Integrated Community Based Pathways Supporting Acute Hospital admission Alternatives in North Dublin

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Patient Flow Academy

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Population Profile

- >65yrs is expected to double to almost 1.6 million by 2051
  - 2019 - 1:7 people >65yrs
  - 2051 - 1:4 >65yrs

- DNE Regional Population Profile 2024
  - 8 CHNs in DNE: higher proportion >65yrs than the national average
  - 25% of people living in Ireland in extreme deprivation live in DNE

HSE Regional Population Profiles-National Comparative Report April 2024 (version 03)

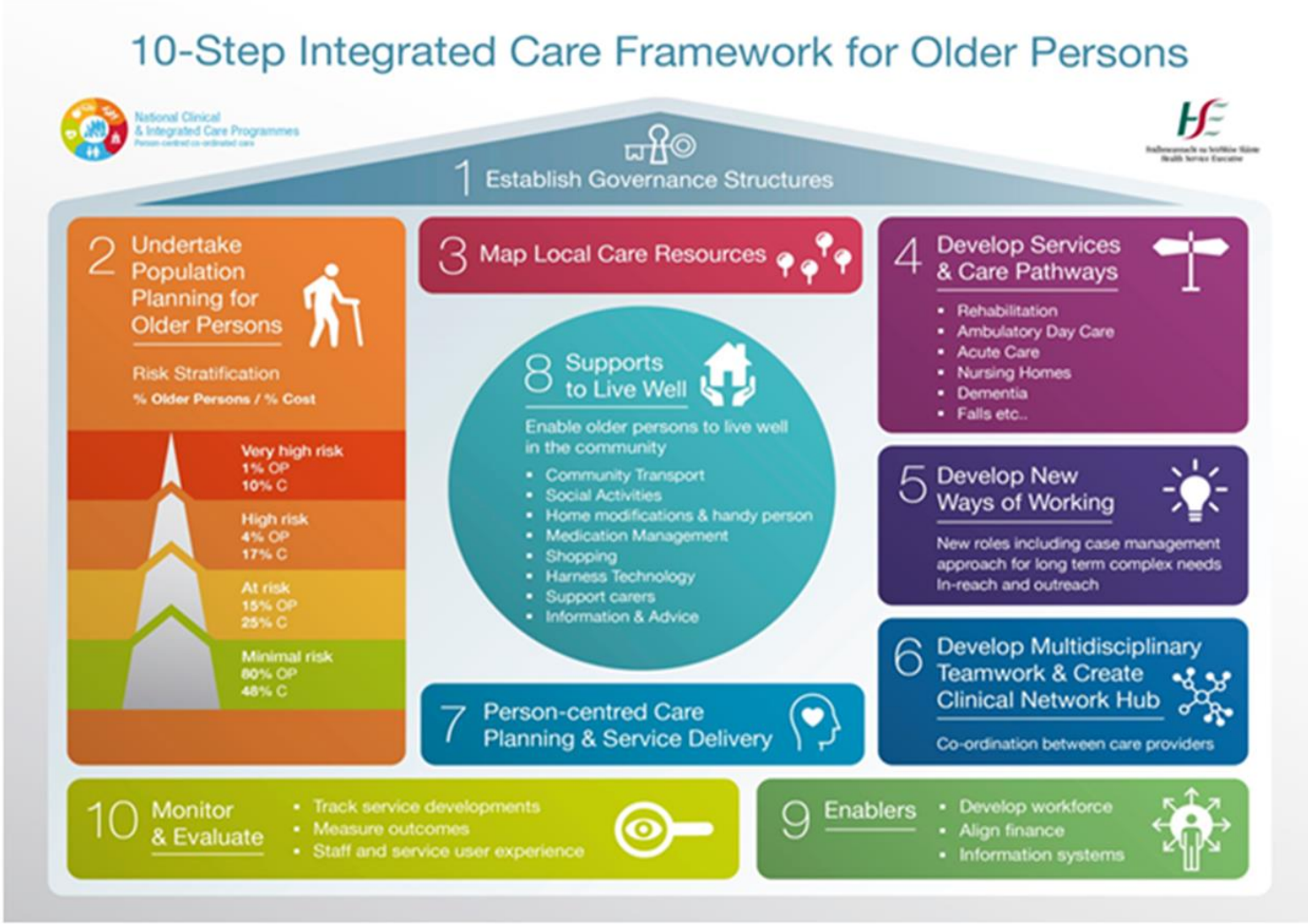
HSE Regional Population Profile-Health Region: Dublin and North East March 2024 (version1:1)

