Integrated Care Programme, Older Persons

ICM frailty webinar
Jan 17th 2019
Overview

• ICP OP story to date (outline of ‘Lessons Learned’)

• Impact and insights

• Recommended next steps

• www.icpop.org
Figure 1.1: ICP OP Programme stages

- Initiation, design and test
- Scale up
- Embed
Challenges

• Complex concept (polymorphous)
• Working across professional and organisational boundaries
• Required new roles
• Required simultaneous implementation of multiple co-dependent strands (workforce, ICT)
• Lack of policy support
• Lots of silos (practice, strategic, budgetary, planning, data)
Opportunity

- Latent professional capacity and appetite for change
- New policy framework (Slaintecare)
- User support and opportunity to go beyond ‘medical’ model.
- Richness of community assets (citizen engagement) not fully realised
- Insights into implementation
- Test Technology
- Support and develop emerging roles (CM, HSCP, SP, cANPs)
We are (usually) talking about the same people!

Community

1 in 5 community dwelling older adults are living with frailty
(Approx. 118,000 older persons)

In a 12 month period older adults living with frailty:
- Will spend 15 days in hospital in a 12 month period.
- Are on 6 medications.
- Will visit their GP on 7 or more occasions per annum.
- 40% of people living with frailty live alone.
- 65% have two or more chronic conditions.
- Comprise 65% of PHN caseloads.

Acute Hospitals

People aged >65 and over occupy 54% of acute hospital inpatient beds.
Almost 30% of older people admitted to acute hospitals have dementia (and have longer stays in hospital).
People aged >65 account for 90% of delayed discharges from acute hospitals.
People aged >75yrs spend 3 times longer in ED than those <65.
36% of patients over 70 admitted to hospital show functional loss at time of discharge when compared to pre-hospital admission. This increases to 65% for 90 year olds.

Residential Care

Demand for Residential Care is expected to increase by 50% by 2030.
Demand for Home Support Services is expected to increase by 40% by 2030.

Falls

1 in 3 over 65’s fall annually
60,000 older adults require medical attention a year for falls
51% of patients have a ‘low fall’ of less than 2 metres resulting in a major trauma
The average age of a person who breaks their hip is 80 and over two-thirds are female

Growing Smarter Every Day!
Integrated Care Pathway Status (2011 v 2014) (Ref: NCP OP Audit 2014)

- **Specialist Geriatric Wards (9-30 beds)**
- **Rehabilitation Ward (on site)**
- **Rehabilitation Ward (off site)**
- **Day Hospital (on site)**
- **Day Hospital (off site)**
- **Community MDT**
- **Older person pathways (2011 v 2014)**
  - Day Hospital (off site)
  - Day Hospital (on site)
  - Rehabilitation Ward (off site)
  - Rehabilitation Ward (on site)
  - Specialist Geriatric Wards (9-30 beds)

**Dedicated Older Person staff (2011 v 2014)- acute in-patient**

- Consultant geriatricians
- SpRs
- Registrars
- ONS
- Physio
- OT
- Dieticians
- SW

**ICP OP**
ICP OP 10 Step Framework

10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures
2. Undertake Population Planning for Older Persons
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
Programme implementation

6 sites
Programme Manager/ Clinical Lead commenced

Initial 6 pioneer sites initiated 35 wte. clinical staff funded

ICP OP Team recruited
ICP OP networking day initiated;
• Site info exchange

6 further pioneer sites funded

Programme PID agreed

ICP OP Networking Day
• Framework lunched

ICP OP networking day
• Data collection
• User engagement

ICP OP networking day
• Dashboard
• Research results

Jan 2016
June 2016
Dec 2017
Jan 2018
Dec 2018

July 2015
Dec 2015
June 2017
Jan 2017
June 2018

6 sites
13 Sites
21 Sites
ICP OP role

Month 1
- Initiate
  - Site engagement
  - Assessment of readiness
  - Preparation of Business case
  - 1:1 engagement with local leaders
  - Relationship building

