Rialtas na hÉireann
Government of Ireland

#EnhancedCommunityCare

Enhanced Community Care Conference 2022
Dublin Castle, Sep 1, 2022
Session 1:
Community Healthcare Networks (CHNs)

Enhanced Community Care (ECC)

Shifting Left - Building the Integrated Pathway:

Community Healthcare Networks (CHNs)

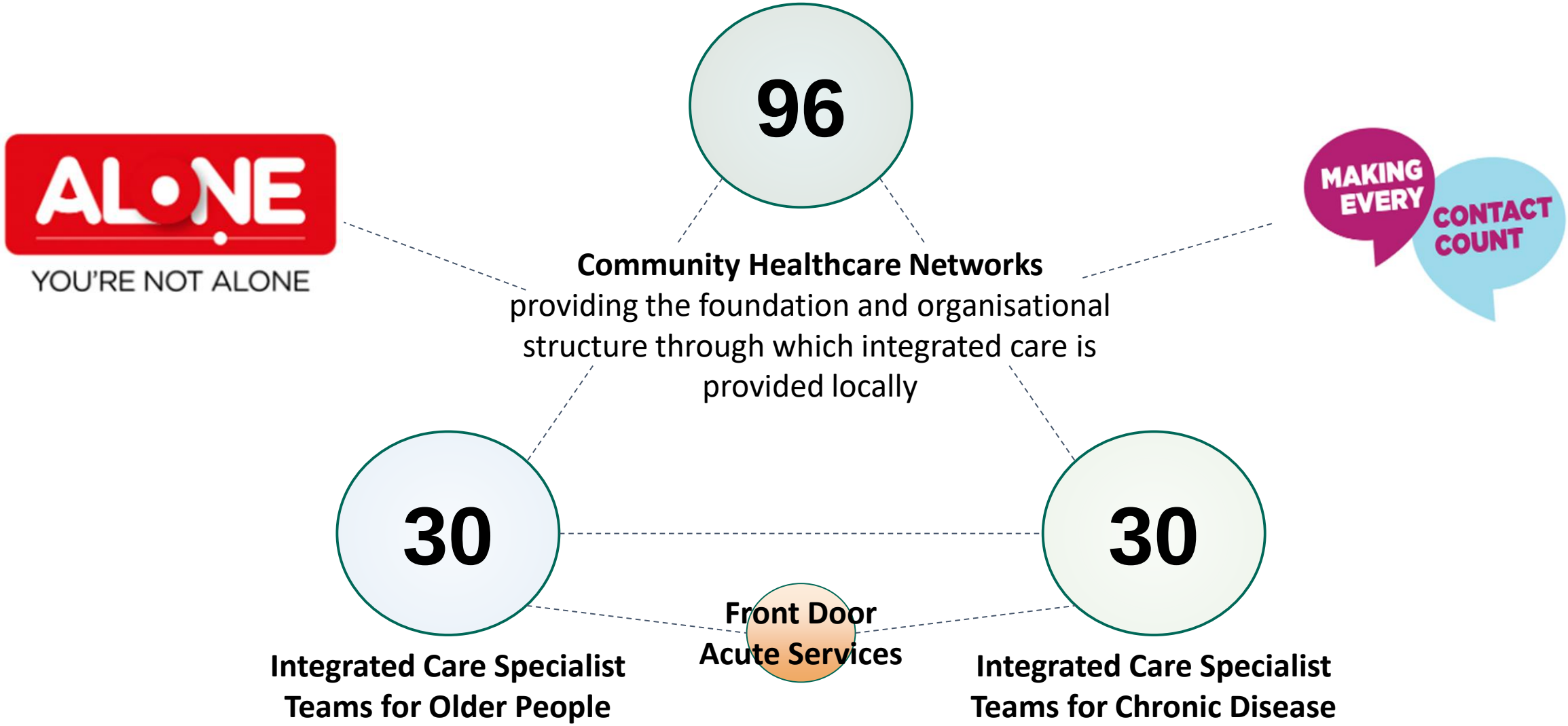
David Hanlon, National Clinical Advisor Primary Care
Alice McGinley, CHN Implementation Lead

