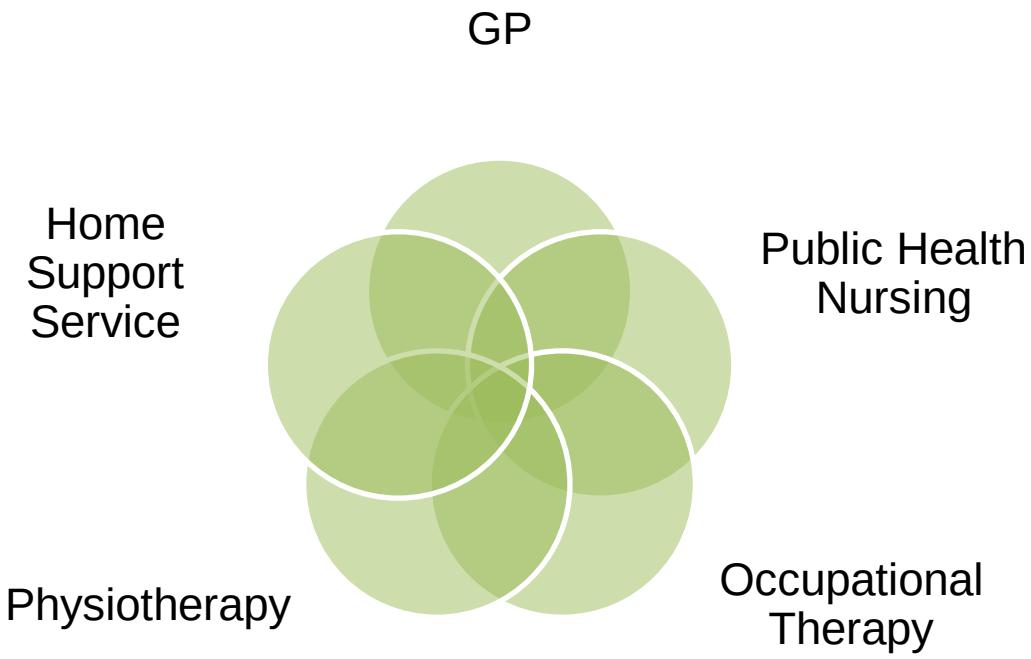
Encourage discussion, input, and facilitate consensus in relation to a multidisciplinary plan of care for Annie

Ensure all involved in Annie's care receive a copy of the plan of care

Link with any other services/external agencies as needed throughout Annie's journey

Schedule Annie for a review at the CTM at an agreed time

Intervention



Integration With Other Services

ALONE: Befriending Service, Personal alarm, Appointments, Technology

ICPOP

Health Promotion & Improvement Officer

“Getting to Know Your Services” Webinar Series

Community Healthcare Network Services Directory

ALONE
YOU’RE NOT ALONE

NICPOP
National Integrated Care Programme for Older Persons

hi
Healthy Ireland

Creating Community Links

- Social Prescriber
- Roscommon Sports Partnership
- Day Services
- Active Retired

Making Every Contact Count (MECC)

- Conversations with people about how they might make positive improvements to their health and wellbeing
- Two MECC initiatives in the Network
- Collaboration with Health Promotion to be a fully MECC enabled Network by December
- MECC Digital Pilot study in conjunction with RCSI.

Annie's Brief Interventions

Physical Activity

Healthy Eating

Mental Health & Wellbeing

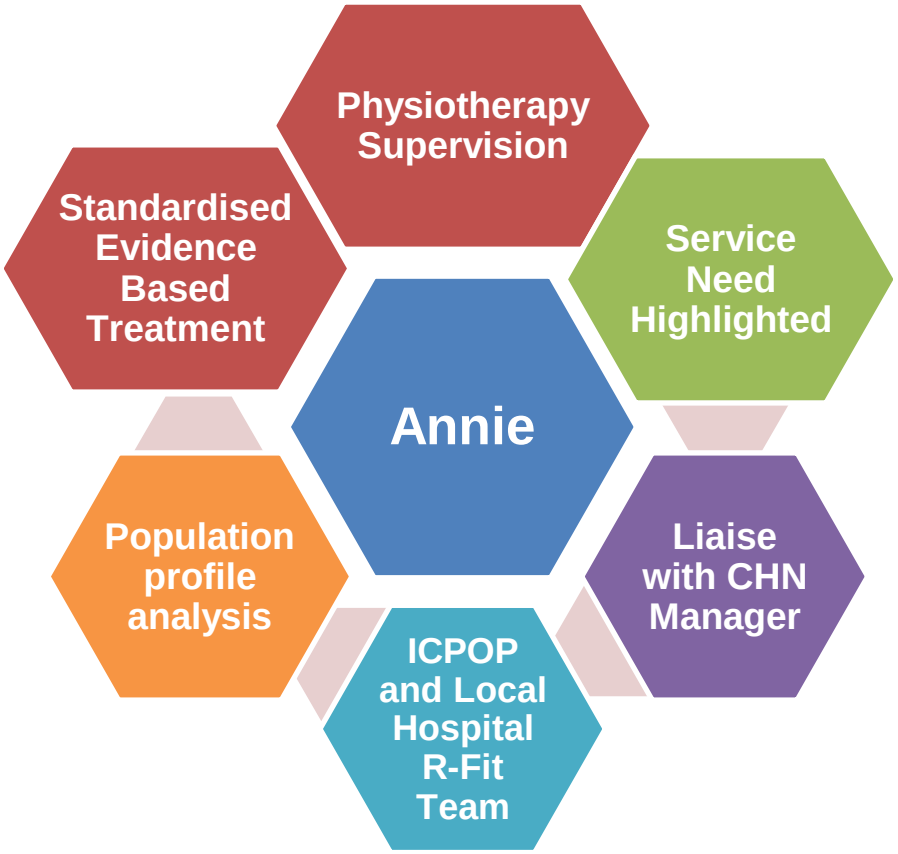
MAKING EVERY CONTACT COUNT

Integrated Care Delivery

Physiotherapist Manager Perspective

Clinical governance for all Physiotherapists in their department:

- ICPOP
- Chronic Disease
- CDNT
- Older Persons
- Urology Pathway
- Physiotherapists in the CHN Model



Integrated Physiotherapy in Roscommon

- Population Needs Analysis
- Referral Patterns
- Gaps in Service Provision
- Waiting List Times
- Co-developing Initiatives
- Pooling Resources
- Collaborating with CHN Manager

Cohesive transfer of care for Annie between services

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Working with Reactions to Change

Fear of the unknown	• Psychological Safety • New services
Fatigue	• Supervision and 1:1 with team members • Health and wellbeing initiatives • Team meetings to celebrate successes
Busy caseloads	• Protected time for meetings
Lack of buy in	• Involve team in co-design of all change pieces to increase engagement • Feedback and Surveys
Communication overload	• Collaboration with HOD and CHN Manager ensures consistent dual communication

Outcomes for Annie

Improvements in mobility & QOL outcome measures

Improved frailty score

Active engagement in the community

Links created with other services

Ongoing care needs discussed at CTM

Annie achieved her goals of:

- Improving her mobility
- Regaining her independence and confidence
- Getting out and about again
- Feeling like she used to

Ultimately….Annie was empowered to continue to live a healthy fulfilled life in her own home and avoided a potential hospital admission

"I felt like everyone was pulling together to help me"

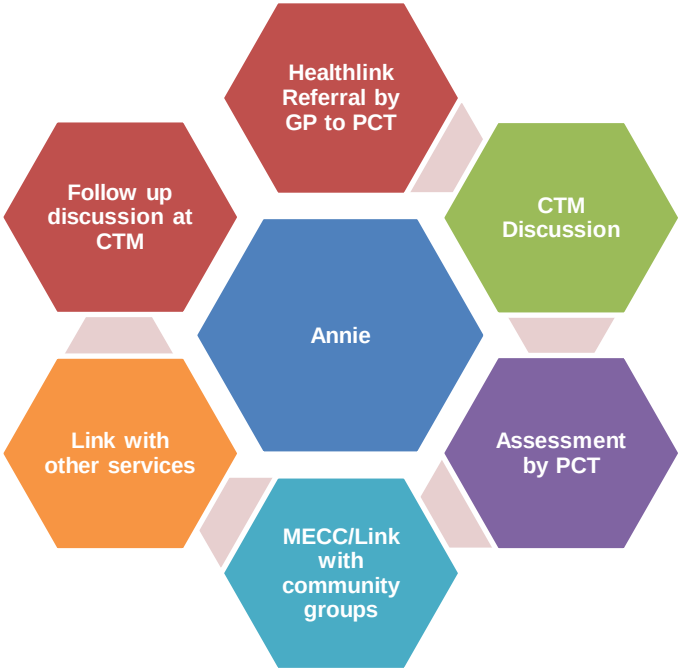
"The team gave me my life back"

Conclusion

Integrated care delivery

Referral to appropriate services

Teamwork



Clinical Coordinator Input

Intervention in a timely fashion

Holistic Approach

Focus on wellbeing

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Integrated Care: Empowering People, Improving Experiences

"Yesterday I was clever, so I wanted to change the world. Today, I am wise so I am changing myself" (Rumi)

Thank you to all of our staff who have embraced change and who are working everyday to make the Health Service better for everyone

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Enhanced Community Care Conference

07 September 2023

ECC in Action: Integrated Care Programme for Older People

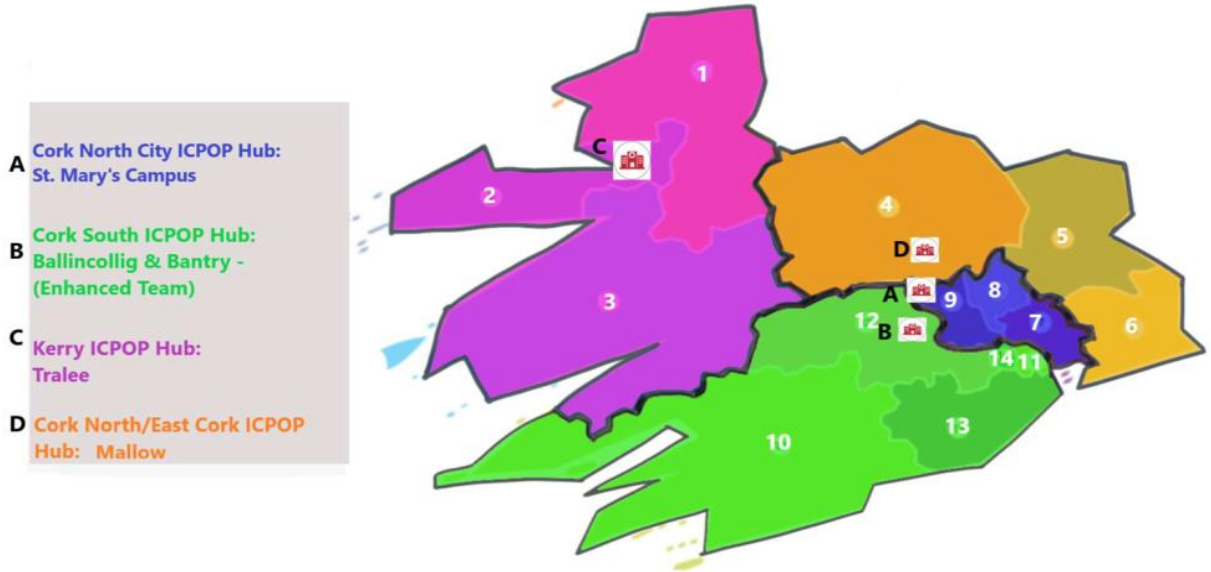
Integrated Care: Empowering People, Improving Experiences

Developing pathways towards an end-to-end model
Dr. Bart Daly

Integrated Care: Empowering People, Improving Experiences

“People don't care how much you know until they know how much you care”

— **Theodore Roosevelt**

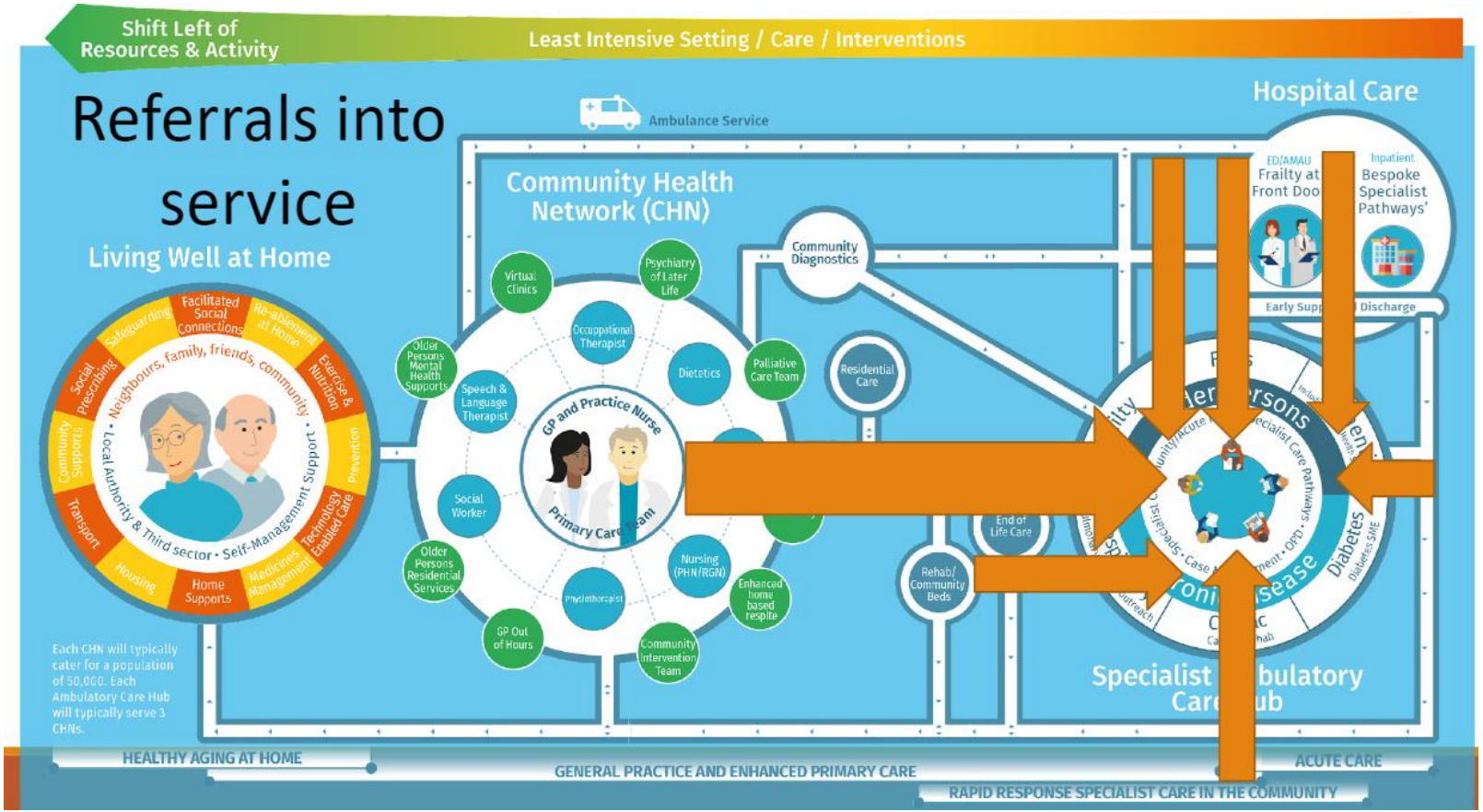


- Pilot ICPOP Hub site in 2020
- Utilising existing Assessment and Treatment Centre structure
- Catchment area – 4 CHN's ~210,000
- Providing temporary cover for 8 CHN's (420,000 population).