Month 3
- Design Local Solution
  - Site visit for operational prep
  - Governance set up
  - Recruitment
  - Care process mapping workshop
  - Resource mapping workshop
  - Provision of guidance & resources
  - Patient and carer engagement
  - Connect with wider ICP OP Network
  - Relationship building

Month 6
- Implement
  - ICP OP team site visits
  - Provision of guidance & resources
  - Framework implementation
  - Structural metrics
  - Data collection and return
  - Connect with wider health and social care economy
  - Connect with wider ICP OP Network

Month 12
- Evaluate & Embed
  - ICP OP team 3 /12 site visits
  - Connection with orphen services for older persons
  - Participation in networking days
  - Programme events
  - Virtual support
  - Expert input as required
  - Monitor and evaluate
Co-Production

Population Planning Workshops

Resource Mapping Workshops

Pathway Mapping Workshops

MDT Team Development Workshops

Service User Engagement Workshops

ICT Planning Workshops
Key elements of integrated care pathways

**Home**
- Living well at home with supports:
  - Health Promotion, Maintaining health, wellbeing & nutrition
  - GP/PCT management
  - Out of hours GP care
  - Medication management with local pharmacist
  - Carer support
  - Home Care/Home help
  - Reducing Social isolation
  - Information on local services
  - Local day service Social opportunities
  - 3rd sector Community support
  - Telehealth
  - Supported self management

**Primary Care**
- Primary Care Team (PCT)
  - HH with knowledge and education re Frailty.
  - PHN who can identify frailty, can support family with care and can link with GP/case manager/ANP/community intervention teams
  - GP who can manage above with PCT and support patient and family

**Ambulatory Care**
- Integrated Care Hub (MDT/Day Hospital). Single Point of access. Case manager who links with community services, mental health team, palliative care services and Acute hospital. Rapid access clinics. Early Diagnosis, CGA (SAT). Post diagnostic supports

**Acute Hospital**
- Timely access at crisis point. Divert/reduce requirement for acute hospital admission. Case manager as point of access at times of crises for Person in community. Community hospital admission if required. Front door response to frailty in Ed, FITT team, CGA(SAT). Early engagement with integrated care team.

**Inpatient**
- Specialist Wards for Older People with Frailty (SGW) staffed by multidisciplinary teams and gerontologically trained nursing, medical and HSCP staff.
- Comprehensive Geriatric Assessment. Early Supported Discharge for admitted patients.

**Residential Care**
- Supports for Person in long term care. Links with Acute hospital team, (ANP,CNS, Geriatrician). Integrated care team Single Point of contact for Nursing home

**Domiciliary care**
- Early Supported Discharge
  - Early review in Day hospital post discharge
  - Support via Case manager post discharge.
  - Community intervention team, increased home care via primary care team.
  - Home care package/home help. Links with voluntary sector

**Rehab**
- Access to inpatient and outpatient rehabilitation with supported assessment, therapies and clinical support.
- Governance & Training to support ICP implementation and sustain

**ED frailty at the front door**
- Divert/reduce requirement for acute hospital admission. Case manager as point of access at times of crises for Person in community. Community hospital admission if required. Front door response to frailty in Ed, FITT team, CGA(SAT). Early engagement with integrated care team.
<table>
<thead>
<tr>
<th>ICP OP</th>
<th>Living at home with supports</th>
<th>Primary Care</th>
<th>Ambulatory Care</th>
<th>ED frailty at the front door</th>
<th>Inpatient</th>
<th>Rehabilitation</th>
<th>Domiciliary follow up by MDT</th>
<th>Residential Care</th>
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<td>Case Managers recently recruited</td>
<td>GEMS Pathway</td>
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- ☀: In place
- ☠: Underway
- ☠: Plans in place
### Outcomes

