Integrated Care Programme, Older Persons

IFIC Webinar 12.6.19
Figure 1.1: ICP OP Programme stages

No. of sites involved

- 13 sites
- 6 sites

ICP OP
Initiation, design and test

2016

2018

Time

Embed
Scale up
Hello, I’m Nora.

Click here to see Nora’s Story

Thank You
Implementing integrated care

- Complex and poorly defined
- Working across professional and organisational boundaries
- Requires new roles
- Requires simultaneous implementation of multiple co-dependant strands (workforce, ICT)
- Lack of policy support
- Lots of silos (strategic, budgetary, planning, data)

Opportunity

- Latent professional capacity and appetite for change
- New policy framework (Slaintecare)
- User support
- Richness of community assets
- Implementation methodology in context of system change
- Technology
- Emerging roles
Programme implementation

- **June 2015**: Programme PID agreed
- **Dec 2015**: Initial 6 pioneer sites initiated; 35 wte. clinical staff funded
- **June 2016**: ICP OP Team recruited
- **Jan 2016**: Programme Manager/ Clinical Lead commenced
- **Dec 2016**: ICP OP networking day initiated; Site info exchange
- **Jan 2017**: Framework launched
- **June 2017**: 6 further pioneer sites funded
- **June 2018**: ICP OP networking day initiated; Site info exchange
- **Jan 2018**: Data collection, User engagement
- **Dec 2018**: Dashboard, Research results

- **7 Sites**: 6 sites + 1 Site
- **13 Sites**: 7 Sites + 6 Sites
- **21 Sites**: 13 Sites + 8 Sites
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
    - Staff and service user experience

Frailty Prevalence
- 11% Severe Frail (Very High Risk)
- 31% Moderate Frailty (High Risk)
- 36% Mild Frailty (At risk)
- 32% Fit (Minimal risk)

Theory of Change

Policy/plan/aspiration of health system

Implementation methodology!!

Future state

"I think you should be more explicit here in step two!"
The small group, capable of responsible autonomy, and able to vary its work pace in correspondence with changing conditions, would appear to be the type of social structure ideally adapted to the underground situation. 

Psychological/sociological insights underpinning the 10 Step Framework

1957
Leon Festinger
Cognitive dissonance

1978
Ken Wallstrom
Locus of control

1986
Albert Bandura
Social cognitive theory (self efficacy)

1988
De Shazer/Kim Berg
Solution focused approach

1988
Martin Seligman
Learned Optimism
Positive Psychology

2000
David Cooperrider
Appreciative Enquiry

2002
Sunstein and Thaler
Ikea effect

2010
Dan Ariely
Cognitive dissonance

2015
David Halpern
Locus of control
Interventions for community dwelling older person living with frailty
Co-Production

Population Planning Workshops

Resource Mapping Workshops

Pathway Mapping Workshops

MDT Team Development Workshops

Service User Engagement Workshops

ICT Planning Workshops
### Co-ordinated Care

#### Integrated Care Programme for Older Persons

**ICPOP Service User Led Service Improvement Workshop CHO 5 Feedback Report**

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<table>
<thead>
<tr>
<th>Group</th>
<th>Theme</th>
<th>What does good look like?</th>
<th>What could we do to improve?</th>
</tr>
</thead>
</table>
| Group 1| Person-centred Care    | - Listening to the patient  
- Clear information about who is dealing with my care                          | - Links with local community services
- Discharge pack with contact names and numbers when leaving hospital          |
| Group 2| Communication          | - GEMs Service  
- Co-ordinated care and communication across disciplines  
- Case Manager  
- Primary care teams                                                  | - Integrated Care teams
- Step-up beds
- GEMs services in hospitals                                             |
| Group 3| Co-ordination          | - Social Prescribing  
- Co-ordinated care and communication  
- Clarity of information  
- Listening to older people and their needs  
- Proactive instead of reactive care  
- Comprehensive joining of the dots                                      | - Ensure the right people are making the decisions, broader range of opinions needed
- Less nursing homes, more developments to facilitate independent living
- Local oversight group to connect services and develop better community links |
| Group 4| Person-centred Care    | - Clear explanation / information about care plan  
- Speaking to the patient, not about the patient  
- Patients given sufficient time to ask questions  
- Autonomy - patient having ownership over care  
- Privacy and dignity  
- Dietary requirements considered                                       | - A case manager
- Discharge pack with numbers and names of people to contact
- Media coverage of services available to people in the community
- Transport to appointments
- Social Prescribing
- Education around planning for future                                   |
| Group 5| Communication          | - Communication between healthcare professionals  
- Information explained properly  
- Knowing who to contact if something goes wrong  
- Patient given enough time with staff  
- Good GP relationship                                                     | - Accurately transferring information about patients condition to other health care professionals
- Using the media positively to get messages out about services in the community
- Information and education on how to stay well, eating, social interaction, exercising
- Involvement of statutory bodies                                          |
| Group 6| Co-ordination          | - Knowing who to contact at a local level  
- Access to social outlets  
- Good contact with PHN  
- Transport to day centre                                                 | - Greater emphasis on prevention
- Develop a comprehensive community network                                |

