Development of the National Integrated Care Pathway for Older Persons

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Cork University Hospital
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Context :Integrated Care Programme for Older Persons (ICPOP)

- Collaboration between Clinical Care Programmes Division and Social Care Division
  - Emergency Medicine Programme
  - Acute Medicine Programme
  - Older Persons Programme

- Overall aim: to ensure a 'joined up' approach to service delivery and in doing so improve the quality and continuity of care for older persons.

High level objectives:

- Supporting Older Persons to live well
- Enabling Older Persons to live in their place of residence by providing secondary community care in the community
- Provide integrated Intermediate care(Hospital/Community care)
- Supporting Older Persons in Residential Care
- Supporting an integrated approach to end of life care

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Introduction and Context

- Successful model of Integrated care team for Falls
  - Community screening in FRAC clinic
  - Therapy and Nursing led services
  - High level Medical review
  - 200 assessments to 1200 assessments in 18 months
  - 2015 commenced

- Why not frailty?
  - September 2015 EM and PB wrote up proposal and submitted to Social Care Division – pioneer site for ICT
  - Unlocking existing potential from services and workstreams involved in CHO4, Cork University Hospital and Mercy University Hospital
  - Letter of understanding signed in 3/2016

10-Step Integrated Care Framework for Older Persons

National Clinical & Integrated Care Programmes
Person-centred co-ordinated care

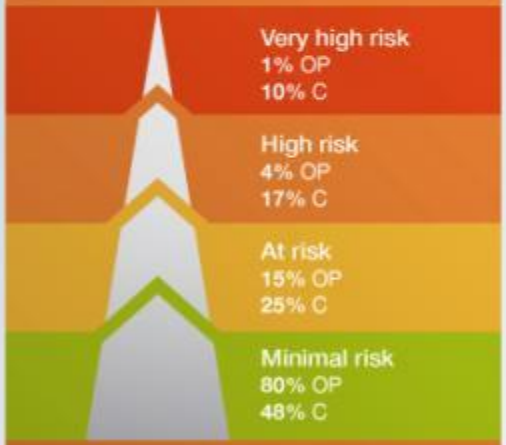
Seirbhís na Sláinte
Health Service Executive

1 Establish Governance Structures

2 Undertake Population Planning for Older Persons

Risk Stratification

% Older Persons / % Cost



3 Map Local Care Resources

4 Develop Services & Care Pathways

- Rehabilitation
- Ambulatory Day Care
- Acute Care
- Nursing Homes
- Dementia
- Falls etc..

5 Develop New Ways of Working

New roles including case management approach for long term complex needs
In-reach and outreach

6 Develop Multidisciplinary Teamwork & Create Clinical Network Hub

Co-ordination between care providers

7 Person-centred Care Planning & Service Delivery

8 Supports to Live Well

Enable older persons to live well in the community

- Community Transport
- Social Activities
- Home modifications & handy person
- Medication Management
- Shopping
- Harness Technology
- Support carers
- Information & Advice

9 Enablers

- Develop workforce
- Align finance
- Information systems

10 Monitor & Evaluate

- Track service developments
- Measure outcomes
- Staff and service user experience

National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

ICPOP Pioneer Areas

Current Programme

Engage with CHO and Hospital Group Leadership to prepare pioneer areas

1. CHO 3 + UHL — Limerick
2. CHO 4 + CUH & MUH — Cork
3. CHO 7 + AMNCH — Tallaght
4. CHO 8 + OLOL — Drogheda

Develop new clinical roles and care pathways to support ICP OP (community paramedic, case managers)

1. CHO 1 + SGH — Sligo
2. CHO 9 + Beaumont — North Dublin
3. CHO 6 + SVUH — South Dublin

Aims of the Cork Pilot

The overall aim is to develop, support , test and embed a model of integrated working

The new Community based integrated care team to work jointly with CUH & MUH

- To improve the **ACCESS** of frail older people to acute care, by providing alternatives to attending the Emergency Dept, where appropriate
- To improve the **PROCESS** of acute care when frail older people do attend the Emergency Dept, by, where appropriate, expediting their early assessment.
- To improve the **EGRESS** of frail older people from hospital to the community with appropriate identified community supports.