#### What difference has it made?

<table>
<thead>
<tr>
<th>National Data Sample</th>
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<tr>
<td><strong>Over 6,050</strong> new referrals into Integrated Care teams.</td>
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<td><strong>3,530</strong> Comprehensive geriatric assessments carried out.</td>
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<td><strong>49%</strong> of patients seen within 7 days of referral.</td>
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<td><strong>7</strong> pilot sites have established a team hub. 5 more have plans underway.</td>
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<td><strong>42</strong> cANPs specialising in older persons care are aligned to the integrated care pilot sites.</td>
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<td><strong>1,200</strong> trained in frailty education by NCP OP.</td>
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<th>Local Data Sample</th>
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<tr>
<td><strong>1,082</strong> annual bed days saved in 1 pioneer site using a day hospital for crisis intervention.</td>
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<td><strong>3%</strong> re-admission rate where early supported discharge implemented (national average is 10.8%, range 9.8-15.4% within 28 days).</td>
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<td><strong>34%</strong> reduction in LoS (&gt;85yrs).</td>
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<tr>
<td><strong>24%</strong> reduction in re-admission (&gt;75 yrs).</td>
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</table>
Annual investment (e.g. “Orphan” dietetic service)  
WICOP Stage II – need programmatic support  
reMIND, DE-FRAIL, Frailty biomarkers,  
Carotenoids, CONVINCE  
3 PhD students, 1 MD student  
1 Research Nurse  
ICPOP acknowledgement of relationships  
cANP Campaign  
New ways of working (Right person, right place, right time)  
Electronic database & CareFolk  
National Frailty Education Programme Roadshows; GPs, PHNs, Hospital  
Patient education (Cognitive Rehab, Dementia Café)  
Cost-neutral change Governance  
Pine Ward – SGW  
Space for WICOP Hub  
FIT team  
CHO-5 as exemplar  
Ref: Cooke, J (2018) IFIC Forum
## ATTENDANCES at ED (Ages: 75+)

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<thead>
<tr>
<th>Hospital Group</th>
<th>Hospital</th>
<th>October 2018</th>
<th>YTD 2018</th>
<th>October 2017</th>
<th>YTD 2017</th>
<th>Change October</th>
<th>Change YTD</th>
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<tbody>
<tr>
<td>South/South West Hospital Group</td>
<td>CUH</td>
<td>796</td>
<td>7,638</td>
<td>695</td>
<td>7,005</td>
<td>14.5%</td>
<td>9.0%</td>
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<td></td>
<td>Kerry</td>
<td>464</td>
<td>4,294</td>
<td>433</td>
<td>3,942</td>
<td>7.2%</td>
<td>8.9%</td>
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<td></td>
<td>Mercy</td>
<td>325</td>
<td>3,280</td>
<td>358</td>
<td>3,053</td>
<td>-9.2%</td>
<td>7.4%</td>
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<td>South Tipp.</td>
<td>388</td>
<td>3,654</td>
<td>371</td>
<td>3,524</td>
<td>4.6%</td>
<td>3.7%</td>
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<td>600</td>
<td>6,178</td>
<td>596</td>
<td>5,801</td>
<td>0.7%</td>
<td>6.5%</td>
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**South/South West Hospital Group**

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<td>2,573</td>
<td>25,044</td>
<td>2,453</td>
<td>23,325</td>
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## ADMITTED from ED (Ages: 75+)

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<td>3,906</td>
<td>396</td>
<td>3,880</td>
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<td>Kerry</td>
<td>244</td>
<td>2,318</td>
<td>250</td>
<td>2,212</td>
<td>-2.4%</td>
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<td>175</td>
<td>1,799</td>
<td>198</td>
<td>1,788</td>
<td>-11.6%</td>
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<td>231</td>
<td>2,144</td>
<td>204</td>
<td>2,100</td>
<td>13.2%</td>
<td>2.1%</td>
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<td>Waterford</td>
<td>255</td>
<td>2,627</td>
<td>276</td>
<td>2,695</td>
<td>-7.6%</td>
<td>-2.5%</td>
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**South/South West Hospital Group**