The Week in Numbers

- 280 new referrals / month
- Rapid access within 2 weeks
- 40 patients Outreach - virtual ward at home
- ~80 - 100 complex case management patients

Older Person / Chronic Disease Service Model



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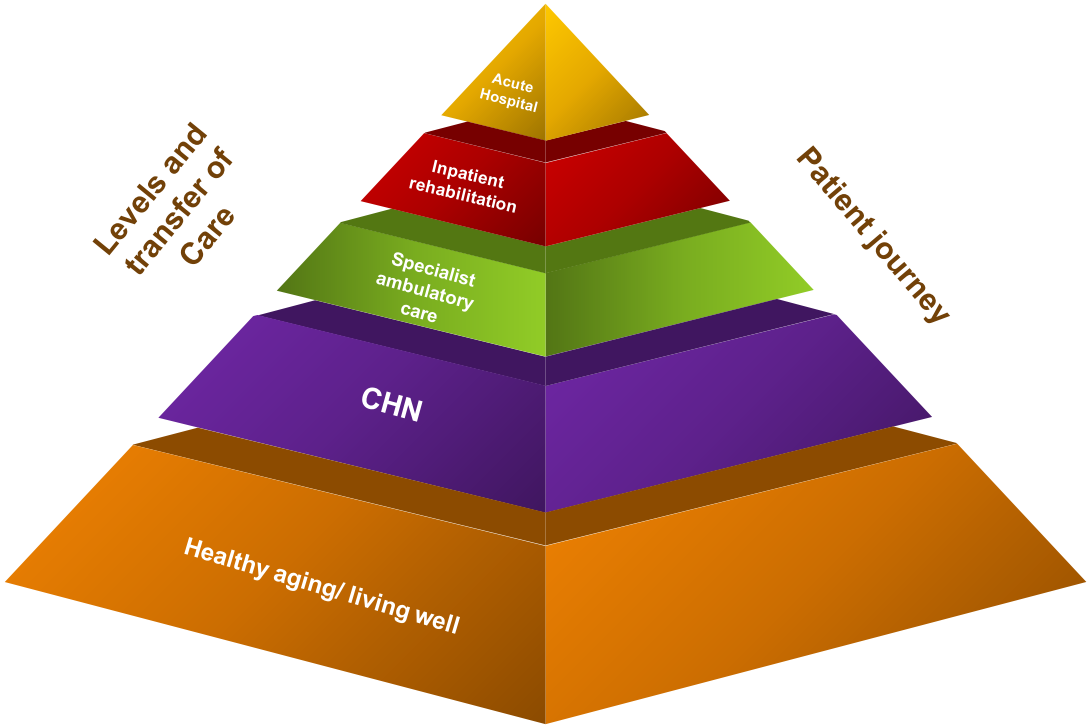
Research on Staff Perceptions

GP Fellow – Dr Andrea Fitzgerald / Professor Tony Foley



- 29 semi-structured interviews – Hub and CHN ICPOP teams
- Positive regarding program goals
- Challenge of context assessment
- Difficulty with transfer of care/information
- Understanding of the hub function

Pathways Structure

MDT triage and case conference for all pathways

MDT led assessment, intervention and case management

Interdisciplinary working within pathways

Enabler for end to end pathway development

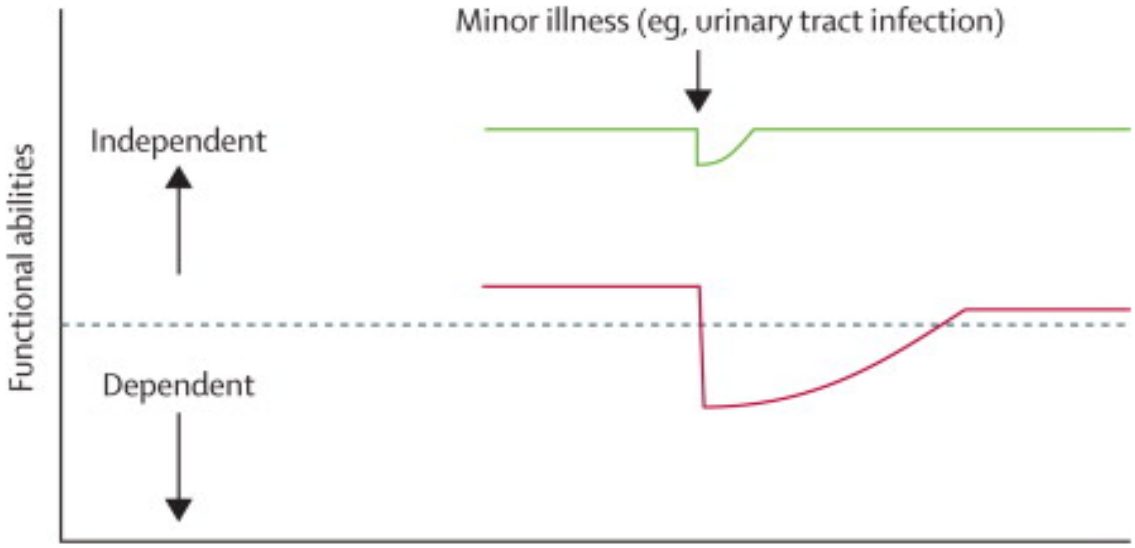


Figure 1 Vulnerability of frail elderly people to a sudden change in health status after a minor illness

Rapid Access - All Pathways

Available across pathways – stabilise and coordinate care

Clinic visit
Home visit
ANP case management

Outreach direct
Community coordinator review

Supported discharge pathway

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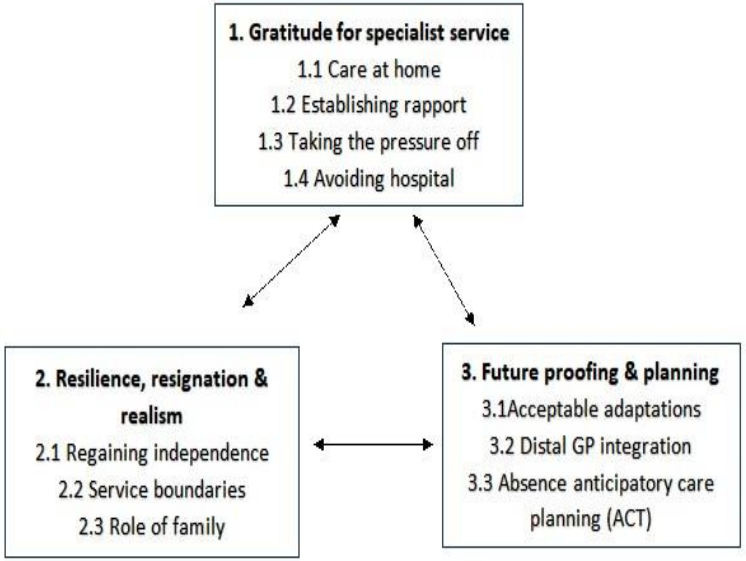
Research - Patient Views

Professor Corina Naughton and UCC team with outreach

They made me feel much happier that I knew that someone was coming about me you know, caring for me like…. [P11]



We hadn't even known how far down she was going…. she needed a good overhaul you know and she received all that and more'… they took over everything in their hands and everything was looked after and dealt with.. like there was no pressure on the family [P2C]

What can we do?

- We can’t replace care best met in hospital
- We can’t always provide certainty
- We can’t always cure

BUT

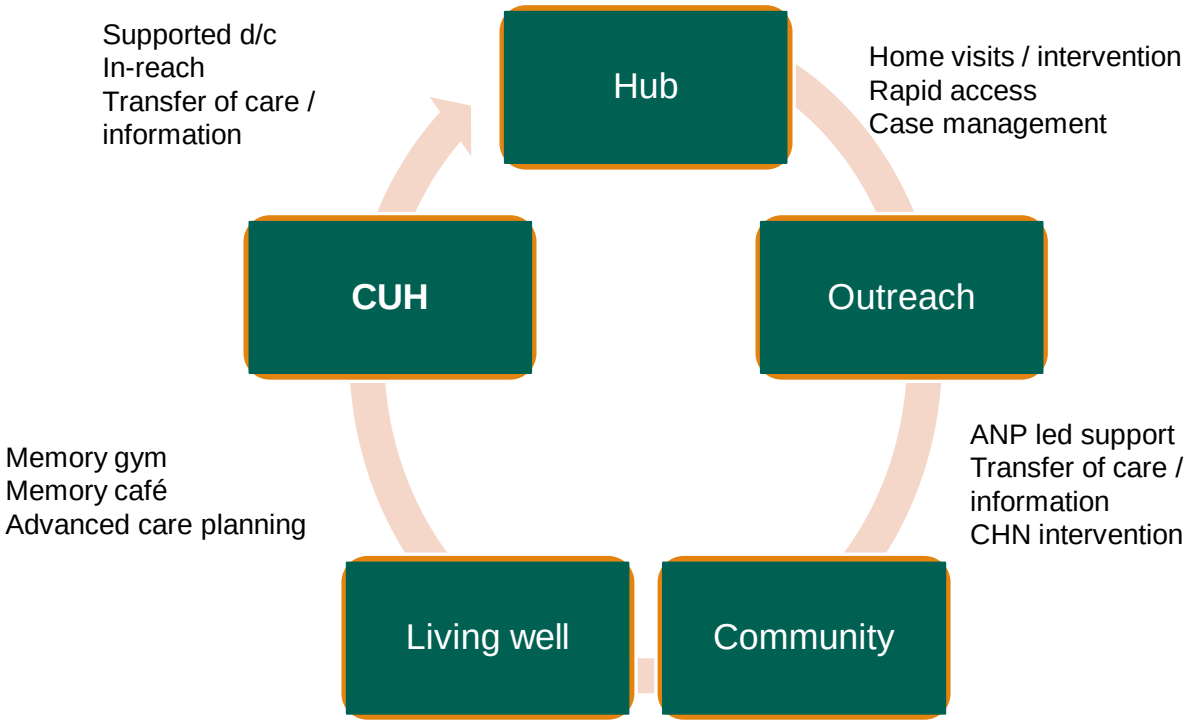
- We can provide high quality care outside of hospital
- We can improve care management and patient experience
- We can optimise function and supports
- We can empower people and future plan with them

He was in hospital and we felt he was mentally we were losing him, that he came home he actually mentally got better because they were coming in doing the physical side of it. The mental side of it, being a home and being around his family and environment. He came back to us [P7C]

Memory Service Pathways

HUB pathways
~70 referrals /month

- Pre-assessment
- Rapid access
- Memory clinic
- MDT led interventions
- Diagnostics
- Coordination of care
- Telehealth
- Case management (Crisis/Acute/Complex)
- Post diagnostic support
- Access to other pathways



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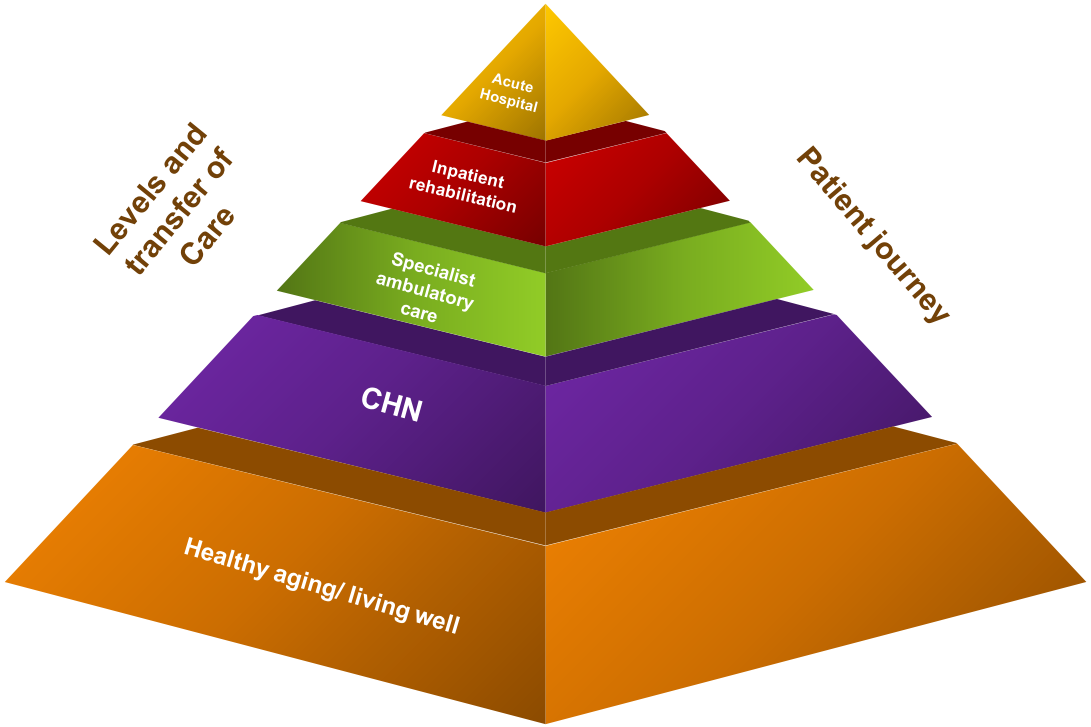
Future Planning

GP Fellow – Dr Andrea Fitzgerald / Professor Tony Foley



- Hub as structural anchor for further developments
- CUH pathways – rapid assessment / in-reach / supported discharge / complex case management
- MDT led assessment and intervention
- Further CHN integration – shared planning within individual pathways
- Living well initiatives / Group Exercise classes

'If we design services for people with only one thing wrong at once but people with many things wrong turn up, the fault is not with the users but with the service, yet all too often these patients are labelled as inappropriate and presented as a problem…'

Prof Ken Rockwood

Evaluating the Patients Experience of an ICPOP Team

James Geoghegan

Integrated Care: Empowering People, Improving Experiences

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Evaluating the Patients Experience of an ICPOP Team

Galway East City & County ICPOP CST Serving Community Healthcare Networks 6&7

Community Healthcare West ICPOP Teams Vision and Mission statement

Empowering Healthy Ageing in your home and community

and provide

A specialist integrated interdisciplinary team working in partnership with older people to coordinate and provide enhanced health and social care services in their home and communities.

Avoiding unnecessary hospital admission and enable positive healthy ageing through comprehensive assessment and interventions

Care experience surveys are a useful way of identifying areas that need improvement in the delivery of health and social care and provide service providers with detailed information on how to fix these problems. By listening and learning from the experiences of patients we can bring about effective and sustainable changes across the Irish health and social care systems. ‘yourexperience.ie’

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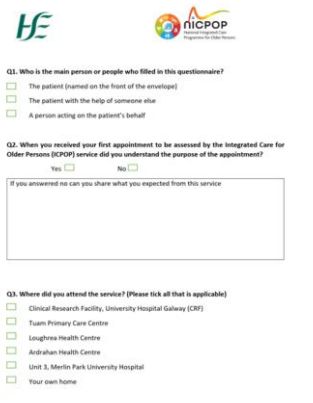
Method of Evaluation

January – April 2023

A survey consisting of 15 closed/3 open questions was developed using a Likert scale for closed questions and thematic analysis for open questions. The questions were adapted from the National Patient Experience Survey from yourexperience.ie.

115 service users who attended our teams and have received a CGA from January 2023 to April 2023 were invited to participate in a postal survey.



Q1. Who is the main person or people who filled in this questionnaire?

- The patient (named on the front of the envelope)
- The patient with the help of someone else
- A person acting on the patient's behalf

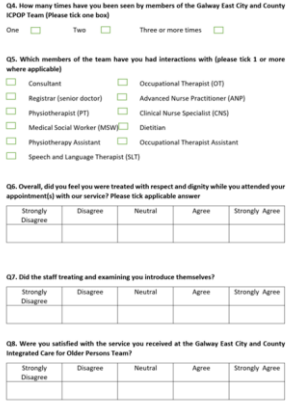
Q2. When you received your first appointment to be assessed by the Integrated Care for Older Persons (ICPOP) service did you understand the purpose of the appointment?

