Complex Case Management Team (CCMT)
South West Cork Kerry Region

Complex Case Management Team

Background

- Guided by the principles of Sláinte Care. The CCMT was developed in November 2022 by Primary Care to **case manage and facilitate timely discharges from acute hospitals for complex patients aged between 18 and 65.**
- CCMT act as a **central referral point** for streamlined processes for acute sites and to enable seamless integration with community services and networks.
- Following discharge from acute hospitals CCMT continue to case manage complex cases in step down units.

Aim

- The aim of the CCMT is to **stratify risks, identify a plan for discharge and implement a plan** via care coordination within the community services and follow up to ensure the plan is addressing the patient's needs. The team will identify and obtain resources to minimise the barriers.

Objective

- The overall objective is to **facilitate timely discharges from the acute hospital settings and to allow people to remain at home for as long as possible** by ensuring the appropriate supports are available.

Barriers to Discharge

- Medical complexity
- Lack of decision – maker
- Lack of caregiver
- Financial barriers
- Social barriers e.g. housing issues or legal concerns

Complex Case Management Team

Scope and Exclusions

- **Inclusion criteria encompasses patients who:**
  - Are 18-65 years of age (> 65 years will be accepted on a case by case basis);
  - Reside in Cork/ Kerry;
  - Meet the complex case definitions for the CCMT;
  - Are in CUH, MUH, SIVUH, SFH, UHK, NRH, BGH, MGH
  - Patients who have transitioned from the Acute Service to Transitional Care Beds, with outstanding needs.
- **Exclusion criteria**
  - Patients residing outside Cork and Kerry; on a case-by case basis, the CCMT will carry out an individualised assessment where there are extenuating complex care needs.

Profile of Complex Cases

1. Persons with mild intellectual disabilities.
2. Persons classified as homeless with complex needs.
3. Persons requiring long term residential placement with complex care needs / challenging behaviour preventing them from living independently.
4. Persons with ABI.
5. Person with Severe and Enduring Mental Illness with high degree of frailty/medical co-morbidity.
6. Person with high degree of complex physical healthcare needs/physical illness in an acute hospital setting awaiting discharge to the community/home.
7. Patients transferred to TCB from the acute services.

Complex Case Management Team

The Composition of the CCMT in CKCH

New Posts: Full Time

- Operational Lead, Complex Cases - Yvonne Cashman
- Social Worker - Sinead Lawless

Reps Mandated (as part of existing roles)

- ADPHN Primary Care -
- Social Inclusion Representative -
- Mental Health -
- Disability Services -
- Continuing Care Placement Coordinator -
- Cork County Council -
- Cork City Council -
- Kerry County Council -

- A weekly meeting is chaired by CCMT to enable integrated planning and solutions to facilitate discharges for complex patients

Complex Case Management Team

The CCMT Process

1. Referral received, CCMT determines suitability

2. The CCMT will visit the patient/review case-notes/engage with relevant care groups/info gathering

3. The CCMT will identify the barriers for discharge and determine next course of action.

4. The CCMT will scope out a service solution as appropriate to meet the needs of the patient

5. CCMT organises a MDT with relevant stakeholders e.g. the hospital team, representatives from community

6. The Operational Lead will escalate any barriers to the Head of Service for discussion with the CHO Management Team.

Breakdown of Referrals Dec 2022-Feb2024

Referral	Percentage of referrals	DTOC –Delayed Transfer of Care
Active	20%	
Complex home support/nursing need/Complex needs	39%	3586
Residential Care Facility	15%	2506
Housing Homeless	14%	2765
Disability Placement	3.5%	1771
Home Adaptation/Equipment	2%	699
Metal Health Placement	1%	522