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<td>1,309</td>
<td>12,794</td>
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<td>12,675</td>
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**Impact**

**CHO 5/UHW (2017-2018)**

- **Intermediate Outcomes**
  - **Admission avoidance**
  - **1,082 bed days saved with crisis intervention (Hub)**
  - **€3.347m return on investment of €0.380m**

- **Reduced Length of Stay**
  - **5-day reduction AvLOS for hip fractures**
  - **BDUs (medical) >64 Oct ’17 – Apr ’18 reduced by 3,938 compared to previous year**

**CHO 2/SUH (2016-2017)**

- **Intermediate outcome**
  - **Reduced LoS by 2.6 day for > 70yrs**
  - **€3.2m return on investment of €0.450m**

**CHO 5/St Lukes (2017-2018)**

- **Intermediate outcome**
  - **Reduced LoS >85 by 34%**
  - **Reduced LoS > 75 by 24%**
  - **€1.2m return on investment of €0.230m**
The following are a synopsis of the key insights into the hidden dynamics associated with implementing integrated care for older persons

1. METHODOLOGY MATTERS (COMPLEXITY TRUMPS CONTROL)
   It is fundamental that there is recognition that implementing change of a systemic nature is taking place in a complex adaptive system. The approach has to be iterative and organic. It also has to accommodate high autonomy professionals where social influence is not amenable to programmatic management.

2. ALL INTEGRATION IS LOCAL
   Local history, resources, ownership and culture are the key ingredients for integrated care. The ability to lead this collaboration locally has a profound impact on the potential to redesign services.

3. IMPROVEMENT IS ITERATIVE, DYNAMIC AND ORGANIC
   It takes time to build trust and confidence. The dynamics are ever-changing opportunities arise and influences change. Incremental steps (the grind) constitute the substantive effort rather than the grand (programmatic control).

4. LOCAL GOVERNANCE IS KEY
   A functioning, local governance structure, underpinned by senior executive clinical and managerial sponsorship, is an essential prerequisite for effective integration of care. This provides strategic and operational coherence and allows opportunities for redesign to be leveraged.

5. POPULATION IS FUNDAMENTAL (NOT ORGANISATION)
   A focus on prioritising population need, specifically those that will benefit from integrated care, has to supersede institutional concerns in order to health and social care to be delivered across boundaries. 'Fixing the system' is secondary to person-centred care population and place-based care.

6. TRUST THE PEOPLE WHO KNOW THEIR BUSINESS
   The most useful function a national programme can perform is to facilitate clinical and managerial entrepreneurs to fulfill their local vision. Meaningful strategic change is driven locally with national supports not vice versa.

7. RESPECTS TRUMPS RESOURCE.
   Whilst necessary, resource is not sufficient for change to happen. Paying attention to and respecting the importance of people work leverages latent capacity to make the transformation of older persons care happen.
Strategic decisions required

1. What are the goals for scaling?
   - Institutional
     - Efficiency
     - Effectiveness
   - Citizen
     - Personal goals

2. What route to scale?
   - Community services
     - MDT
     - Ambulatory pathway
     - In-patient pathways
     - FFB
   - AH pathways

3. How to scale?
   - Earned local autonomy
   - Workforce
   - Capital
   - Programmatic support
   - Analytics
   - ICT
   - Commissioning model
   - New and existing resource

2. What is being scaled up?
   - CHN (50,000 pop.)
   - Vol Services
     - CIT
     - ICT OP
     - CMNHT
   - AH
   - Bespoke pathways
In summary

- Governance is fundamental
- User engagement enriches vision and generates potential
- Engaged workforce
- Care pathways
- Efficiency and effectiveness
Hello, I’m Nora.

Click here to see Nora’s Story

Thank You