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**What does it mean?**

- Nearly 1 in every 2 people are experiencing a smooth journey
- 1 in 4 people experience a disrupted journey
- Nearly 1 in every 2 people do not experience team decision making
- Nearly one third of people do not know who made decisions about their treatment and a quarter don’t know what’s happening after the experience was over
- For more than half of people follow-up is happening
- Not knowing what is happening is disempowering for people
5 Key Implementation Phases

1. INITIATE
- Site engagement
  - 1:1 engagement with local leaders
  - Relationship building
  - Assessment of readiness
  - Preparation of Business case
  - Funding approval
  - Governance set up
  - Provision of Guidance Documents & resources

2. DESIGN (Local Solution)
- ICP OP team Site visits
  - Local PM appointed
  - Governance established
  - Recruitment
  - Population Planning
  - Resource mapping
  - Care Pathway mapping

3. IMPLEMENT
- ICP OP team Site visits
  - Provision of ICT hardware (OoCIO).
  - ICT Workshop
  - Frailty Education Training
  - Case finding in target CHNs
  - Measurement Workshop
  - Structural metrics return
  - Process metrics return
  - Team Development Workshop
  - Connect with wider health & social care economy
  - Ecosystem Workshop
  - Networking event

4. EVALUATE & EMBED
- ICP OP team Site visits
  - Dashboard to Monitor and evaluate
  - Connection with other older persons services
  - Participation in networking days
  - Link with research institutions
  - Link with EU JA Frailty Prevention and international orgs
  - Virtual support

5. ASSIMILATE
- Ongoing Evaluation
- Continued links with other OP services and ICPOP network after ICP OP involvement is complete

Key Implementation Phases:
- Month 1
- Month 3
- Month 6
- Month 12
- Month 15
- After ICPOP

5 Key Implementation Phases:
- INITIATE
- DESIGN (Local Solution)
- IMPLEMENT
- EVALUATE & EMBED
- ASSIMILATE
Products
1. Asset Map
2. Issues Map
3. Current State Map

= Redesign of Older Persons Pathway
Joining the service delivery model dots

Benefits of a HUB

- Reduction in crises in the community
- Access to diagnostics
- Immediate (same day if necessary) access to specialist assessment,
- Reduced bed days in hospital,
- Streamlining of access to rehabilitation,
- Early access to specialist expertise and greater efficiencies in their use
- Opportunities for strategic service redesign which makes older persons an attractive career option
- Opportunity to test technology (Carefolk).

Submitted under Slaintecare innovation fund (2019)
WICOP HUB IMPACTS

Experience of care
- Patients flow through 5 defined care pathways
- All patients in receipt of CGA in ≤2 visits
- Case management offered to most complex patients (seen within 24 hours)
- Direct admission to inpatient rehab (avoiding ED) for eligible crisis patients
- Immediate escalation of HCPs for crisis patients
- Expedited admission from home to NH for appropriate crisis patients

Service impact
- 5-day reduction AvLOS for hip fractures
- Medical DCs >64 Oct 17 – Apr ’18 reduced by 719 compared to previous year
- BDDs (medical) >64 Oct 17 – Apr ’18 reduced by 3938 compared to previous year

Cultural change
- Community Management of frailty
- WICOP roadshow has visited >60 PHNs
- All PCTs involved from outset
- Frailty Education Programme delivered to >150 nurses
- Inpatient Management of frailty
- End PJ Paralysis #UHWGetMoving
- Pine Ward in new build allocated to frail elders

Improved use of resource
- Synergy between “old” and “new” integrated services
- Many existing services have asked to join WICOP
- Previous “orphan” therapists now under WICOP umbrella
- WICOP steering/governance committee meeting quarterly
- Rehab SubComm streamlining rehab processes (Legacy waiting list eliminated)
- Stroke SubComm completed RCPQI Course streamlining acute management
- SGW Subcomm will direct development of Pine Ward to SGW
ICP OP- Local ripple effect (WICOP)

National Support

Local Credibility

Research

Education

WICOP Hub

Relations

MFTE

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

Pine Ward – SGW
Space for WICOP Hub
FIT team
CHO-5 as exemplar

National Frailty Education Programme
Roadshows; GPs, PHNs, Hospital
Patient education (Cognitive Rehab, Dementia Café)

Cost-neutral change
Governance

Ref: Cooke, J (2018) IFIC Forum
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<th>CHO</th>
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<th>Ambulatory Care</th>
<th>ED frailty at the front door</th>
<th>Inpatient</th>
<th>Rehabilitation</th>
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- ★ In place
- ★ Underway
- ★ Plans in place

ICP OP
Groundhog day
The following are a synopsis of the key insights into the hidden dynamics associated with implementing integrated care for older persons.

**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.

**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.

**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).

**LOCAL GOVERNANCE IS KEY**

A functioning, local governance structure, underpinned by senior executive clinical and managerial sponsorship, is an essential pre-requisite for effective integration of care. This provides strategic and operational coherence and allows opportunities for redesign to be leveraged.

**POPULATION IS FUNDAMENTAL (NOT ORGANISATION)**

A focus on prioritising population need, specifically those that will benefit from integrated care, has to supersedes 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.

**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.

**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.
Implementing Integrated Care for Older Persons in Ireland
Early stage insights and lessons for scale up

https://www.icpop.org/