Governance structure

Joint Project Sponsors

Ger Reaney,

Chief Officer Cork & Kerry CHO,

Tony McNamara,

CEO CUH,

Sandra Daly ,

CEO MUH

Project Implementation Group

Gabrielle O'Keeffe & Dr Mike O'Connor (joint chairs),

Dr. Pat Barry, Dr Liam Healy, Dr Paul Gallagher, Dr Kieran O'Connor, Catherine O'Mahony, Eileen Moriarty, Valerie Walshe (Economist), Judith Purkiss ADPHN, Deirdre Cullen (AHP rep), Natasha Lewis (ATC rep), Mike O'Regan (IT), Dr Dan Crowley (ICGP rep), Betty Hickey (SSWHG rep), Dr Patricia Kearney (UCC), Carmel Walsh (MUH)

Models of care work-stream

(Care pathways , Care Processes and Clinical roles)

Lead: Catherine O'Mahony, Liam Healy, Pat Barry, Kieran O'Connor , Paul Gallagher, Judith Purkiss, Natasha Lewis, Dr Dan Crowley, Mary J. Foley, Deirdre Cullen, Eileen Moriarty

Technology/ Information Sharing Work-stream

Lead: Mike O'Regan

Evaluation Work-stream

(Population planning , Value, Quality and Outcomes.

Lead: Valerie Walshe

Inclusion Criteria.

- Age > 75 years
- Frail, Medically Unwell, Scrrening
- Under clinical governance of a Geriatrician after Comprehensive Geriatric Assessment
- Those who can be managed without an acute admission or with an abbreviated admission and early supported discharge
- Within a Geographic area

Screening - why

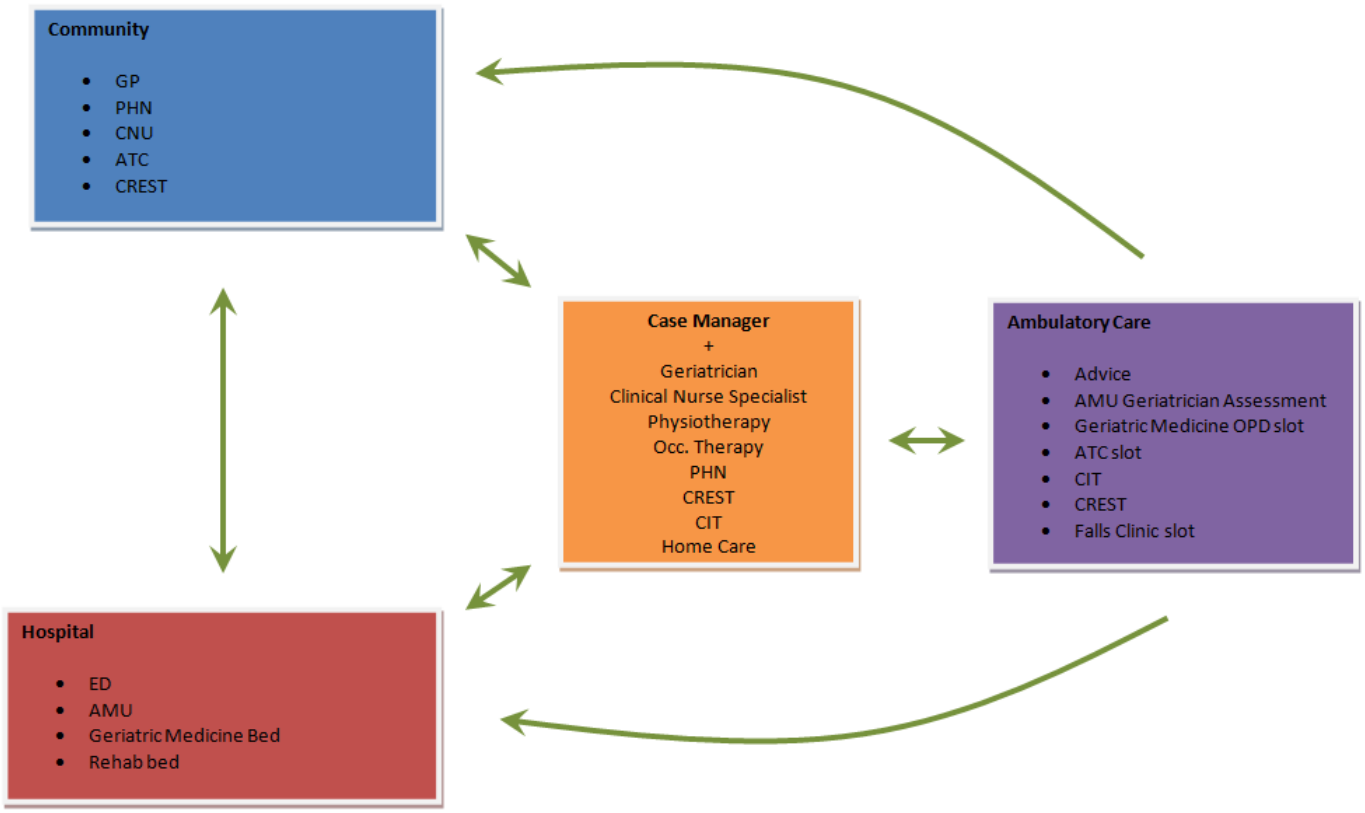
- 20% increase in over 75 year olds attending CUH in 1 year
- Admission/Conversion rate at least twice those of < 65 years old