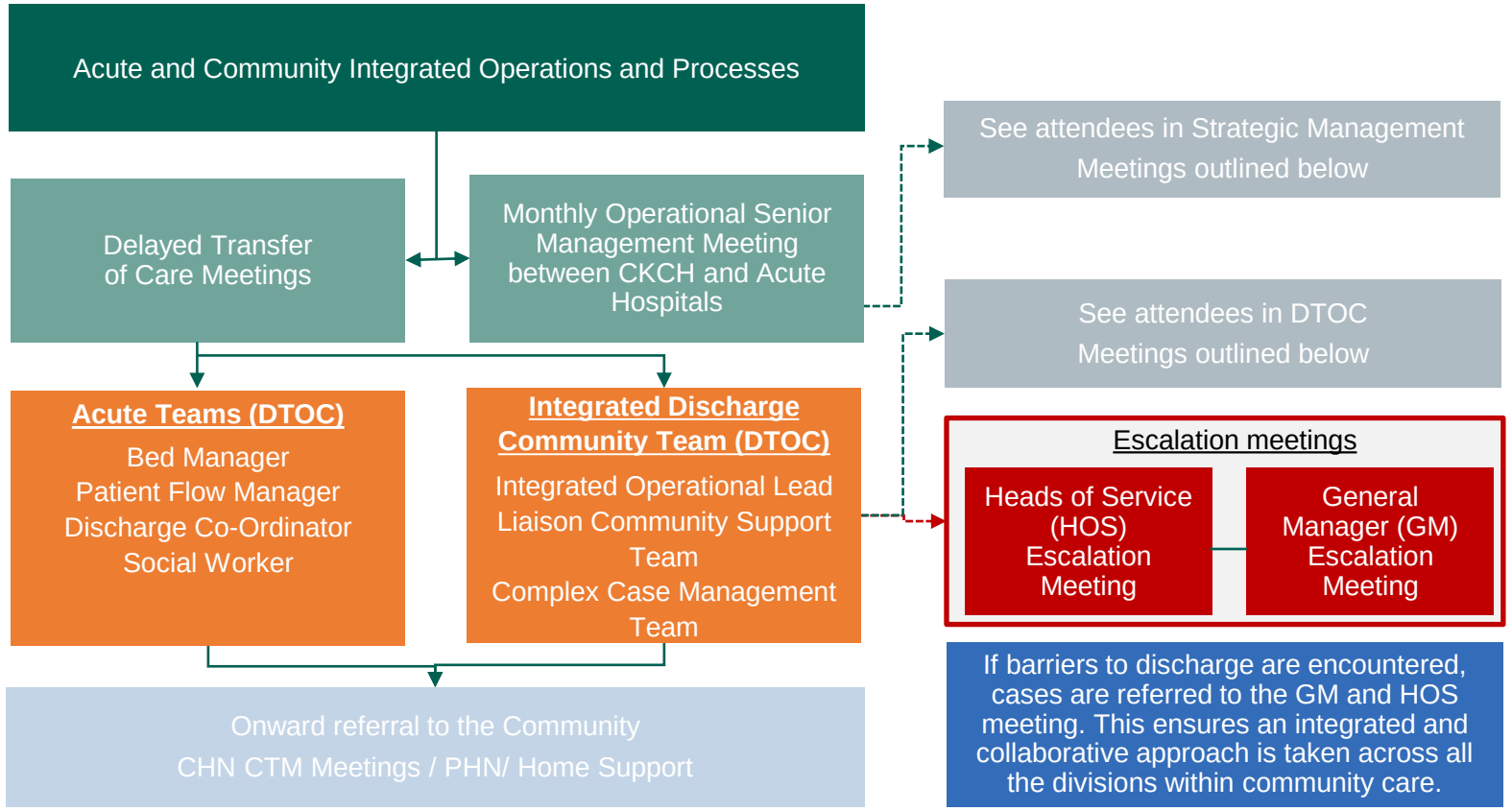
Integrated discharge from acute hospitals

CKCH services have been reconfigured to improve the management of complex patients between acute and community services.