Yes ☐ No ☐

If you answered no can you share what you expected from this service

Q3. Where did you attend the service? (Please tick all that is applicable)

- Clinical Research Facility, University Hospital Galway (CRF)
- Tuam Primary Care Centre
- Loughrea Health Centre
- Ardrahan Health Centre
- Unit 3, Merlin Park University Hospital
- Your own home



Q4. How many times have you been seen by members of the Galway East City and County ICPOP Team (Please tick one box)

One ☐ Two ☐ Three or more times ☐

Q5. Which members of the team have you had interactions with (please tick 1 or more where applicable)

- Consultant
- Registrar (senior doctor)
- Physiotherapist (PT)
- Medical Social Worker (MSW)
- Physiotherapy Assistant
- Speech and Language Therapist (SLT)
- Occupational Therapist (OT)
- Advanced Nurse Practitioner (ANP)
- Clinical Nurse Specialist (CNS)
- Dietitian
- Occupational Therapist Assistant

Q6. Overall, did you feel you were treated with respect and dignity while you attended your appointment(s) with our service? Please tick applicable answer

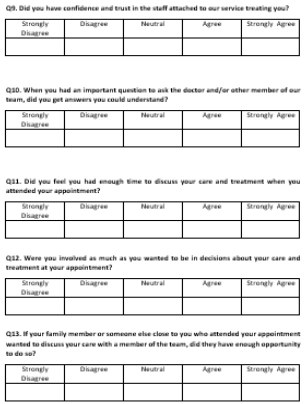
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Q7. Did the staff treating and examining you introduce themselves?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Q8. Were you satisfied with the service you received at the Galway East City and County Integrated Care for Older Persons Team?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree



Q9. Did you have confidence and trust in the staff attached to our service treating you?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Q10. When you had an important question to ask the doctor and/or other member of our team, did you get answers you could understand?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Q11. Did you feel you had enough time to discuss your care and treatment when you attended your appointment?

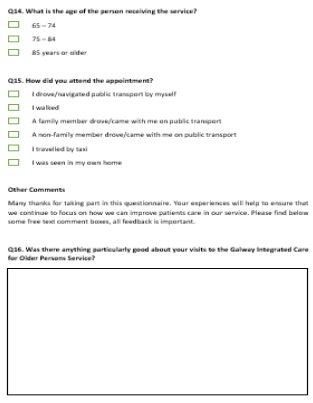
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Q12. Were you involved as much as you wanted to be in decisions about your care and treatment at your appointment?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Q13. If your family member or someone else close to you who attended your appointment wanted to discuss your care with a member of the team, did they have enough opportunity to do so?

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree



Q14. What is the age of the person receiving the service?

- 65 – 74
- 75 – 84
- 85 years or older

Q15. How did you attend the appointment?

- I drove/navigated public transport by myself
- I walked
- A family member drove/came with me on public transport
- A non-family member drove/came with me on public transport
- I travelled by taxi
- I was seen in my own home

Other Comments

Many thanks for taking part in this questionnaire. Your experiences will help to ensure that we continue to focus on how we can improve patients care in our service. Please find below some free text comment boxes, all feedback is important.

Q16. Was there anything particularly good about your visits to the Galway Integrated Care for Older Persons Service?

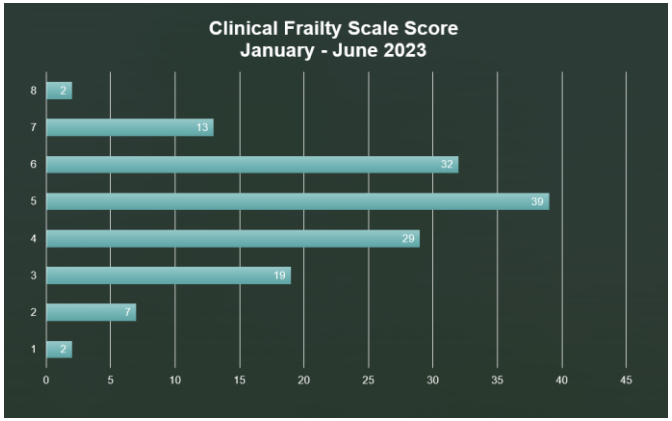
Q17. Was there anything that could be improved?

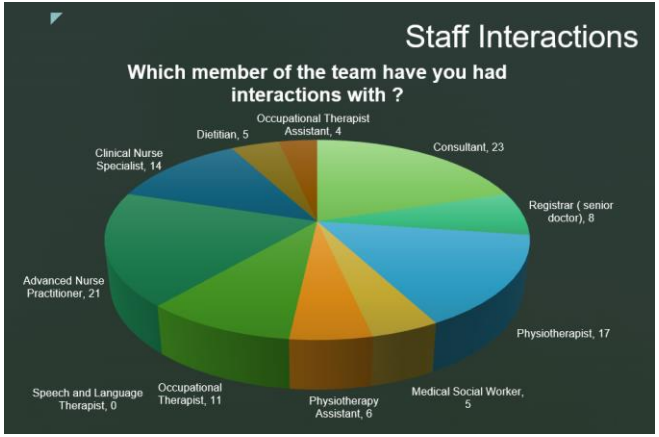
Q18. Are you involved in any local community group/ Day Centre / local health programmes (not limited to your experiences with the Galway Integrated Care for older persons?)

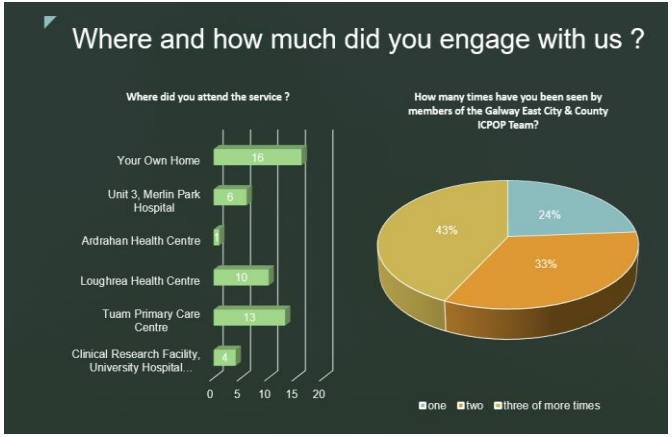
Thank you for completing the questionnaire.

We would be grateful if you could return by post using the stamped addressed envelope attached by Monday 22nd May

Enhanced Community Care





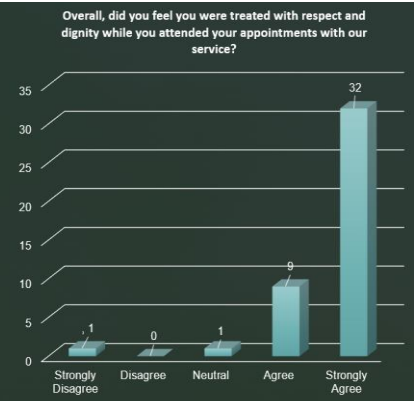


Enhanced Community Care

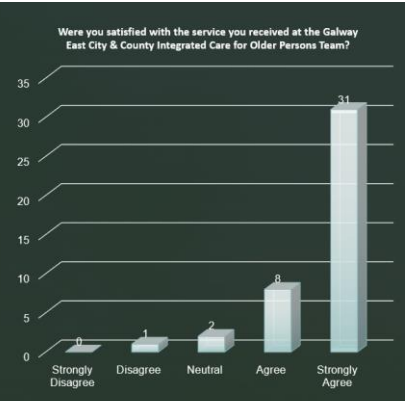
'I thoroughly enjoyed it, very friendly and respectful people are involved'

'Professor Michelle Canavan was very empathetic and supportive to my mother'

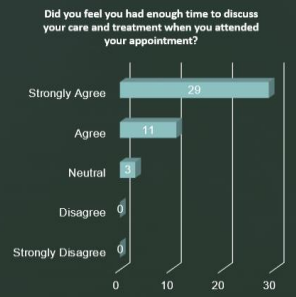
'spoke directly with me the patient all through appointment. Listened to any queries I Had. Took their time and didn't rush the appointment'

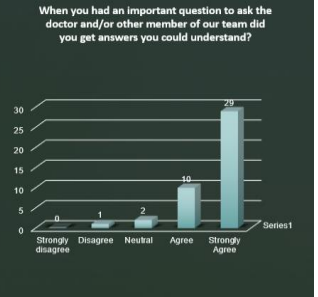


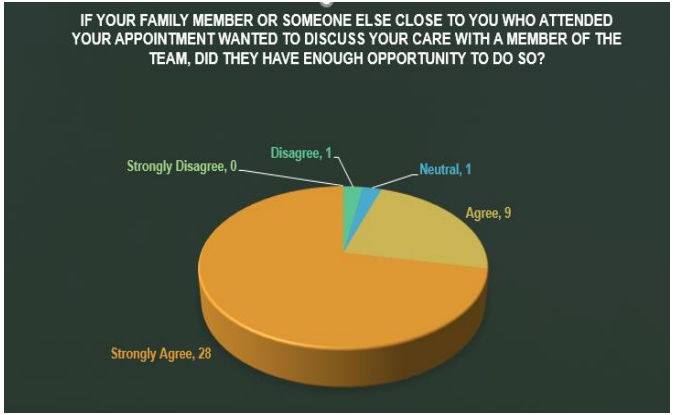
'it was timely and very professional. Our locum GP acted on our request. The ANP was excellent re full assessment bloods etc. The video consult with Prof was re-assuring and x-ray arranged immediately. This was competed by therapy services/assessments and it has helped greatly in continuing to care for my mother at home so far. It is also reassuring that we can access this integrated service at any time which is essential for older persons'



'We are very happy with the swift response and the amount of support received so far. They covered every possible issue and continue to offer support and recommend services'







Conclusions

Headline Findings:

Service Users had an overwhelming positive experience from their interactions with our team with

95% agreed/strongly agreed that they were satisfied with the service.

95% felt they were treated with dignity/respect and had confidence in the service.

Themes identified:

- Care close to home

Learnings for the team:

- Acknowledge the positives from our interactions with our service users
- What can we learn from the areas for improvement identified from our responses ?
- How do we ensure that we as a team go about and address the issues identified ?

Integrated Care: Empowering People, Improving Experiences

"People will forget what you said, people will forget what you did, but people will never forget how you made them feel." Maya Angelou

Enhanced Community Care

FFD Lived Experience – Mater FIT

Dr. Keneilwe Malomo

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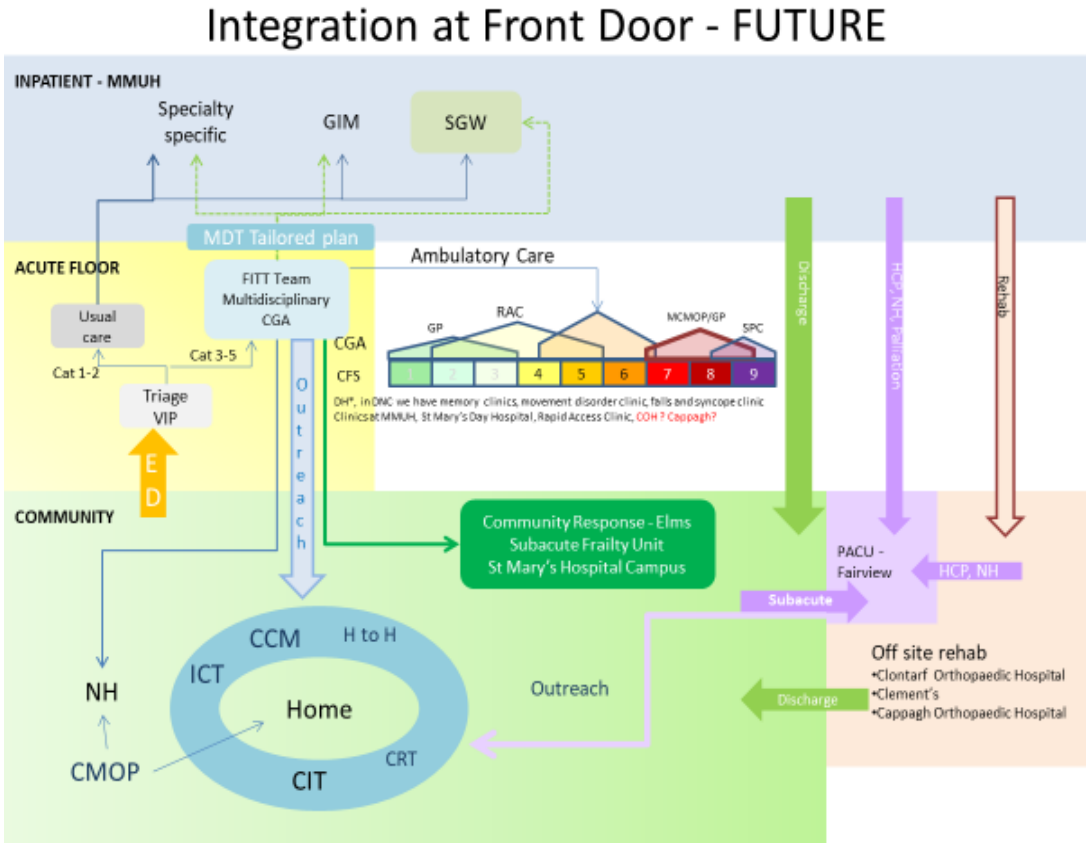
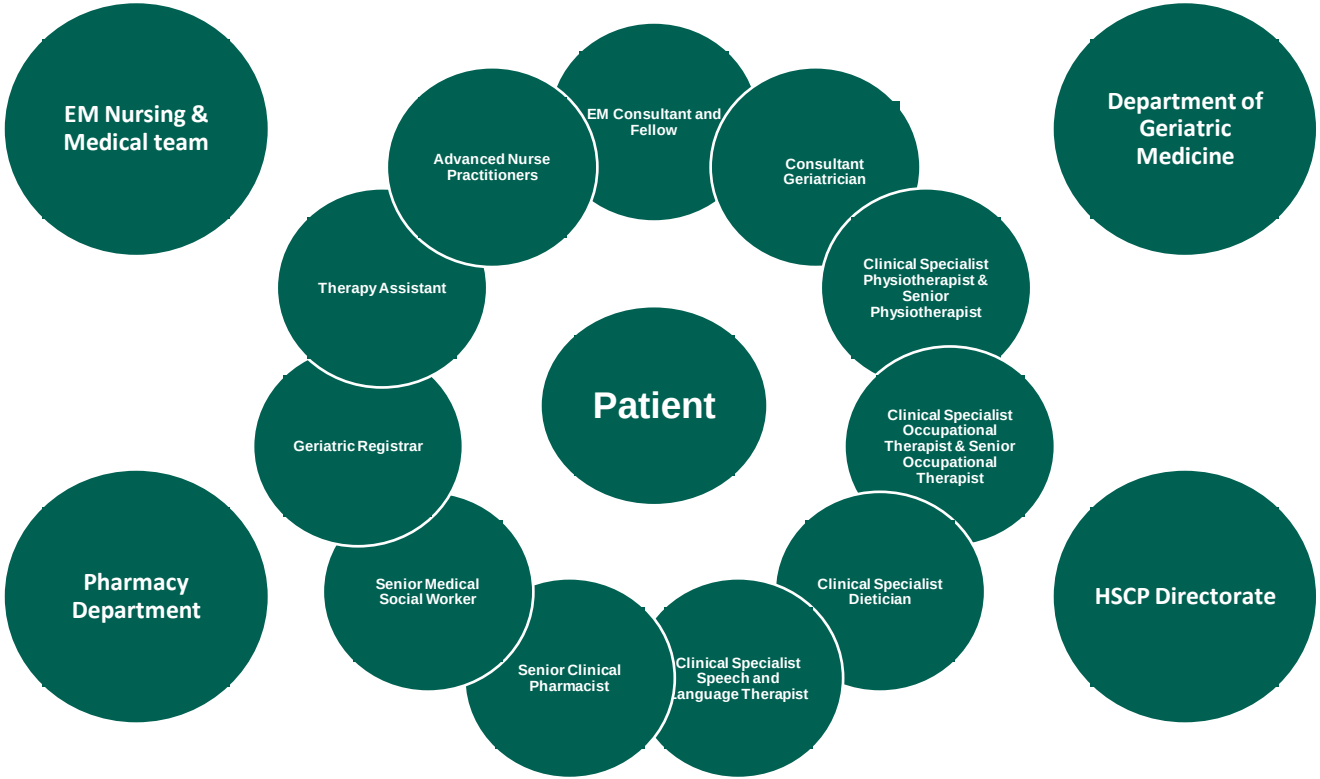
Enhanced
Community
Care