Aim

To develop key pathways providing evidence-based, quality and equitable care

- Hazards with acute hospital admission for the frail older person
- National Clinical and Integrated Care Programme
  - Evidence based
  - Components of integrated care
  - ‘Deliver end to end clinical pathway…cohesive primary, secondary and acute’

Methods


10-Step Integrated Care Framework for Older Persons
National Clinical & Integrated Care Programmes
1 Establish Governance Structures
2 Undertake Population Planning for Older Persons
Risk Stratification
% Older Persons / % Cost
Very high risk
1% OP
10% C
High risk
4% OP
17% C
At risk
15% OP
25% C
Minimal risk
80% OP
48% C
3 Map Local Care Resources
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
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
10 Monitor & Evaluate
Track service developments
Measure outcomes
Staff and service user experience
9 Enablers
Develop workforce
Align finance
Information systems

ED Referral

Refer for Med/surg adm

Refer Off-site Rehab or PACU

Patient sees GP and needs CGA

Refer to OPD (1/more)

- MMUH (4/52)
- SMH (4/52)
- Charter (2/52)
- CMOP(2/52)

ED Referral

FIT

1. Refer for Med/surg adm
2. Subacute specialist community rehab ward
3. Home with CST-OP
4. Post Acute Care Unit

Patient sees GP and needs CGA

CST-OP

Central Hub Referral
- Consultant Geriatrician triage

CST-OP - if unable to attend clinic/ED avoidance

Specialty clinic-MMUH/St Mary's/ Clontarf/ Charter clinic

- D/C to GP
- D/C to OPD
- If deterioration
  - refer ED
  - FIT invx
  - Admit subacute frailty ward