Weekly meetings and reports

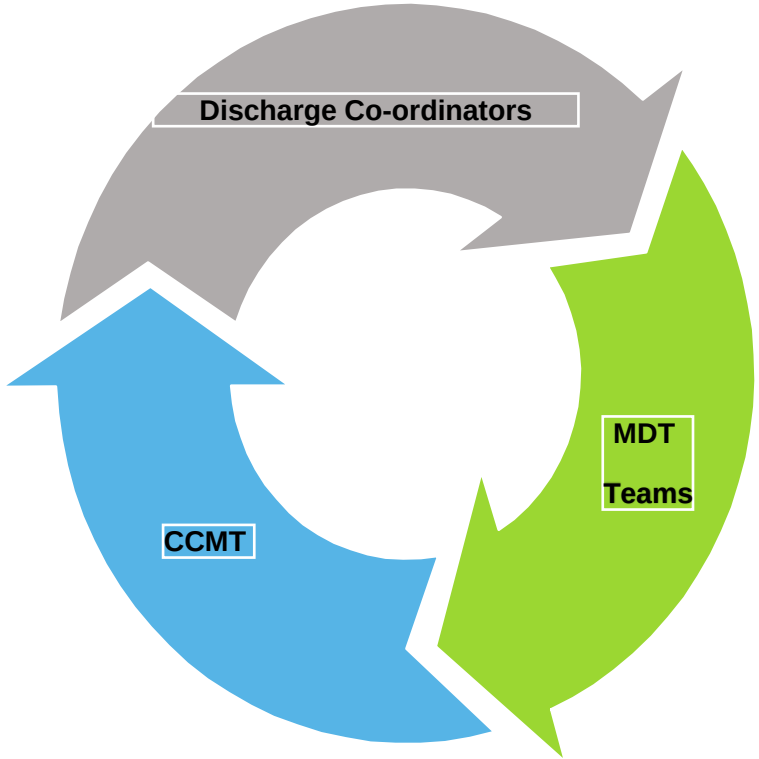
"General Manager"/ "Heads of Service" meetings are held weekly to mitigate barriers to discharge and to develop integrated solutions which facilitate successful discharges from acute hospitals

A weekly DTOC report for all acute sites is produced to facilitate continued monitoring identification of areas for improvement



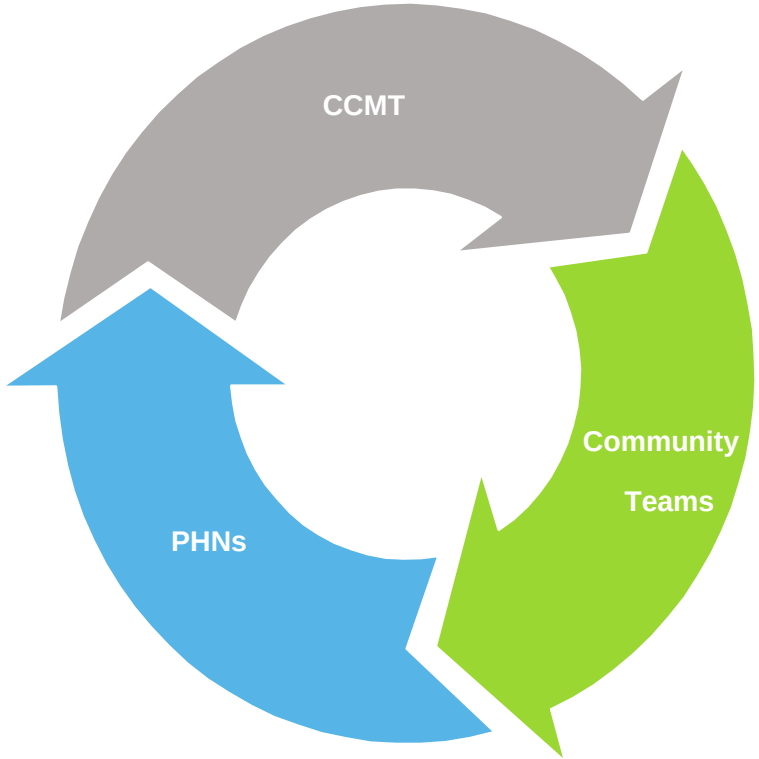
Integration within Acute Hospitals teams

- Engagement and integration within the Acute setting is a key priority for the CCMT.
- It is integral to providing updates and planning a coordinated discharge plan to meet the patient needs in a timely manner.
- E.g. NRH bi-weekly meetings.
- Attendance at MDT meetings.
- Onsite assessment of patient care needs.
- Bi-weekly meetings with Acute hospital-Discharge Co-Ordinators /CPCC/Social work Team.
- Weekly meeting CCMT/Social work Department.
- One referral form for all Community Services.



Integration within Community services.

