Making a start in Integrated Care for Older Persons

A practical guide to the local implementation of Integrated Care Programmes for Older Persons
10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   - Frailty Prevalence
     - 11% Severely Frail (Very High Risk)
     - 21% Moderate Frailty (High Risk)
     - 36% Mild Frailty (At risk)
     - 32% Fit (Minimal risk)

3. Map Local Care Resources

4. Develop Services & Care Pathways
   - Focus on Frailty
   - Acute Care Pathways
   - Ambulatory Care
   - Rehabilitation
   - ICPs for Falls, Dementia & Nursing Homes Outreach

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
Develop MDT Teamwork and Create Clinical Network Hub

Hub (ARCU)

- Acute Hospital Care
  - Staffing
  - Environment optimisation
  - Case Manager > FRAILTY team
  - Orthogeriatric Service
  - General Surgical Liaison
  - Emergency Department
  - Acute Medical Unit
  - Consultation service
  - Surgical Liaison

- Home Care
  - Community Intervention Team
  - Early Supported Discharge
  - Therapy at Home
  - Public Health Nurse
  - General Practitioner

- Day Care
  - General Day Hospital (Rapid access)
  - Specialty Multidisciplinary Clinics
  - Frailty
  - Memory
  - Falls
  - Movement Disorder
  - Therapy-led clinics

- Information & Communication Technology
  - Website
  - Education
  - Referral
  - Frailty Register
  - Complex case management
  - Vulnerable adults
  - Referral Pathway
  - Governance
  - Resourcing
  - Referral Pathway
  - Governance
  - Capacity planning
  - Referral Pathway
  - Future?

- Long-term Residential Care
  - Smoother access to LPF decision

- Intermediate Residential Care (Dungarvan & St. Patrick’s Community Hospitals)
Healthcare & Social Services Access to MCMOP

North Dublin Steering Group for OP

St Mary’s Hospital
- Day Hospital
- MDT
- Community Response

Frail Elderly
- At Home
- PHN
- Senior SW for OP

Clinical & Social Care
- Other CCM Community RANP

Diagnostics & Intervention
- CIT
- CRT
- Imaging

Frail elderly In NH
- CGA
- Acute, chronic illness
- End of life

Acute Hospital
- Post dc follow up
- Non-attendance
- OPD
- ED

MCMOP
- Geriatrician
- RANP
- CCM (CNS)

Management
- Respite care
- Home care
- Package
- CSAR

PCCT
- GP
- Social worker
- Safe guarding

Specialist Palliative Care

POA
Emergency Attendance of Nursing Home residents: DNC

Outcome of Nursing Home residents at ED 2008 to 2016

ED Transfer and Admission rate per bed per year 2008 to 2016

Proportion of ED attendances requiring inpatient care (monthly vs yearly)

Presenting Complaint at Triage

<table>
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<tr>
<th>Year</th>
<th>Unwell Adult</th>
<th>Fall</th>
<th>Shortness of Breath</th>
<th>Limb Problem</th>
<th>Urinary Problem</th>
<th>Collapse</th>
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<td>59</td>
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“I want to stay home, sit in my chair to watch TV, look out the window”
He lived at home for 18 months

Integration in Action

- 78 yo Man, sheltered accommodation,
- Diabetes Mellitus,
- Insulin requiring (PHN),
- heart failure,
- recurrent cellulitis
- bilateral forefoot amputee,
- recurrent falls,
- mild vascular cognitive impairment,
- dietary non-compliance,
- medication non-adherence
- NOT SAFE TO BE AT HOME

St Mary’s Hospital
Day Hospital
MDT
Community Response *

Frail Elderly
At Home
PHN *
Senior SW for OP

Clinical & Social Care
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CCM *
(CNS)

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