ED Referral

FIT

1. Refer for Med/surg adm
2. Subacute specialist community rehab ward
3. Home with CST-OP
4. Post Acute Care Unit

Patient sees GP and needs CGA

Central triage of referrals

Specialty clinic-MMUH/St Mary's/ Clontarf/ Charter clinic

CST-OP Urgent need and unable to come to clinic

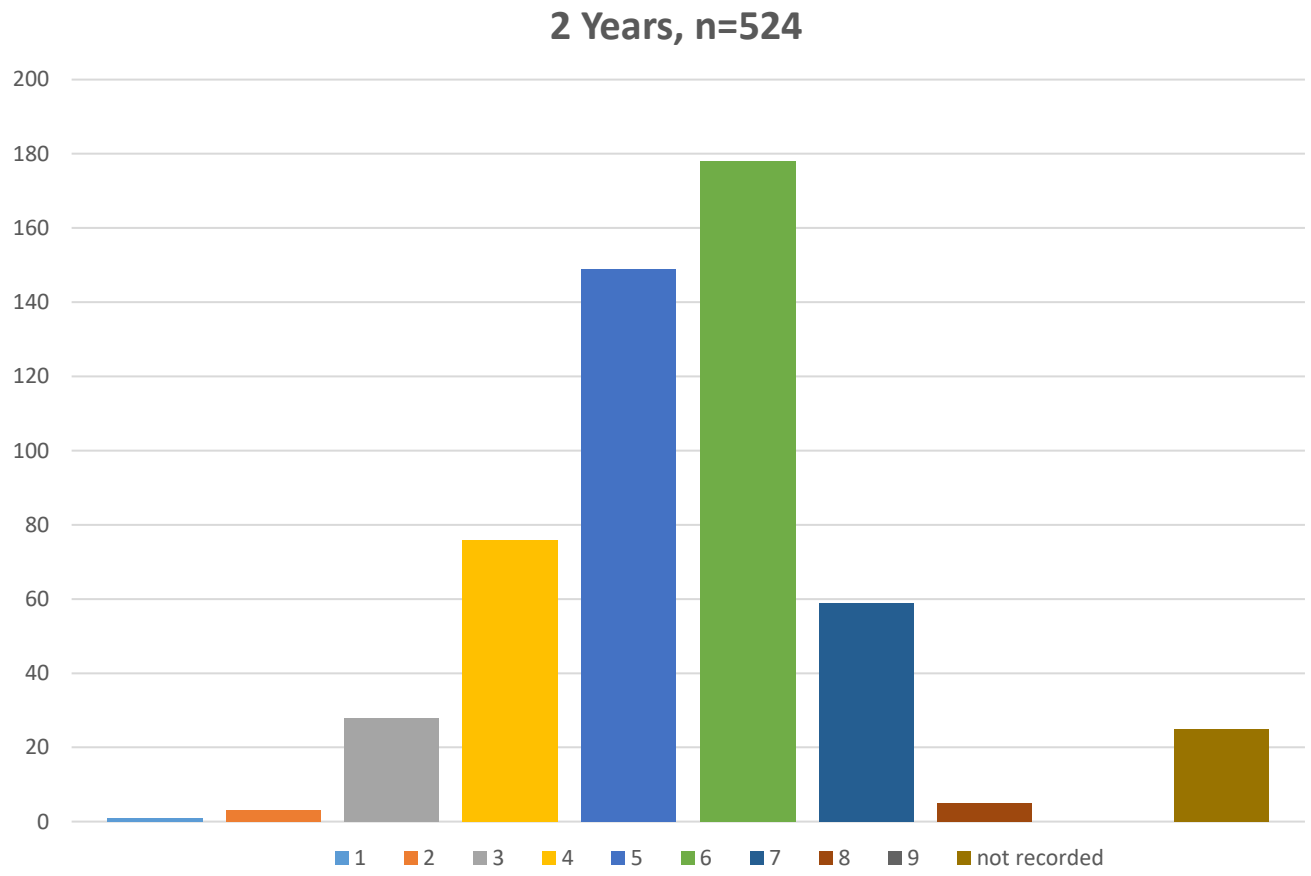
Numbers

	CST-OP	Rehabilitation Hospital beds/Subacute care	Post Acute Care Unit/Complex discharge	Total
July 2022-June 2023	258	223	21	502
July 2023-June2024	266	227	24	517

1019 patient episodes

CST-OP: Community Specialist Team - Older Person (domiciliary service)

Clinical Frailty Score CST-OP cohort



Results of New Pathways

9000 acute hospital bed days saved per annum

Number of inpatient beds – 25

Sustained Effect - Readmissions to Acute Hospital

- Total referrals Accepted: 258
- Readmissions **during CST-OP**: 18 (7%)

- Within **30 days after discharge from CST-OP**:
- Readmissions within 30 days after discharge: 21 (8%)

Voice of the Patient and Families

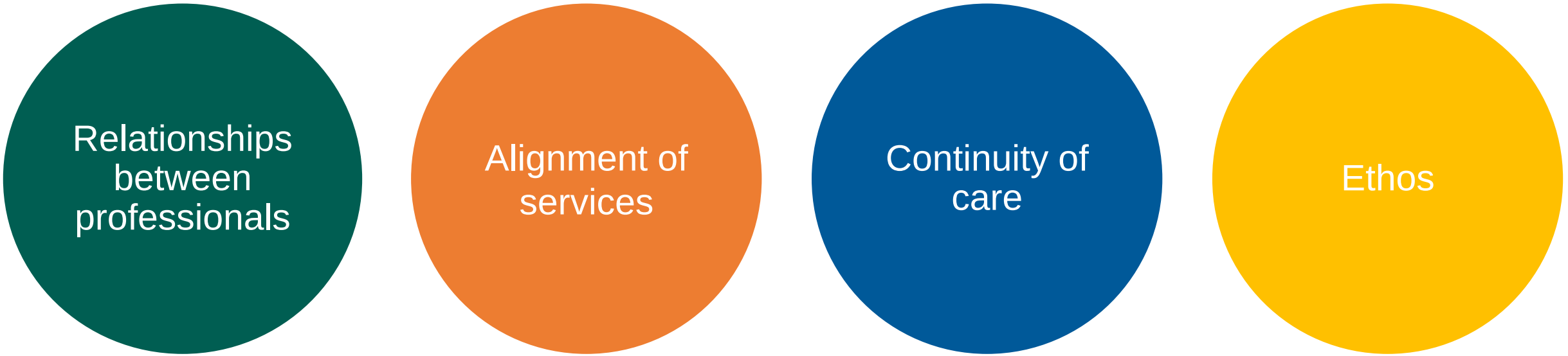
"Very respectful and caring during a very difficult time for us"

"Fantastic service, really beneficial – feel a lot better now"

"amazing continuity.. the emergency department to the rehab ward ….and at home when we needed them a few months later"

"Many thanks for your input with this lady, she died peacefully at home on Saturday 2/11/24. Thank you again for your help and care"

Upscaling: What makes this successful?



Next Steps

- Further engagement and development of primary care pathways
- Age-attuned ED with non-biased designated clinical spaces

Acknowledgements

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- Frailty Intervention Team, MMUH
- St Mary's Hospital & staff of Lambay ward
- Clontarf Hospital & staff Kincora ward
- Post Acute Care Unit, Fairview
- Patient flow teams on all sites
- Dept. of Emergency Medicine, MMUH
- Dept. of Geriatric Medicine, MMUH

Thank You