- Engagement and integration with Primary Care Teams/Mental Health Disability Services/Social Inclusion Services and all relevant services e.g. ABI/Headway is a key priority for the CCMT to ensure continuum of care in a timely manner.
- It is integral to providing collaborative and coordinated care, and ultimately, patient-centered care;
- The development of the CCMT has led to enhanced communication of complex cases between required services.
  - Relevant Teams are notified by the CCMT if a complex patient is admitted giving ample time to facilitate discharge planning.
  - The CCMT links in with the Relevant Teams and PHNs on complex patients, facilitates a MDT and provides updates.



CCMT –Complex case discharge from NRH

Barriers

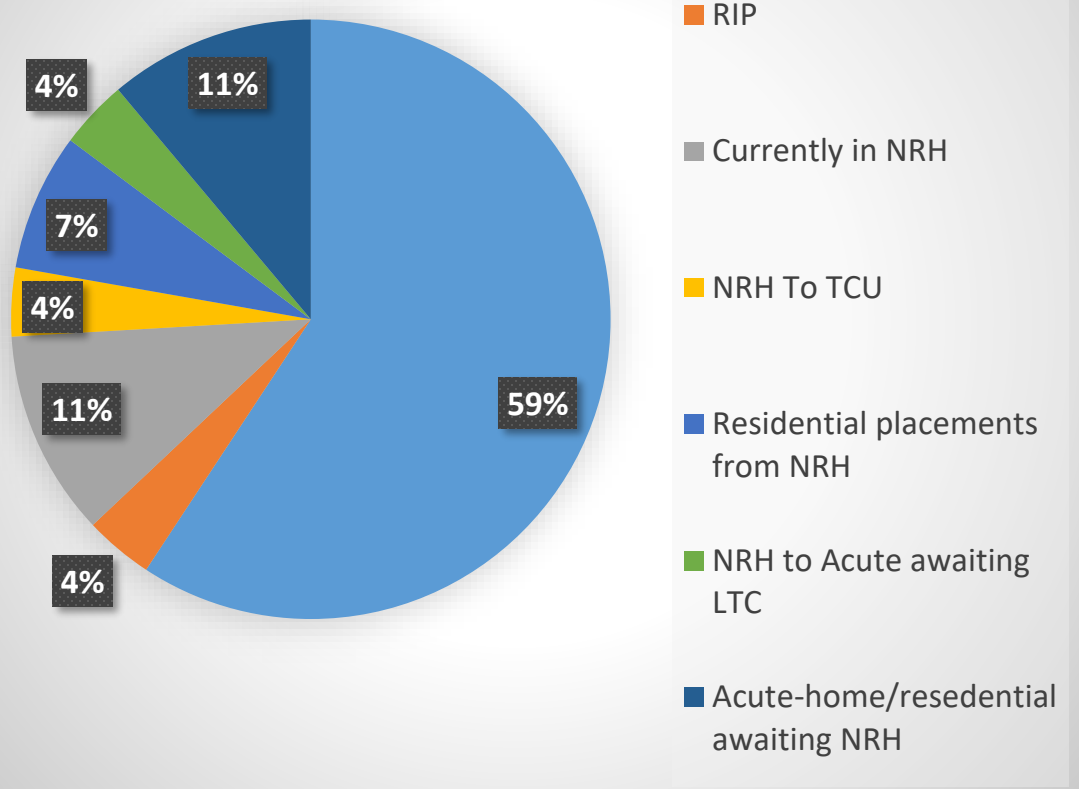
- High numbers of patients awaiting NRH
- Long wait times for transfer to NRH (Currently longest patient on DTOC waiting NRH **322** days) April 2024
- Patients with complex needs discharged back to their referring hospital once rehab has finished

Enablers

- Early referral to CCMT from an acute hospital
- Early identification of care needs
- Bi-weekly meeting with NRH

Improvements to patient flow

- The Complex Case Management Team received 27 referrals for patients under 65 years of age who attended NRH.Of this 16 **59%P**atients were discharged home directly from NRH.**3** 11% patients were discharged from acute to home/residential settings while awaiting an NRH bed (reducing acute bed usage. 3 11%Patients currently in NRH.1 4%Patient RIP.1 4% Patient to TCU-Awaiting LTC.2 7% Residential Placement LTC from NRH. 4% Patient to Acute-awaiting LTC