Model for Integrated Care - MMUH



Courtesy of Dr Chie Wei Fan

Model for Integrated Care - MMUH



INTERVENTION TEAM (FIT) MATER FRAILTY

Est. October 2020

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Model for Integrated Care - MMUH

- Patient finding service
- Based in ED/Acute floor

- Comprehensive Geriatric Assessment (CGA)
- Early assessment, intervention and discharge planning

- Frailty, delirium and risk identification
- Development of Alternative Care Pathways

- Home first ethos
- Collaborative working with patient, ED, inpatient and community teams

Overall goal of reducing harm, improving outcomes, reducing LOS and improving patient care

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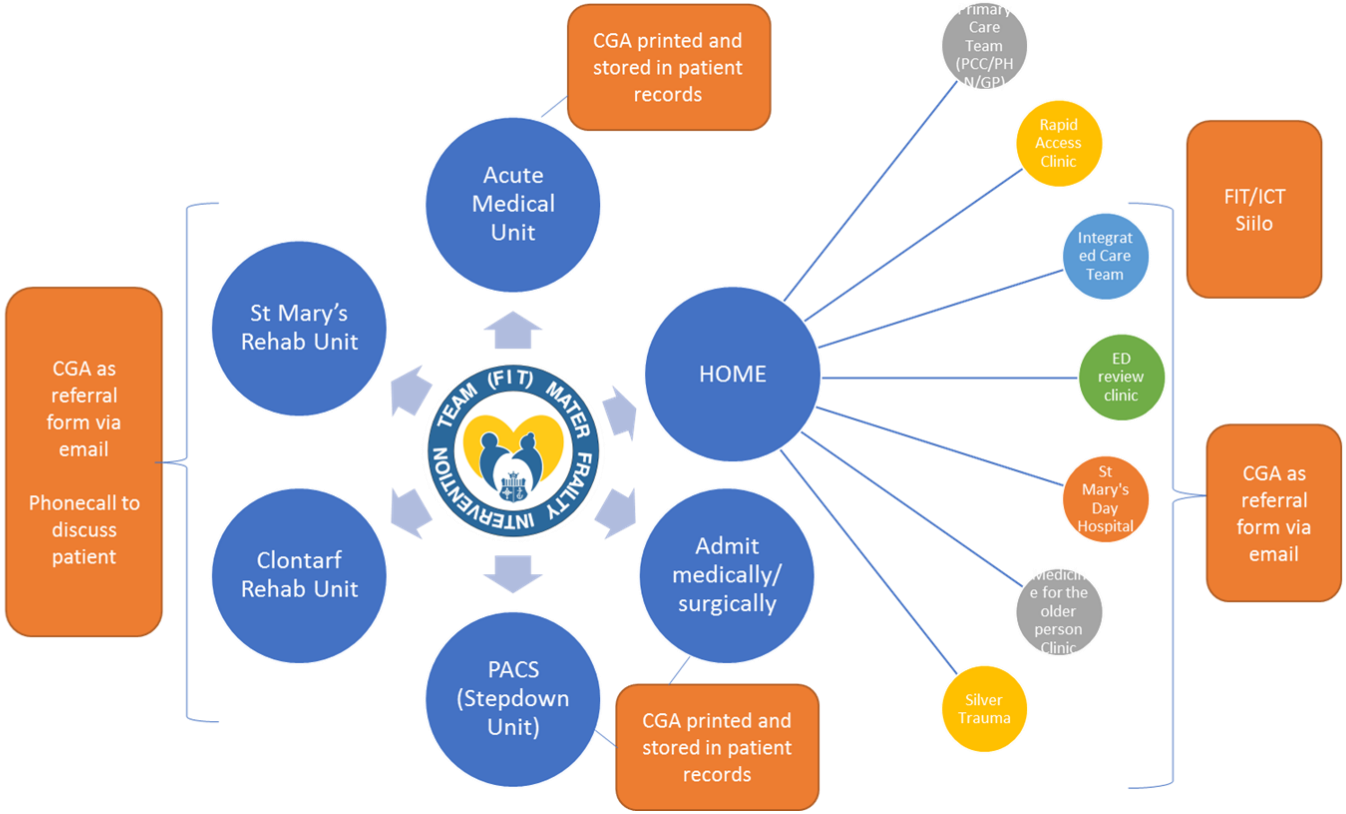
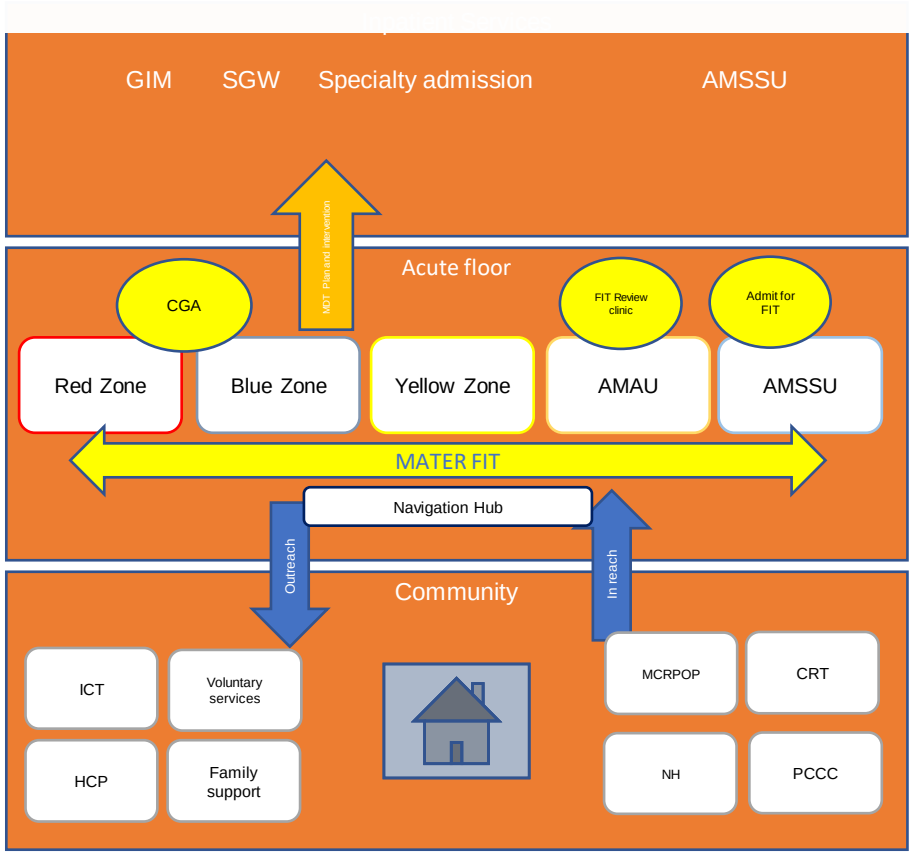
Pathways


CGA printed and stored in patient records
Acute Medical Unit
St Mary's Rehab Unit
CGA as referral form via email
Phonecall to discuss patient
Clontarf Rehab Unit
TEAM (FIT) MATER INTERVENTION FRAILTY
HOME
Admit medically/ surgically
PACS (Stepdown Unit)
CGA printed and stored in patient records
Primary Care Team (PCC/PH N/GP)
Rapid Access Clinic
Integrated Care Team
ED review clinic
St Mary's Day Hospital
e for the older person Clinic
Silver Trauma
FIT/ICT Siilo
CGA as referral form via email

Pathways



Rehabilitation
St Mary's
Clontarf

OPD
Specialty specific
Rapid access
Limited MDT

PACU

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Rehabilitation

- Sub Acute Frailty Ward in St Mary's Hospital and Clontarf Hospital
- Patients admitted from acute floor (ED, AMU or AMSSU) in MMUH or within 72 hrs of admission
- 16 bed unit in each hospital
- "Home First" philosophy
- Focus is on early interventions to enable discharge home
- Under the clinical governance of Integrated Care Consultant Geriatrician with full HSCP, medical and nursing care.
- Also access to Post Acute Care Unit in Fairview

Out of hours access

- Admit for FIT
- Silver Trauma Clinic
- Return and review clinic
- Siilo handover group

FIT Data 2022

	2022
No of CGA	3134
No DC ICT	110
No DC Silver Trauma	57
Total discharges from ED	1124
No TF Clontarf	28
No TF SMH	70
TF PACU/Mount Carmel	19
Total TF offsite	117
No Admission Avoidance	665
Total discharges from FIT	1241

Length of Stay - Geriatrics

	June - July 2019	June - July 2021	July 2022
AvLOS	21.1 days	15 days	17.4 days
Med LOS	13 days	7 days	5 days

Representation Rates to ED

Representation to ED	5/18-4/19	5/21-4/22
<7 days	963	1057
0-28 days	2035	2250

Survey Results

- 43% response rate
- 73% very satisfied with their experience
- 87% felt FIT helped facilitate discharge from ED

Themes

- ✓ Thorough assessment
- ✓ Great team & team work
- ✓ Quick access to specialties
- ✓ Compassionate
- ✓ Patient centred
- ✓ Follow up a priority

"The staff in general were very helpful and kind"

"Treated by the FIT service. Quick discharge and follow up appointment"

"The honest way they explained everything to me"

"Fantastic service. Highly recommend"

"Very quick access to experts. Was a really positive experience. From it cam home help and access to daycare. This has made huge positive difference"

Summary

- Integrated services can provide quality care to patients while better utilising scarce public resources
- Collaborative working and whole system planning are necessary
- Patient centred, home first approach

Hospital Avoidance - Providing Specialist Geriatric Services to Nursing Homes

Josep Duran

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Community Medicine Older Persons

Chapelview, St Mary's Hospital, Phoenix Park, Dublin 20.
Tel: 01 778 4205

Email: cm.op@hse.ie

Team members: C.W. Fan, J. Duran, T. Keating, C. Geary

our health service

Enhanced Community Care

Mater Misericordiae University Hospital

nICPOP National Integrated Care Programme for Older Persons

COMMUNITY MEDICINE OLDER PERSONS

MMUH NURSING HOME CATCHMENT AREA

What we do:

Provide specialist **geriatric consultation** for older adults living in nursing homes (NH) in Mater Misericordiae University Hospital (MMUH) Catchment area.

Our goals:

- Promote appropriate **hospital avoidance** through collaboration of nursing home, hospital, primary care and extended-care team.
- Provide **timely access** to geriatric services to older adults living in NH.
- To facilitate appropriate/early **discharge** from Emergency Department (ED) and Hospital Ward.
- Support, empower, educate and enable **nursing home staff, residents** and their **family/carers**.
- Promote the health, function and quality of life of **frail older people**.

COMMUNITY MEDICINE OLDER PERSONS

MMUH NURSING HOME CATCHMENT AREA

Examples of what we do:

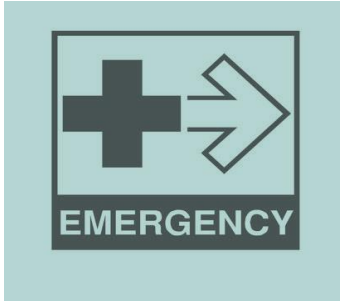
- Provide specialist opinion regarding management of a number of **chronic health conditions.**
- Collaborate in development of **advanced care planning** for frail older people.
- Participate in **MDT** and **family meetings.**
- **Education** and **Support** for NH staff, resident and their families.
- Organise relevant **test** and **referrals** as required; ICTOP, Charter Medical, Sage, SFH CPC, MMUH.
- Assisting in other **relevant aspects** such as completion of CSAR, Capacity Assessments, support for discharge home, dispense High-Tech scripts, circulation of guidelines, policies and trainings, crisis situations such as Covid-19.

COMMUNITY MEDICINE OLDER PERSONS

MMUH NURSING HOME CATCHMENT AREA

The referral pathway

- **GP referral** for older persons (>65) living in NH.
- Follow-up nursing home residents after attending **MMUH ED**.
- **Medical referral** post-discharge from the **MMUH** of patients who fulfil the service criteria.
- Post- discharge from **other** hospitals; Connolly Hospital, Beaumont Hospital, St Mary's Hospital, Fairview PACS, etc.



COMMUNITY MEDICINE OLDER PERSONS

MMUH NURSING HOME CATCHMENT AREA

The impact of presentations to ED 2022

- The **NH´s bed** capacity has increased by **21%** over the last 10 years. From a bed capacity of 1377 in 2013 to **1660** in 2023.
- In 2022, there was an **15% increase** in ED attendance of >65 compared with 2019 (pre-Covid 19).
- Of all the >65 years attending ED, NH residents represented **2.87%** .
- Of the 2.87% attending ED, **58%** required **inpatient** treatment.
- Of the 623 NH residents that attended ED, **2** died in the ED.

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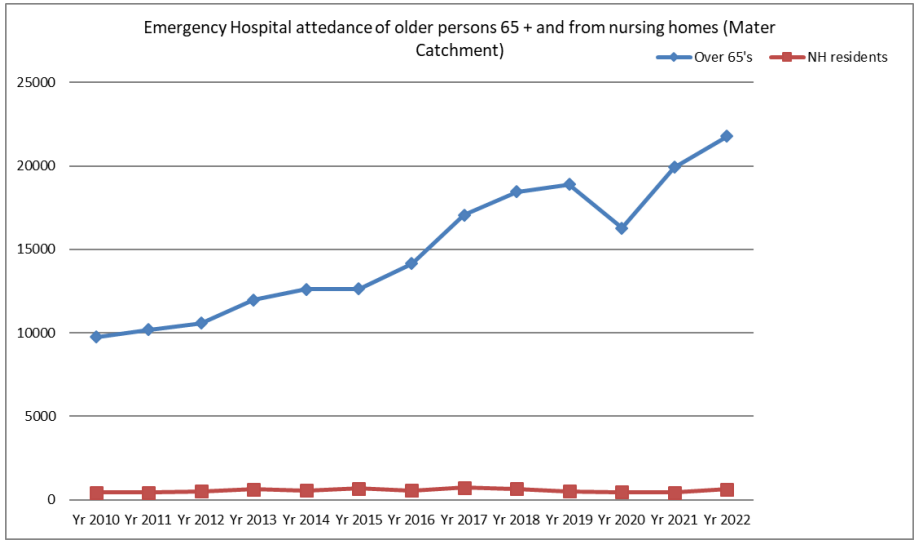
COMMUNITY MEDICINE OLDER PERSONS

MMUH NURSING HOME CATCHMENT AREA

The impact of presentations to ED

ED Attendance	Over 65's	NH residents	Percent
Yr 2010	9744	422	4.33
Yr 2011	10196	428	4.20
Yr 2012	10584	516	4.88
Yr 2013	11969	618	5.16
Yr 2014	12602	544	4.32
Yr 2015	12640	670	5.30
Yr 2016	14157	560	3.96
Yr 2017	17045	730	4.28
Yr 2018	18451	646	3.50
Yr 2019	18901	517	2.74
Yr 2020	16273	452	2.78
Yr 2021	19922	428	2.15
Yr 2022	21771	625	2.87



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CMOP Workload 2022

249 GP Referrals

185 post ED attendance

44 post discharge from acute hospital follow-up

275 returns

Total episodes of care

2022: 753
2023: 499 [as of 31/07/2023]

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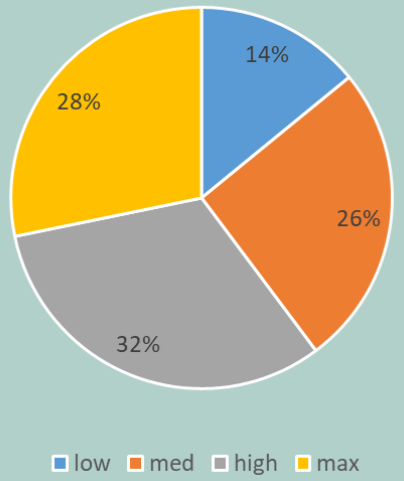
CMOP in numbers

Nursing Home residents
(n=3076)

- Median age **84.2 years**
- **66%** women
- Median **6 diagnoses**
- Median **10** regular **meds**
- 70% **dementia** diagnosed
- 60% **high** or **maximum** dependency