- Universal frailty screen
  - If positive (40%)
    - CGA – delivered by FITT team and Geriatrician
  - If negative
    - Usual care
- Early streaming to
  - Home with ICT, CIT, Falls team
  - Admission to Acute Frailty Unit and service
  - Acute Medicine Unit
    - Both above to lead to early supported discharge
  - Specialist Geriatric Medicine Unit
  - Rehabilitation

Integrated Care Team

- **SHORT-TERM** (up to 12 days)
- Implement Geriatricians agreed Care Plan.
  - Domiciliary Nursing & Rehabilitation.
  - Additional Home Care Support if required.
  - Arrange urgent Geriatrician assessment *in AMU.*
  - *Timely communication of care plan, progress and discharge to GP and PHN.*
  - Arrange access to Voluntary Group support where acceptable.
  - Adjust Care plan as agreed and required.

Draft Schematic of New Integrated Care Model for Acutely Ill Older Persons



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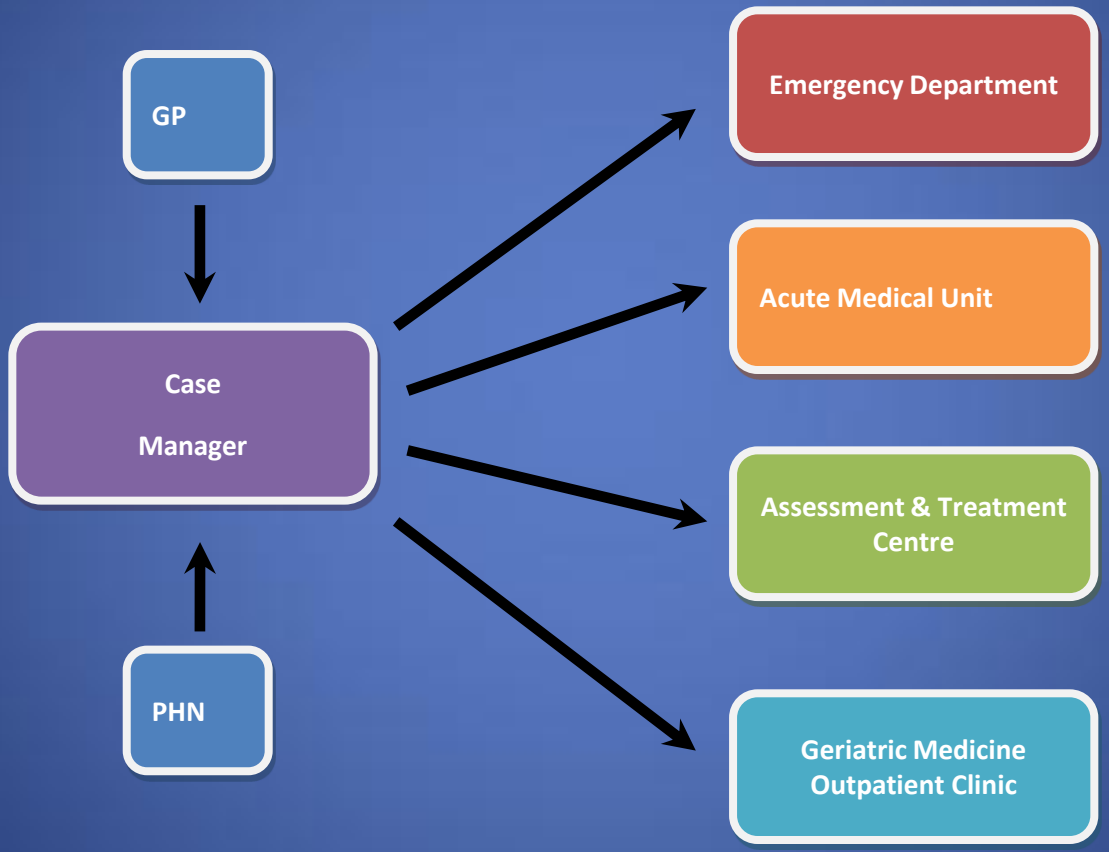
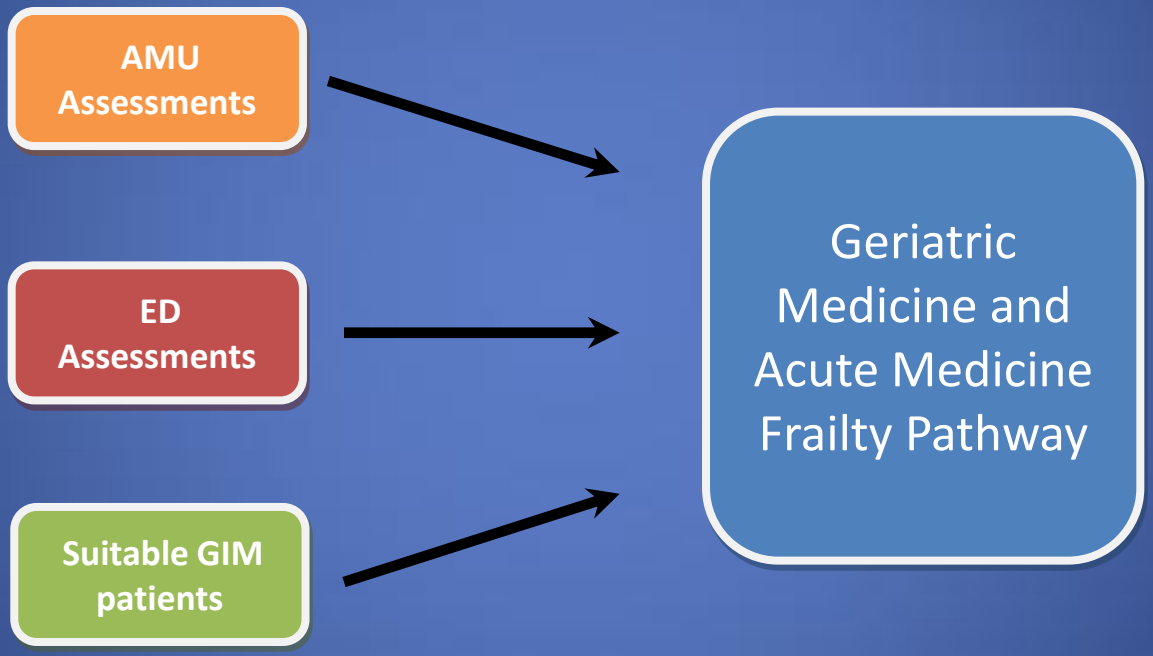
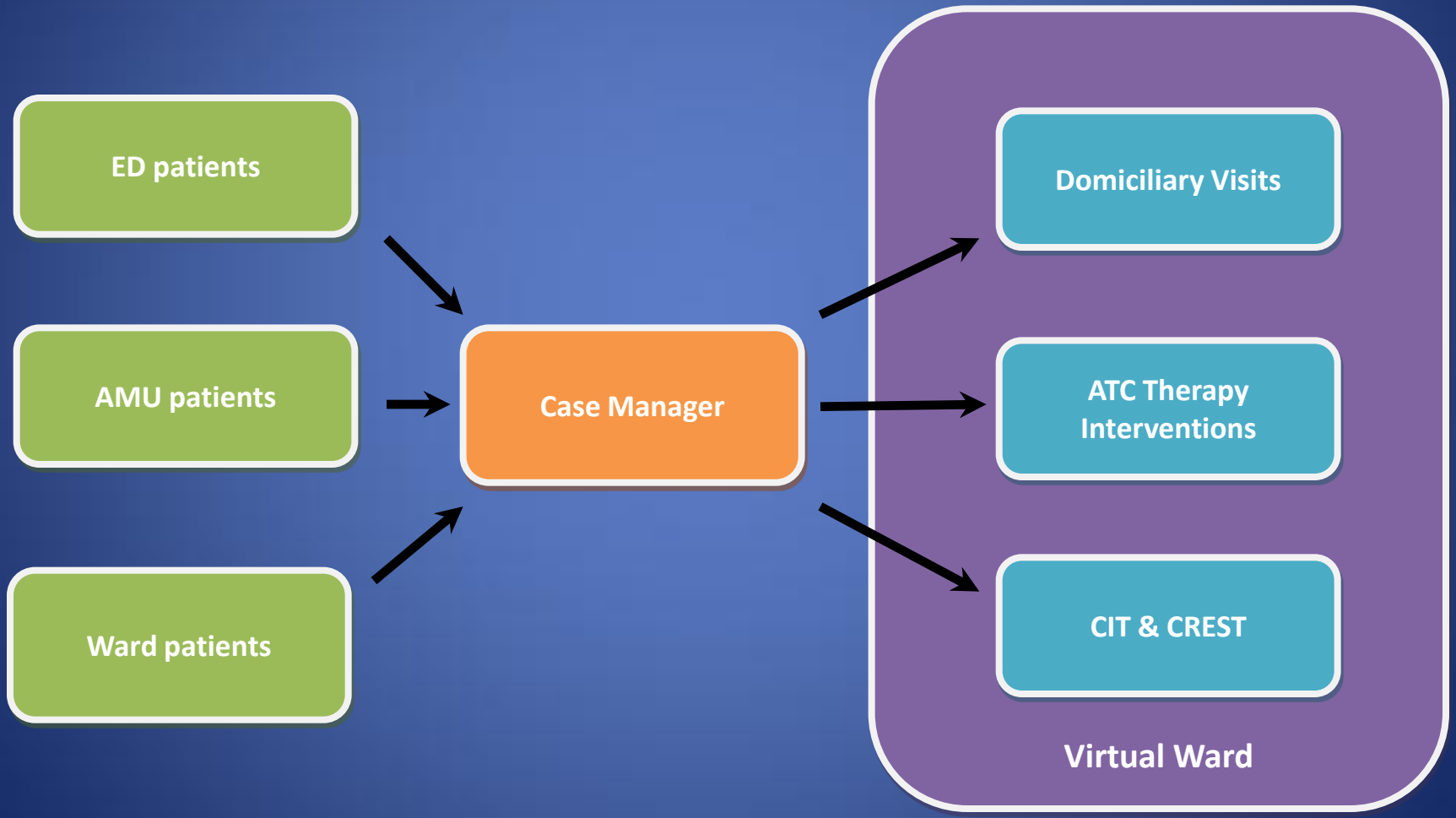

GP
Case Manager
PHN
Emergency Department
Acute Medical Unit
Assessment & Treatment Centre
Geriatric Medicine Outpatient Clinic

Process


AMU Assessments
ED Assessments
Suitable GIM patients
Geriatric Medicine and Acute Medicine Frailty Pathway

Egress


ED patients
AMU patients
Ward patients
Case Manager
Domiciliary Visits
ATC Therapy Interventions
CIT & CREST
Virtual Ward

Development locally

- Significant internal re-organisation
- Internal resource requirements
  - CHO4
    - Capital
    - Integrated Care Team
  - Mercy Hospital
    - 0.5 WTE of Consultant Geriatrician
  - Cork University Hospital
    - 6th AMU post to support weekend opening and lead out on Frailty pathway
    - ED/AMU based therapy resource – currently 1.0 WTE Physiotherapist; need FITT team to meaningfully screen and push to community resource
    - Capital – no dedicated space - ? Unblock AMAU for ideal location
    - Acute Frailty Unit – 10 beds within existing 35 bed cohort in Specialist Geriatric Medicine Ward
- Ensuring appropriate care by appropriate people in the appropriate place