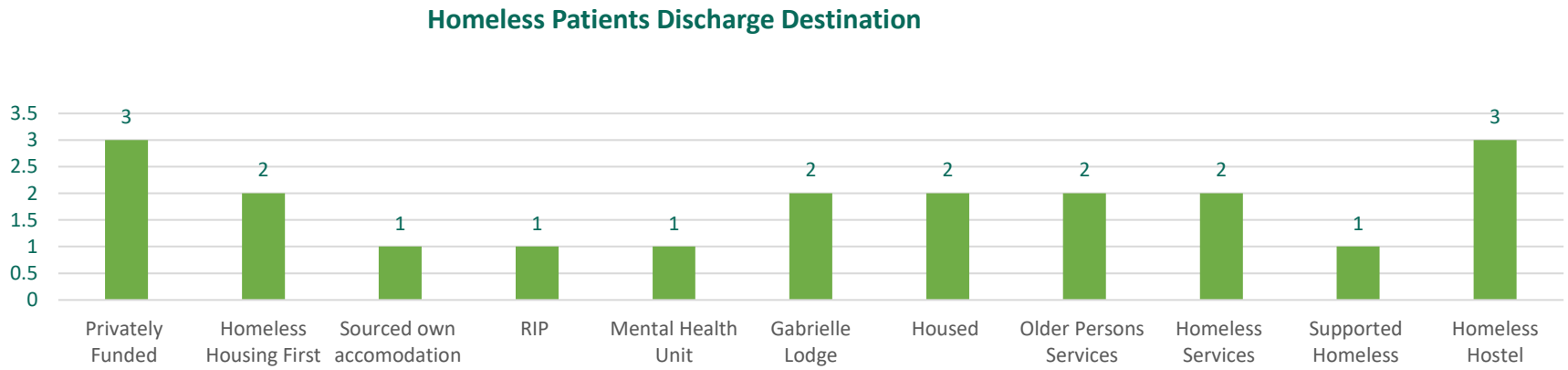
Complex Case Pre CCMT versus Post CCMT.

Pre CCMT	Post CCMT
Patient transferred from NRH Nov-22 to Acute service	Patient referred to CCMT PRE NRH
Referred to CCMT on 12th December 2022	Renovations escalated via Council-same commenced-patient awaiting NRH MDT with Community services to raise Awareness/Equipment Loss of sight- Recommendations from Blind Council re build HCP – Preliminary submitted
HCP/Equipment/Neurogenic bowel	Whilst in NRH-Fortnightly meetings with NRH. Continuous discussion re adaptation progress with Council. Update to Home Support Office re potential date of discharge.
Planned Discharge Date 21st March 2023-Home	Weekend release accommodated – Community Services input.
99 Days on CCMT	Discharge home on Planned date of discharge from NRH

Complex Case Management Team (CCMT)

- Of the 242 patients a total of 24 patients were referred due to homelessness (10% of total caseload)
- In addition to referrals for homelessness CCMT received an additional 26 referrals for patients with housing issues due to complex care needs

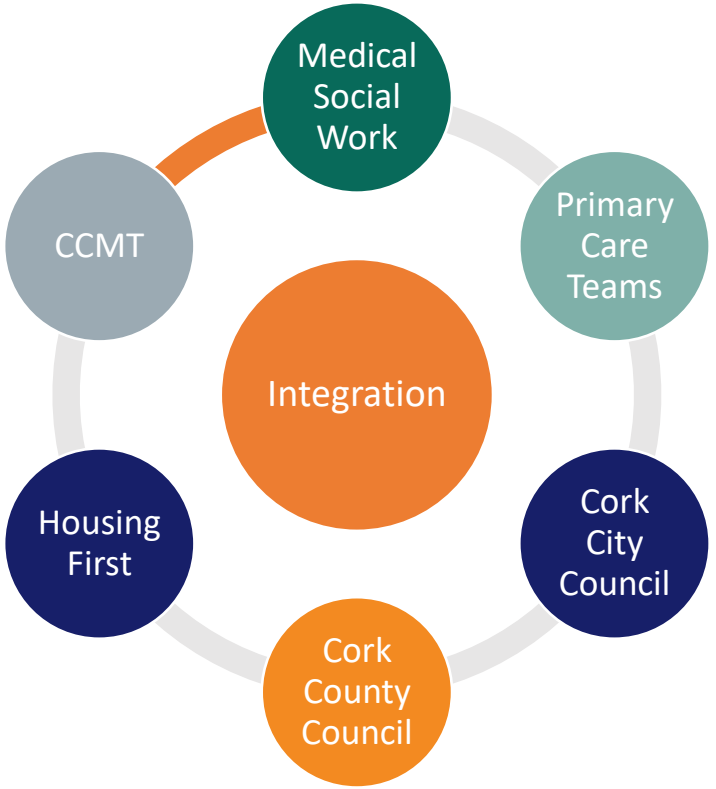
- In addition to homelessness many of the patients had additional complexities including;
  - Mental Health Issues
  - Addiction Issues
  - Wheelchair Users
  - Personnel Circumstances
  - Complex care needs