3215
NH Residents in database

Dependency levels



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THANK YOU FOR YOUR ATTENTION

“We couldn’t have done it without you”, A Service-User’s Perspective

Laura Maguire

Integrated Care: Empowering People, Improving Experiences

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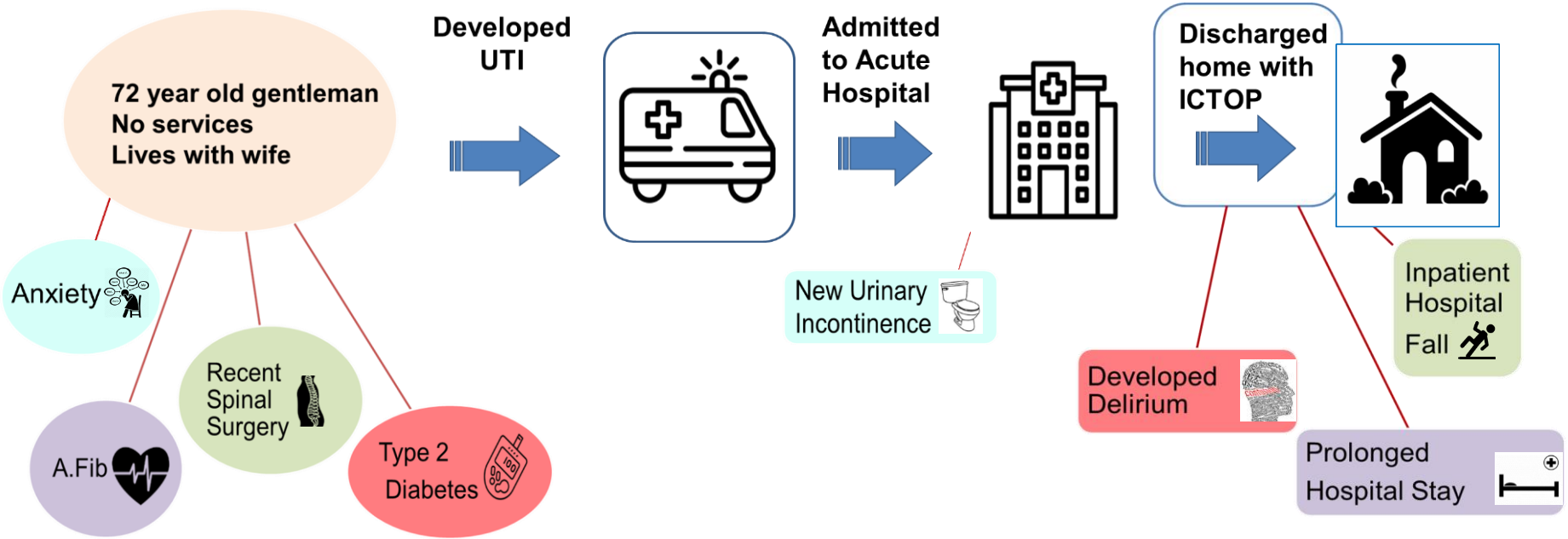
Service-User's Journey

Background history and hospital journey



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Comprehensive Geriatric Assessment

Education	Avoided another admission thanks to early UTI treatment with geriatrician
Signposting	Integration of care with enhanced healthcare navigation
ADL Rehab	Increased patient's independence, leading to reduced carer burn-out
Cognition	Increased independence by using cognitive compensatory strategies and routine
Falls Prevention	Reducing risk of adverse outcomes from future falls
Mobility	Improved Timed up and Go (TUG). Significant reduction in Fear of Falling

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

"We felt really supported, it's an amazing service"

"We'll miss ye when your finished"

"I don't know what we would have done without ye"

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Integrated Care: Empowering People, Improving Experiences

Team Members

- Dara Dardis, Senior OT
- Laura Maguire, CNS Gerontology
- Maria Armstrong, Senior PT
- Rosario Johnson, Therapy Assistant

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Enhanced Community Care Conference

07 September 2023

ECC in Action: Integrated Care Programme for Chronic Disease

Integrated Care: Empowering People, Improving Experiences

The Integrated Model of Care for the Prevention & Management of Chronic Disease: enhancing care for individuals living with chronic disease & multimorbidity

Dr. Sarah O'Brien

Integrated Care: Empowering People, Improving Experiences

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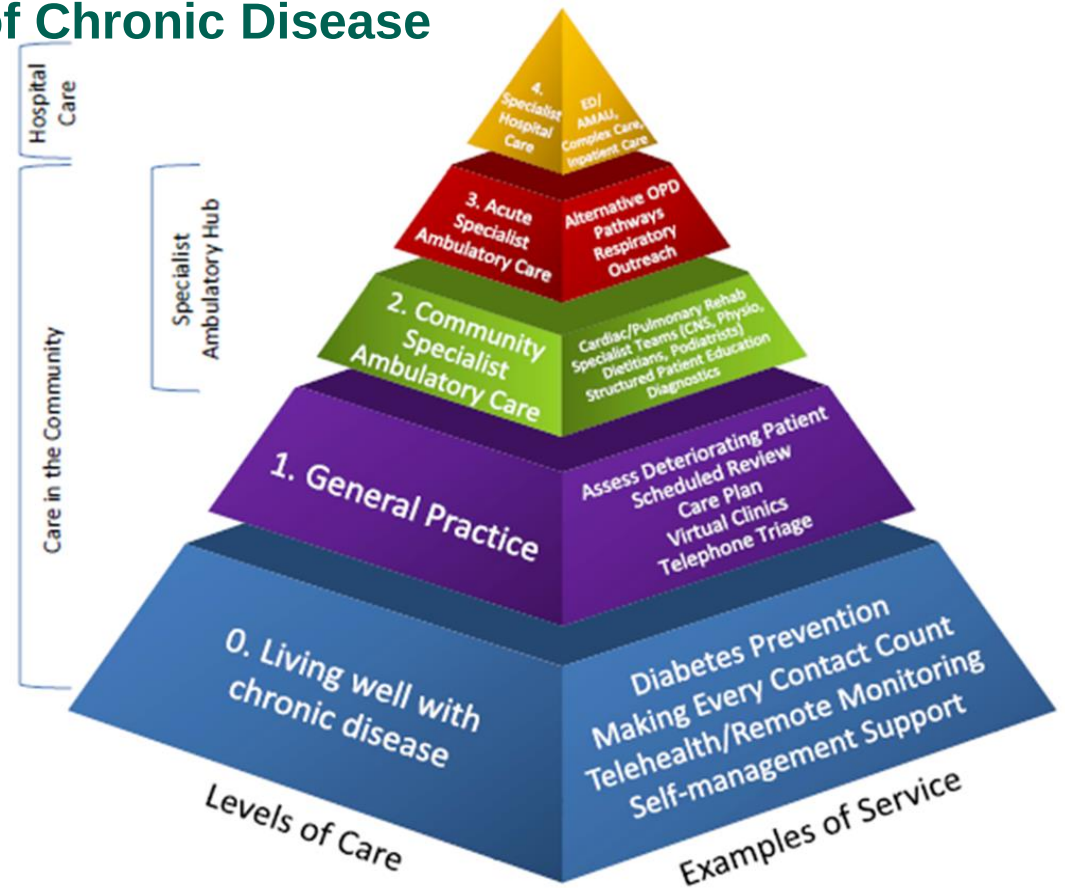
Integrated Model of Care for the Prevention & Management of Chronic Disease

- Five levels of care across community and hospital
- Bulk of care provided in the community (Levels 0-3)
- Aim is to provide “end-to-end” care for individuals living with chronic disease and multimorbidity in the community
- Focus on prevention, early detection & proactive management of chronic disease



Source: HSE National framework for the integrated prevention and management of chronic disease in Ireland 2020-2025, 2020. Available from: https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/documents/

The Chronic Disease and Prevention Programmes in General Practice

Dr. Joe Gallagher

Integrated Care: Empowering People, Improving Experiences

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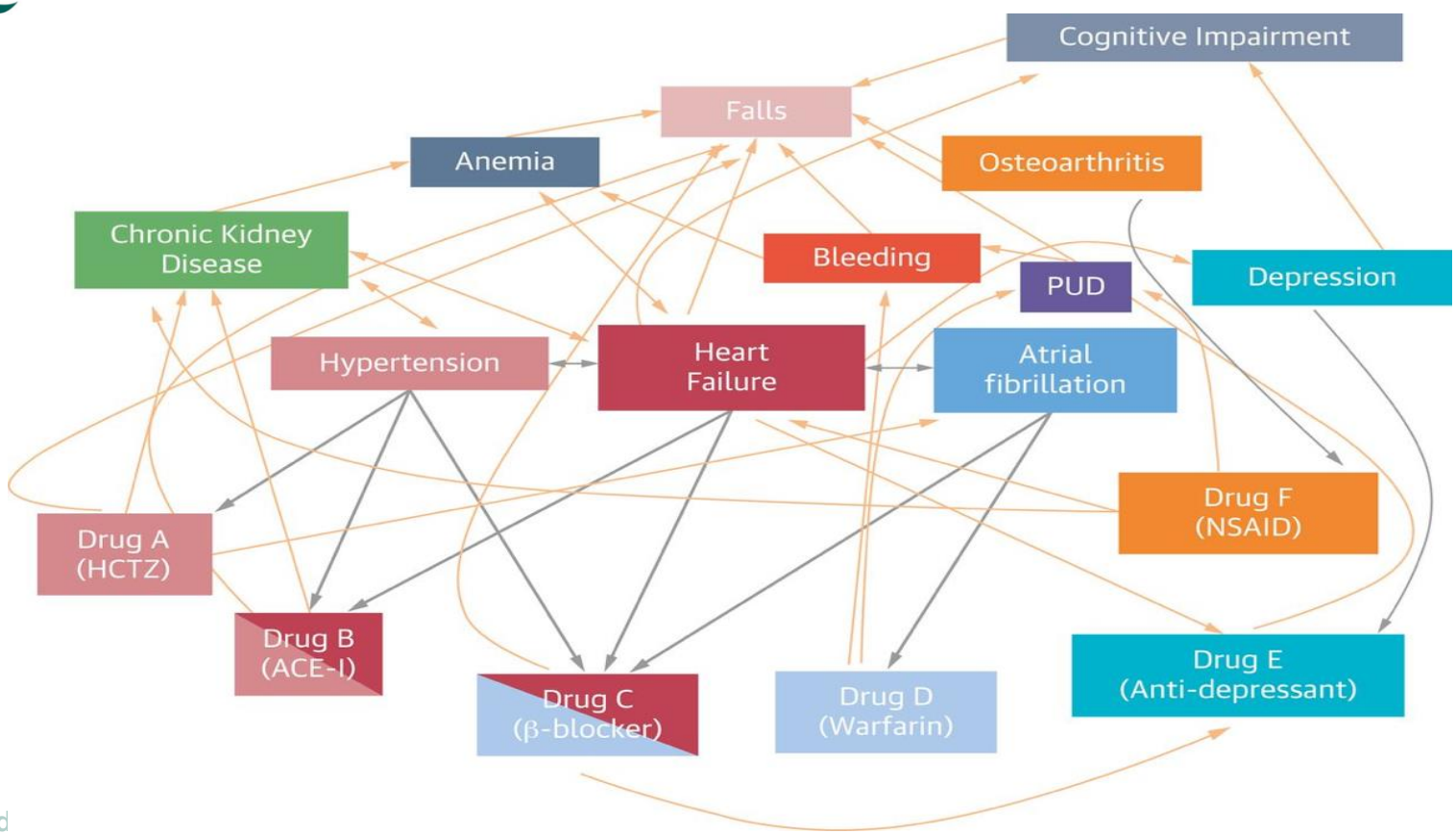
World Health Organization
#buildbackbetter



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Forman, D.E. et al. J Am Coll Cardiol. 2018;71(19):2149-61.

The Chronic Disease and Prevention Programmes in General Practice

Conditions covered

- Type 2 Diabetes
- Asthma
- COPD
- Coronary artery disease
- Heart Failure
- Atrial fibrillation
- Stroke TIA

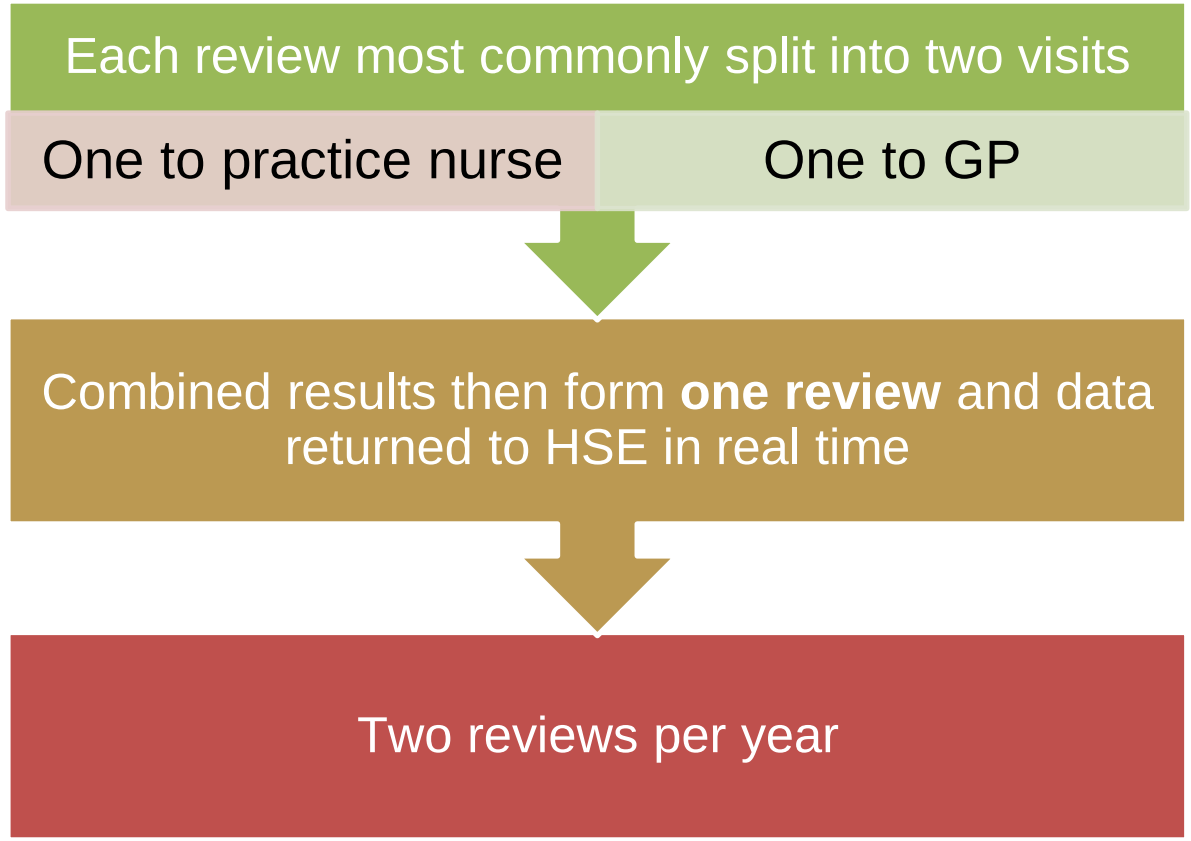
Age:

- Over 18 years

Eligibility:

- GMS or DVC card only

The Chronic Disease and Prevention Programmes in General Practice



Chronic Disease Programme

Opportunistic case finding

Risk assess those at higher risk e.g.