Case Study – Background and Integration

A **36 year old referred to CCMT** from acute hospital due to homelessness;

- Additionally had complex needs including wheelchair user, drug and alcohol misuse, victim of previous trauma and domestic abuse
- When medically fit the patient was discharged to emergency accommodation that was unable to meet her needs
- Increased difficulty in managing patient in community due to constant nomadic behavior
- As a result unable to establish a continuum of care impacting
  - Wound Care
  - Social Support and Contact
  - Challenge to Community services to manage and establish a care plan
  - Physical and social care needs not being met
- Frequent readmissions to acute hospital-



<u>Outcome :</u>

- CCMT/Social Inclusion /Housing First/CNT/Primary care integrated discharge plan:
- Housed with Housing First/Care via Primary Care/Social Inclusion Funding/

Integrating Services to Support People who are Homeless to Safely Discharge from Hospital:
Conference Report Inter-agency Report April 2024

Enablers

- Inter-agency collaboration (including HAT meetings and homeless forums)
- Established procedures and protocols
- Point of admission referrals
- Clearly defined roles
- Staff education
- Access to liaison psychiatry/addiction services
- MSW Advocacy Homeless Action Team and Local Homeless Forum
- NGO Support
- Agreed Protocol with City Councils and City Hospitals. - APS Service in City

Barriers

- Lack of pharmacotherapy supports / services
- Language (public health messaging in more common languages)
- Need for a services directory
- Lack of resources: supported emergency accommodation (including wheelchair accessible)
- Lack of resources: supported accommodation for those leaving prison
- Escalation of complex discharges: length of decision-making time
- APS Service (ED Friday presentations)
- Exclusion criteria – Anti-social behaviour/history of arrears/home ownership
- Lack of access to APS in County areas

A review of CCMT

- **Enablers**
- Weekly Complex Integrated Meeting
- Strong integration and communication with all stakeholders-Strong working relationships with Acute Hospitals .
- PHN and community healthcare network teams responsiveness with care provision
- Solution focused integration with councils and homeless providers
- Social Inclusion commitment to being solution focused

Scope to improve

- In comparison to the over 65 co-hort CCMT case load had far higher days on DROC -93 patients having a total of 18,367 days on DTOC.
- Decreasing these days has potential to improve :

➢ Patient flow.

➢ Reduce the impact of prolonged hospital stays.

➢ Decrease pressure on Acute Services including trolley numbers and improve patient care-Bed days lost equates to 3012 additional patients acute care- based on average National Acute days of 6.1.

CCMT-Gap Analysis. Future Planning

Accessible accommodation.

Emergency accommodation for patients with complex needs

Emergency accommodation options for patients with specialist equipment.

Step down under 65 transitional care accommodation.

Increase residential beds for young complex care needs/chronic conditions .

Increase rehabilitation services for under 65, Analysis of patients requiring NRH and up skilling of current staffing to meet their rehab needs in step down facility.

Review and identification of level of support and resources including infrastructure and staffing to meet under 65 cohort in 24 hour care.

Financially – NHSS is based on older persons requiring care – Younger adults have different care needs and calculations for cost of care needs to incorporate and additional support care and treatment younger adults require.

Future planning needs to include the development of a placement Forum specifically for young adults.

Community Resources – Rehab/HCP.

Contact details of CCMT

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Any Questions?