- Hypertension
- Dyslipidaemia
- CKD
- Obesity
- Severe mental illness
- Minority ethnic groups

If meets high risk criteria

Prevention Programme

- All with hypertension from late 2023
- Pre-diabetes
- Qrisk3 >20%
- Gestational diabetes or pre-eclampsia

Annual review

Age over 45 years with GMS or DVC card

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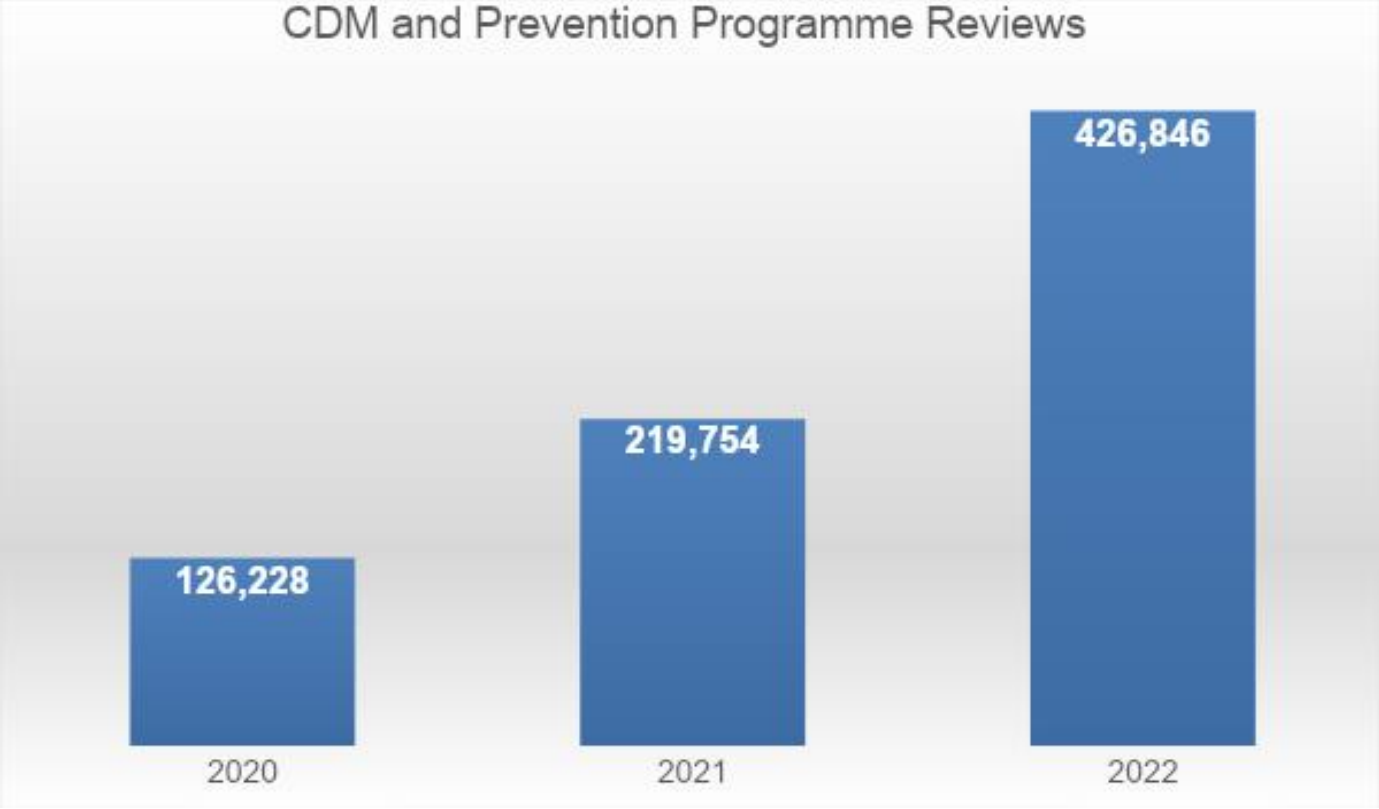
CDM and Prevention Programme Reviews



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GP Chronic Disease Programme Results

January to July 2023

412,275 reviews undertaken:

- Opportunistic case finding 71,427
- Prevention programme 31,474
- Chronic disease programme 309,824

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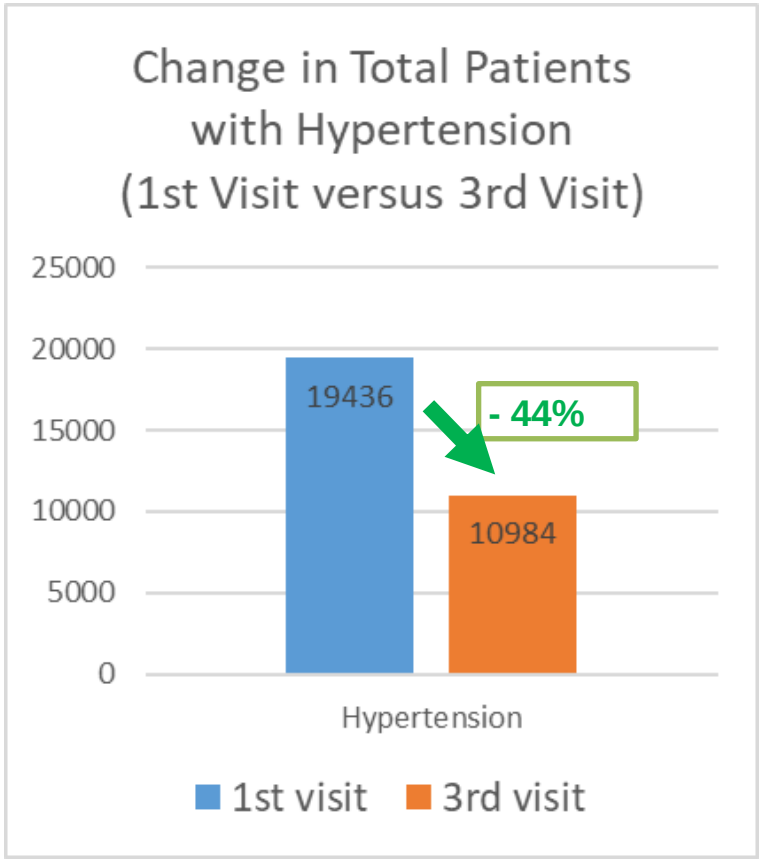
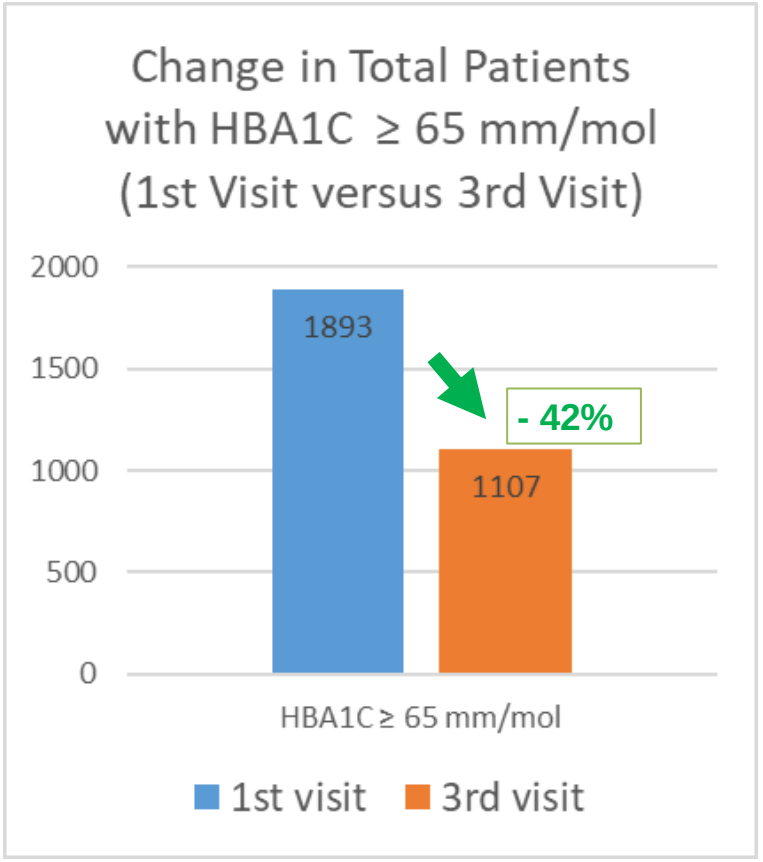
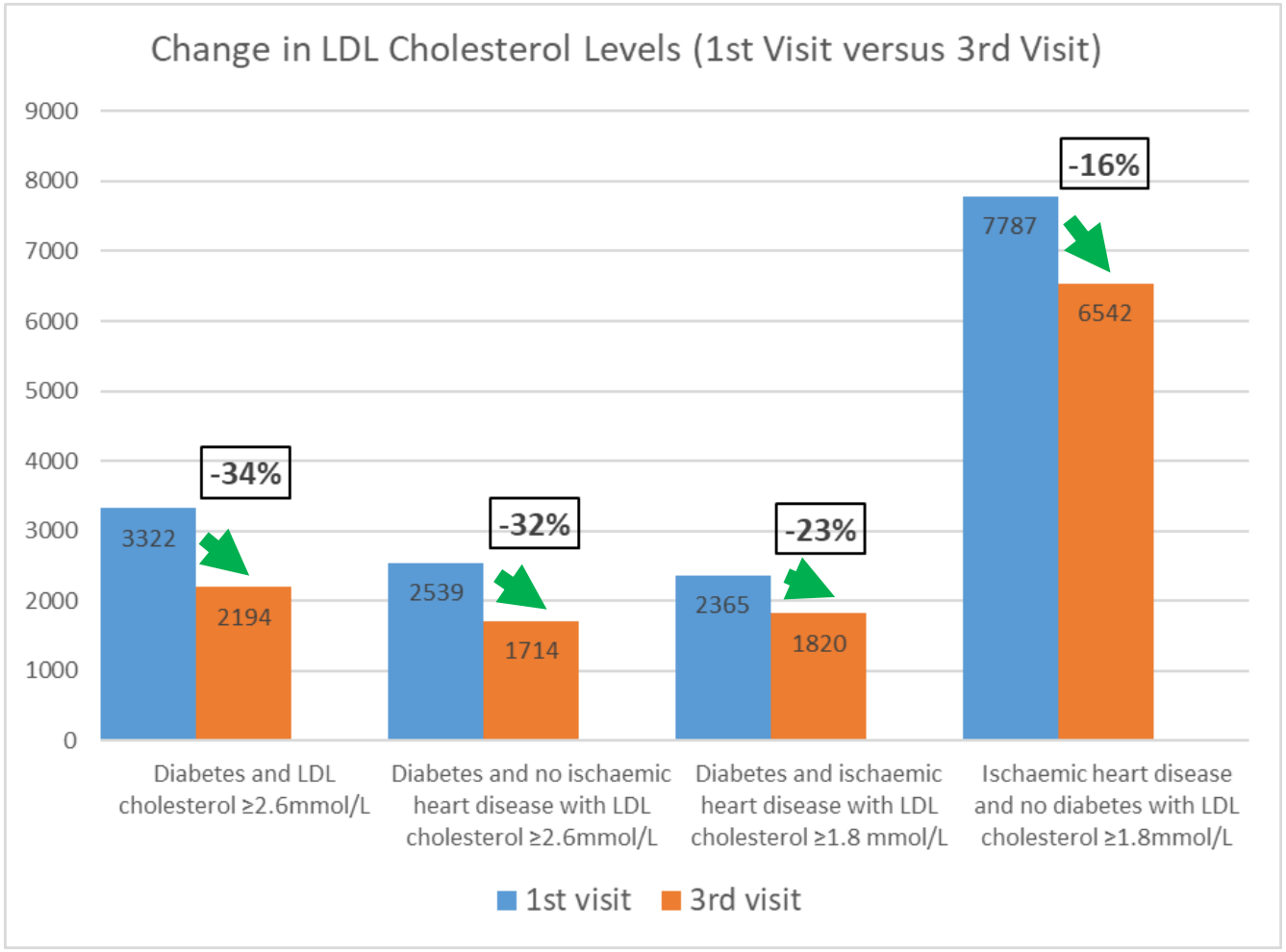




Enhanced Community Care

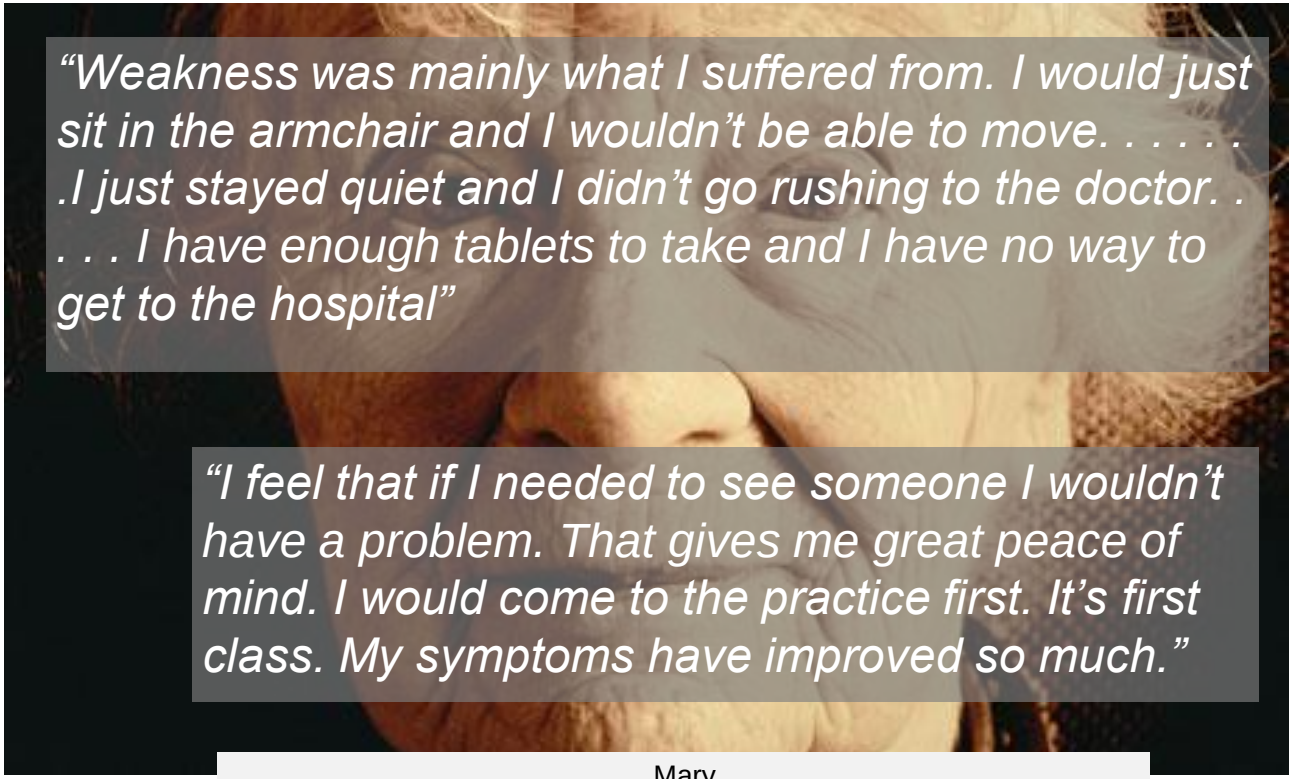

Change in LDL Cholesterol Levels (1st Visit versus 3rd Visit)
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
3322
2194
2539
1714
2365
1820
7787
6542
-34%
-32%
-23%
-16%
Diabetes and LDL cholesterol ≥2.6mmol/L
Diabetes and no ischaemic heart disease with LDL cholesterol ≥2.6mmol/L
Diabetes and ischaemic heart disease with LDL cholesterol ≥1.8 mmol/L
Ischaemic heart disease and no diabetes with LDL cholesterol ≥1.8mmol/L
1st visit
3rd visit

Some challenges . . . .

Does not cover all conditions e.g. CKD, valve disease

Resource provided for two reviews for CDM annually and one review for prevention programme

Only covers people with GMS or DVC cards



Mary

Enhanced Community Care

Implementing Cardiovascular Integrated Care and Addressing Multimorbidity

Dr. Susan Connolly and Niamh Elwood

Integrated Care: Empowering People, Improving Experiences

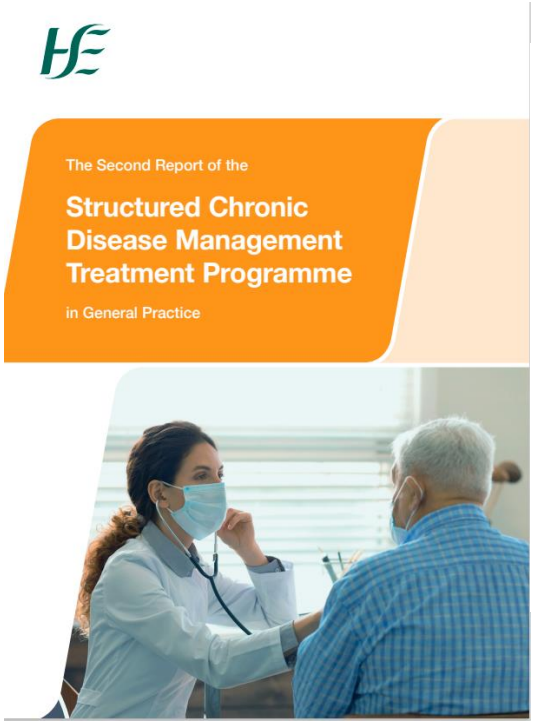
Enhanced Community Care

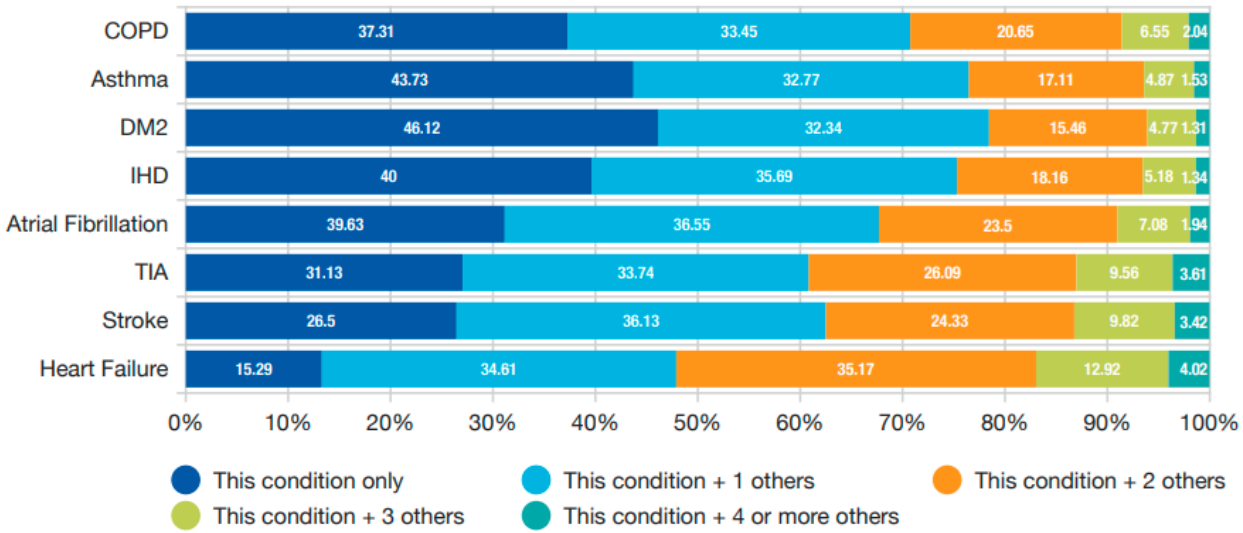
Implementing Cardiovascular Integrated Care and Addressing Multimorbidity

Dr. Susan Connolly, Consultant Cardiologist, Galway University Hospital and CHO2 West
Ms. Niamh Elwood, Cardiovascular Nurse Specialist, Galway City Hub

Enhanced
Community
Care

Prevalence of Multimorbidity in Patients Attending the CDM Programme in Primary Care



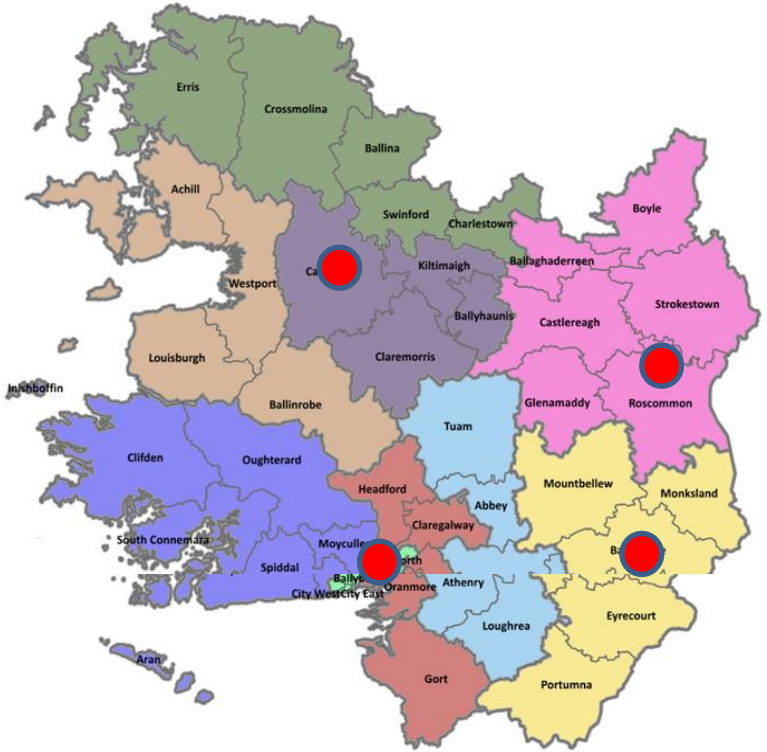


Enhanced Community Care

Deep Dive Existing Cardiovascular Services

Saolta/CHO2 West

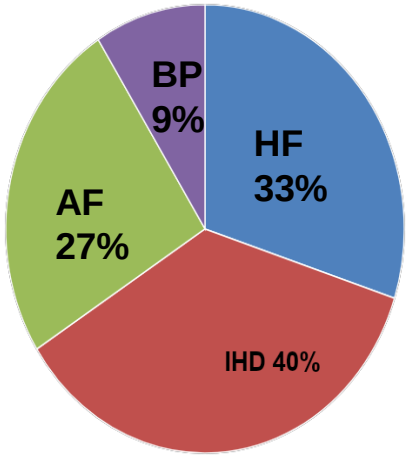
- Regional HIPE data to define emergency CV episodes
- Analysis of existing heart failure (HF) and cardiac rehabilitation (CR) services – staffing/structure/programme of care
- Regional heat mapping of referral data to these services



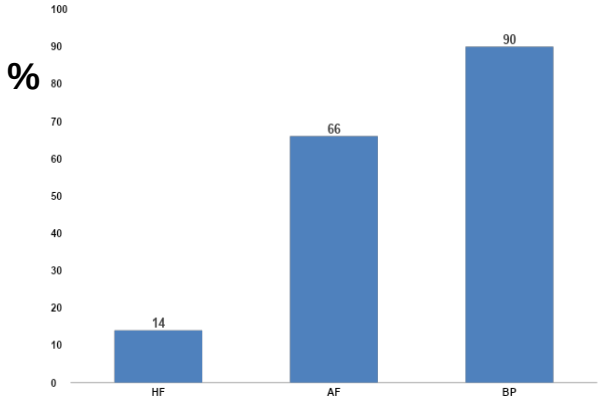
2021 Emergency Cardiovascular Admissions Galway University Hospital

Galway City Hub Area

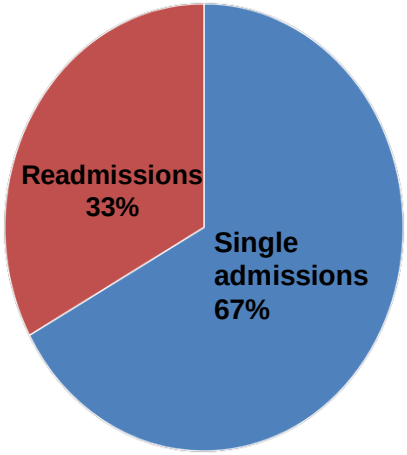
Emergency CV Episodes



Length of Stay <48 Hours



Admissions v Readmissions



N=885

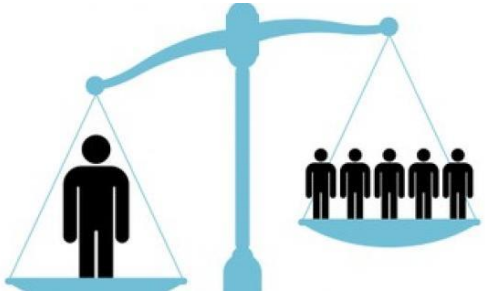
Potentially Avoidable Admissions Overall ~20-40%

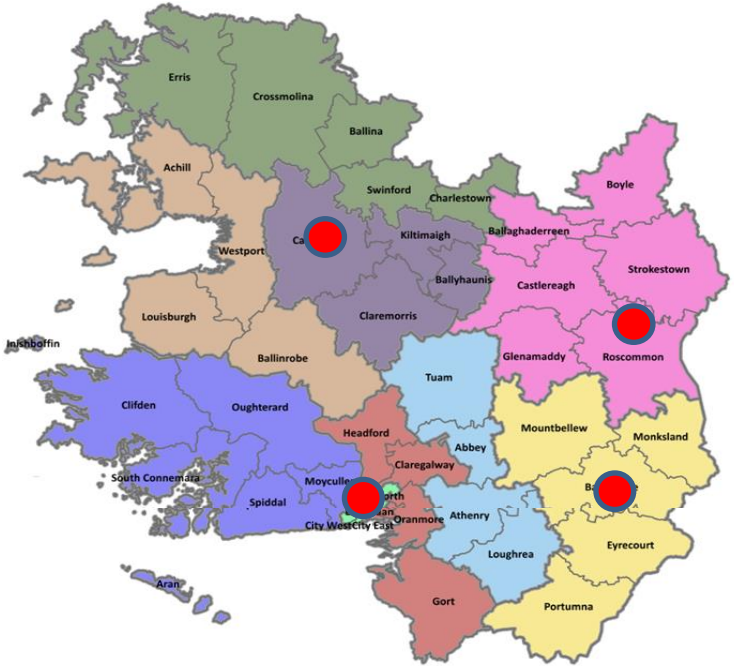
Enhanced Community Care

Analysis of Existing Heart Failure and Cardiac Rehabilitation Services

Significant Variation

- Nurse staffing levels/grades
- MDT Representation
- Assessment/Programme structure
- Proportion Eligible Patients Receiving CR
- Wait Times
- Consultant support

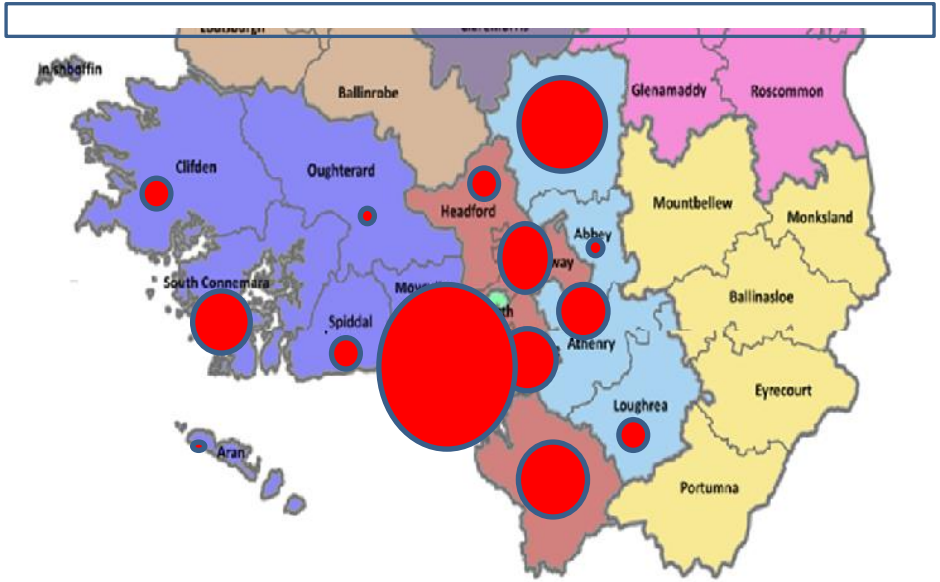




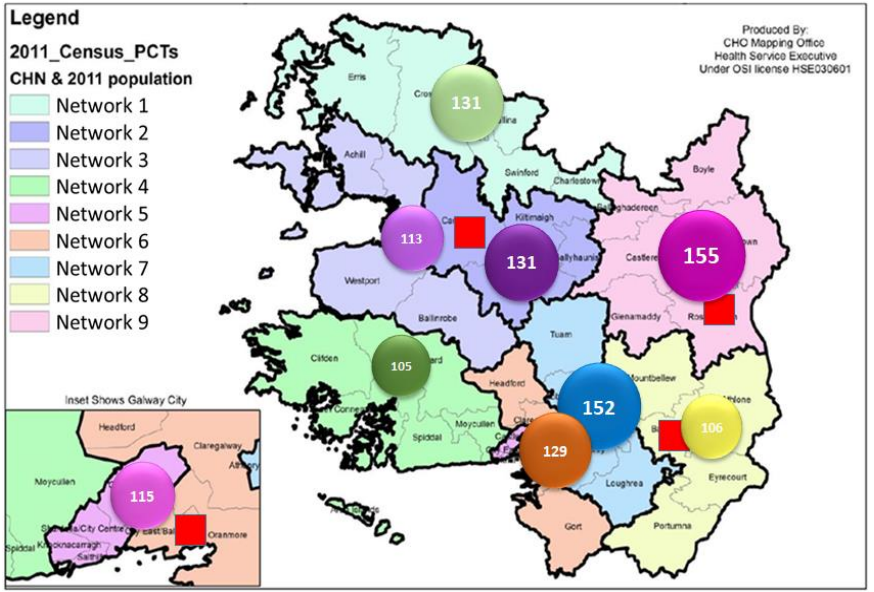
Enhanced Community Care

Mapping Of Referral Data to Identify Population Need

Residential Area Patients Attending GUH HF Clinic



Network Area Patients Referred Hospital CR

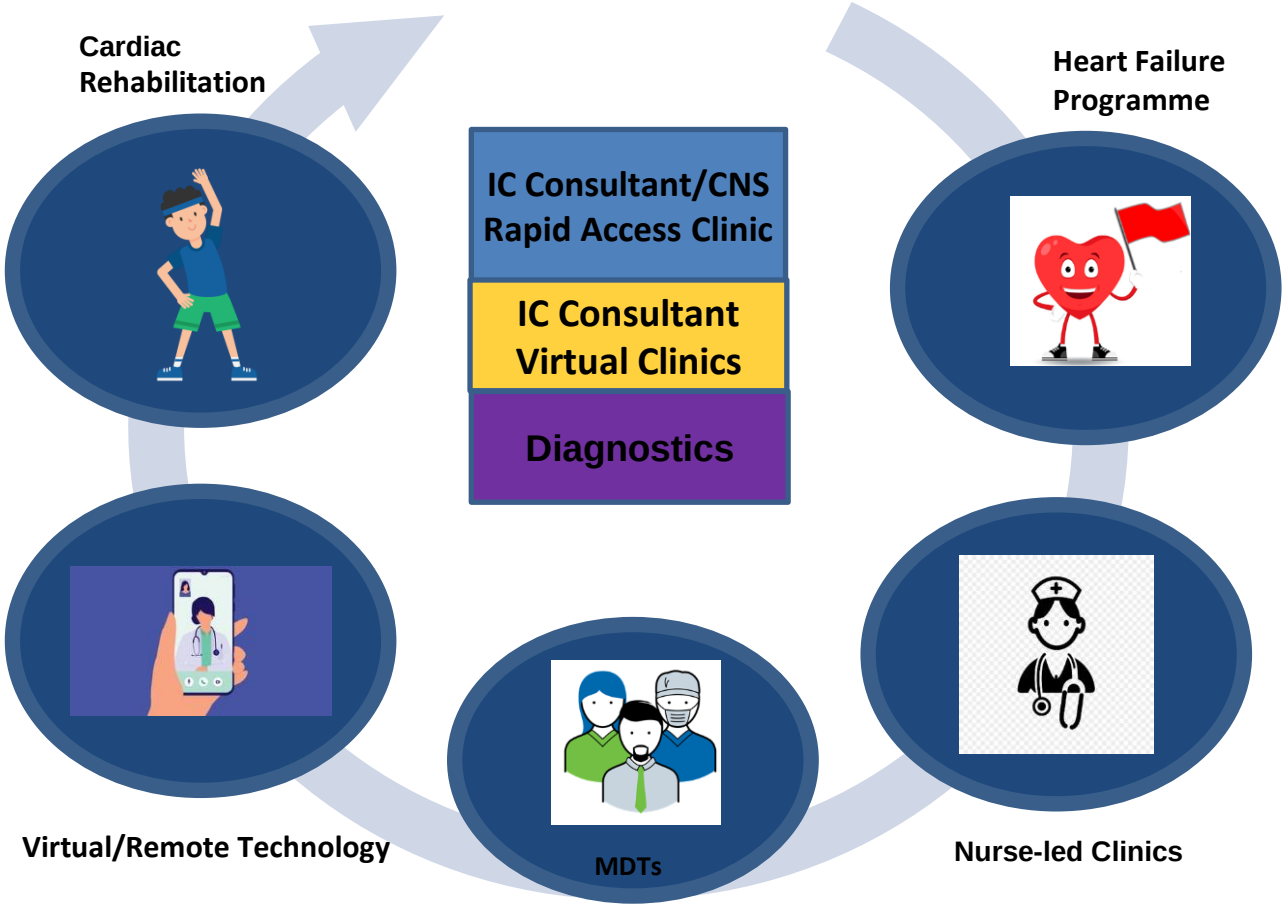


Enhanced Community Care

Integration of GUH Acute Cardiology, Hospital-based HF/CR and Hub

- Acute CVD Nurse as Coordinator
- Inpatient Rota GUH (Hub CVD Nurses/Hospital-based HF/CR Nurses)
- Choice of venue for follow up given to patient
- Central referral Log
- Hospital and Hub HF/CR Nurses Joint MDTs

Integrated CV Hub Service



Enhanced Community Care

Not “Just” CR
Panvascular CVD Prevention Programme

EuroAction for our hearts

Nurse-coordinated multidisciplinary, family-based cardiovascular disease prevention programme (EUROA(asympto disease:

D A Wood, K Kotseva, EUROACTION Study

Summary
Background Ou cardiology progr

Methods In a ma pairs of general coronary heart d at 1 year—were concentrations: ISRCTN 71715

Cardiac risk factors and prevention

OPEN ACCESS

ORIGINAL RESEARCH ARTICLE

Outcomes of an integrated community-based nurse-led cardiovascular disease prevention

► Additional material is published online only. To please visit the journal or (http://dx.doi.org/10.113 heartjnl-2016-310477).

European Journal of Preventive Cardiology

Original scientific paper

Translating guidelines to practice: findings from a multidisciplinary preventive cardiology programme in the west of Ireland

European Journal of Preventive Cardiology
2014, Vol. 21(3) 366–376
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DOI: 10.1177/2047487313498831
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SAGE

Irene
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and Ja

Quantitative Research

Evaluation of a Community-Based Cardiovascular Prevention Program in Patients With Type 2 Diabetes

American Journal of Health Promotion
2021, Vol. 35(1) 68-76
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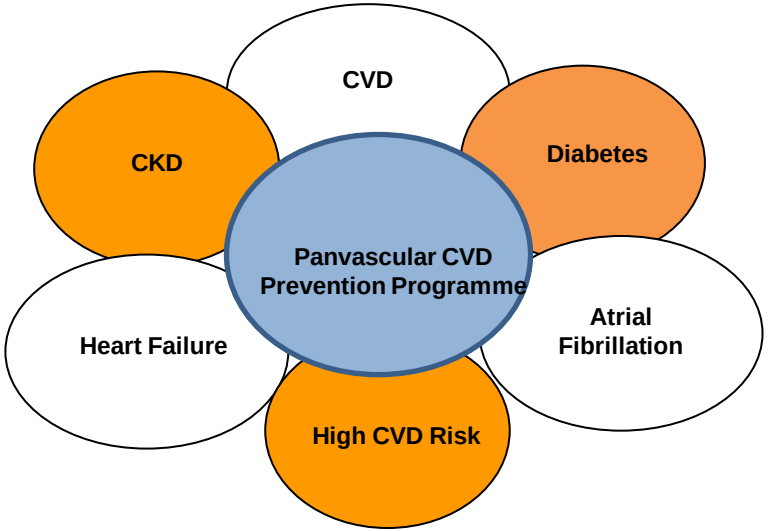
Yvonne Finn, MD[1,2,3], Miroslawa Gorecka, MB[4], Gerard Flaherty, MD[1,3], Fidelma Dunne, PhD[1,2,3], Timothy O’Brien, PhD[1,2,3], James Crowley, MD[1,3,4], David Wood, MD[1,3], Susan Connolly, PhD[3], Jennifer Jones, PhD[3,5], and Irene Gibson, MA[1,3]



Enhanced Community Care

Panvascular CVD Prevention Programme Structure

Multidisciplinary Initial Assessment		
Dietitian	Nurse	Physio

Individual goal setting and plan

Behaviour change strategies

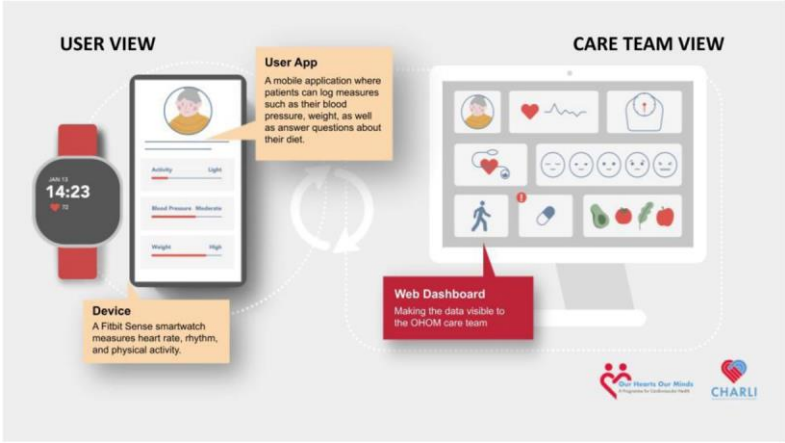
12 week programme

- Supervised exercise and education group sessions
- Healthy lifestyle change
- Risk factor management
- Appropriate cardioprotective medication
- Psychosocial Health

Multidisciplinary Initial Assessment		
Dietitian	Nurse	Physio

Menu Based
Flexible
Virtual option
using
Digital/Wearables

CHARLI (Cardiovascular Health Application and Real Life Integration)



Moving Towards a Regional Service

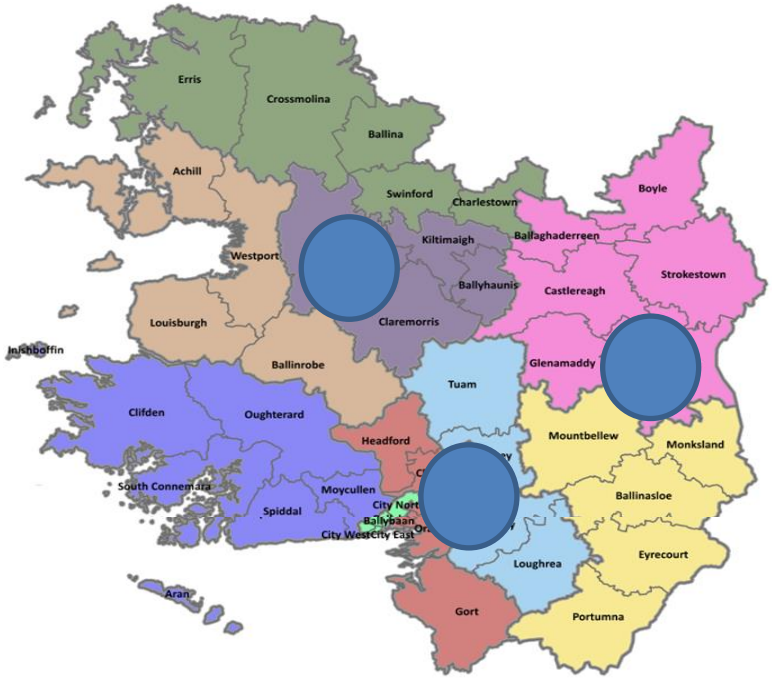
Hub in East Galway/Roscommon and Mayo now operational

Cardiology IC Implementation Group

Regional CR service

CNM3 Nurse Lead

Consultant Strategic CR Lead



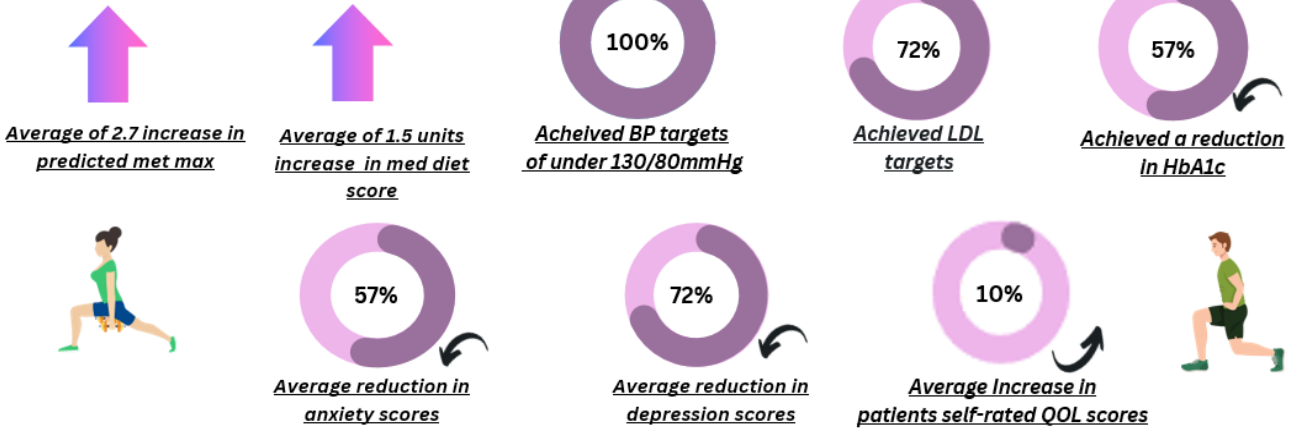
Cardiovascular Integrated Care:
Measuring Effectiveness

Potential Reduction:

- ✓ Short stay Admissions (HF, AF) through provision of Rapid Access Clinic
- ✓ Emergency CV Readmissions
- ✓ Cardiology OPD Wait List

Improvements in:

- ✓ Clinical *and* Patient-Reported Outcomes
- ✓ Service User Experience



Delivering Patient-Centred Care

Integrated Acute Cardiovascular CNS

Heart Failure ANP Integrated Care

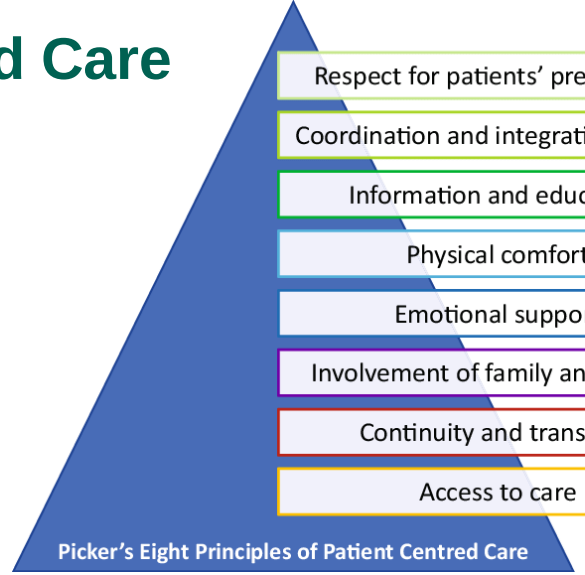
Integrated Hub Cardiovascular CNS

Cardiac Rehabilitation Nurses

Senior Cardiac Physiotherapist

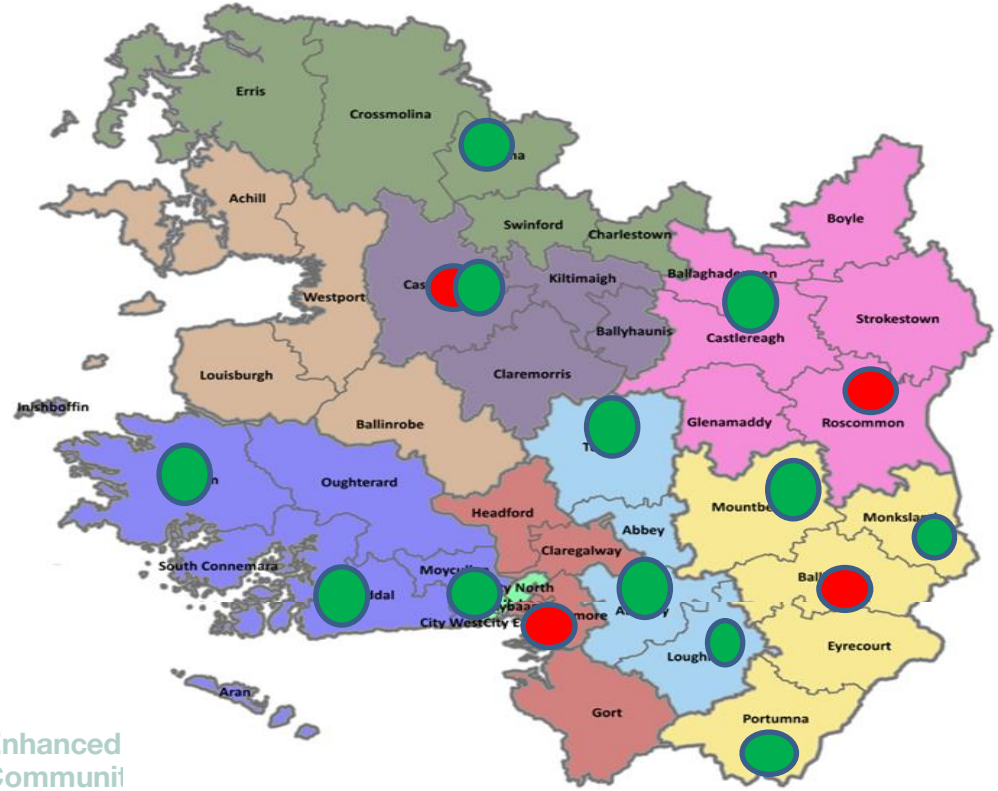
Cardiac Psychologist

Integrated Consultant Cardiologist



Enhanced Community Care

Delivering Care Closer to the Patient



Nicola Fahy Hub ANP HF starts Heart Failure Community Clinic in Clifden

East Galway/Roscommon Hub Team start Cardiac Rehabilitation in Athenry

Donough McBrearty, Senior Physio, Louise Gardiner, Hub CVD Nurse, Danielle Derivan, Staff Nurse

Galway City Hub Cardiac Rehabilitation Programme

Ashling Clancy Hub CVD Nurse, Ailis Loughnane, Senior Physiotherapist

Enhanced
Communit
Care

Empowering Patient Self-Management

Self Monitoring

Patient Education

Working Collaboratively to Address Multimorbidity

Consultant-led
Cardiometabolic & Renal MDM

CV Team Acute
- Structural
- Cardiothoracic
- Chest Pain
- Cardioversion

ANP/CNS
- Diabetes
- Respiratory
- Renal
- ICPOP

Pathway Development
- MAU
- IV Iron
- Community Intervention Team
- Palliative Care

Enhanced Community Care

Patient Experience

‘You have gone above and beyond to give me courage after life changing diagnosis.’

‘Everything I can say about it is all positive. I look forward to coming back each week. It’s a great focus point. It drives us to do more’

‘Considerably better than any previous experience’

‘Could not praise it highly enough’

‘Feel more confident about my health’