Thursday, 1st September 2022

ECC Programme Principles

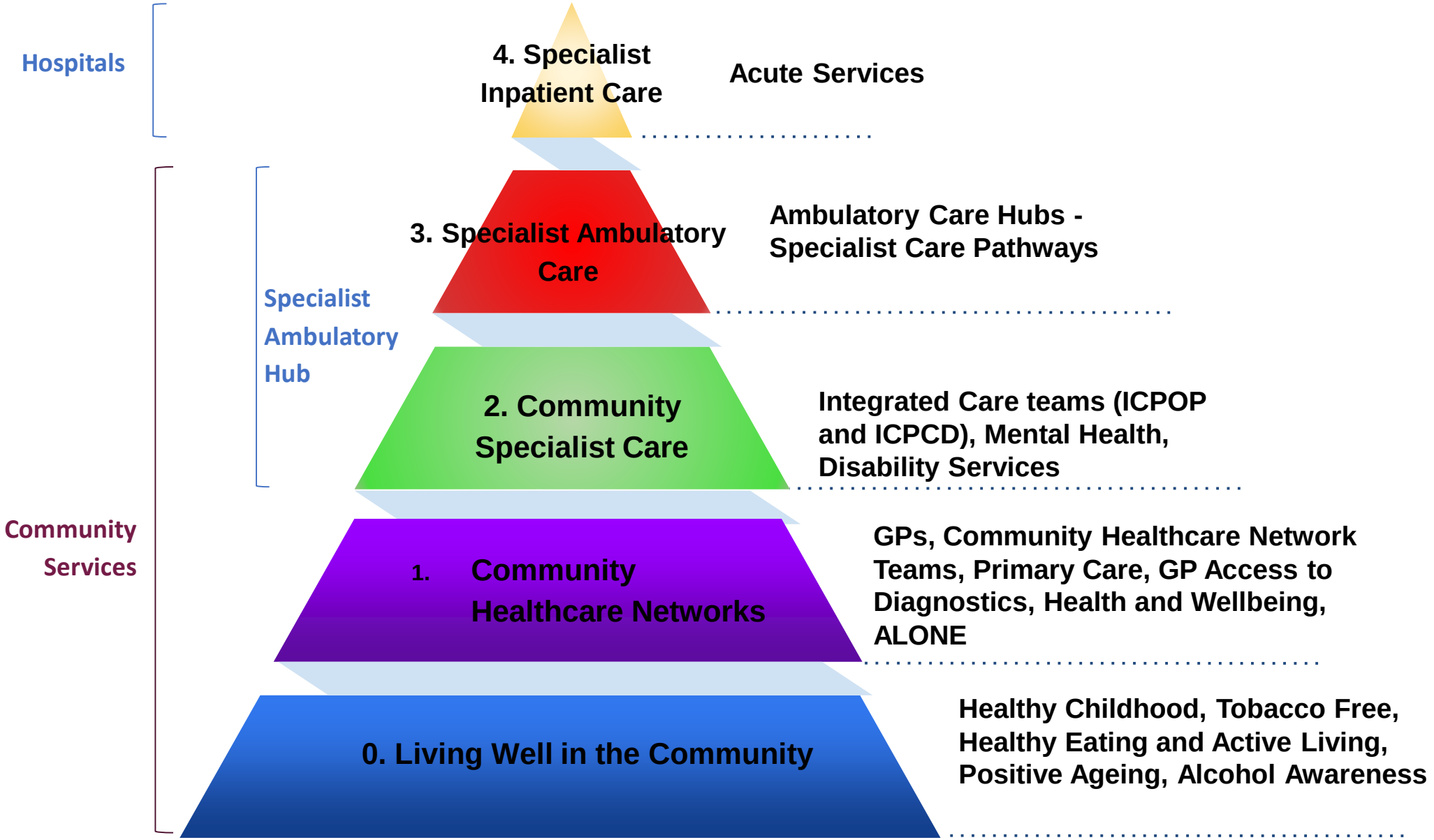
- Keep people well in their own homes
- Provide services on a population basis
- Provide primary care and GP services in the community
- Link with other community services, voluntary and statutory bodies
- Develop and provide access to specialist services in the community to targeted groups
- Ensure that discharge from acute hospitals is coordinated
- End to end model approach enables the implementation of integrated care programmes
- Apply resources intensively in a targeted manner to a defined population

The ECC Model



ECC Programme

Levels of Care



Role of the General Practitioner in ECC

GP Contractual Reform 2019

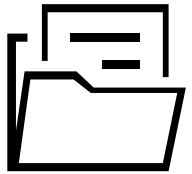
GP Contractual Reform 2019

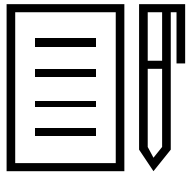
GP Access to Community Diagnostics

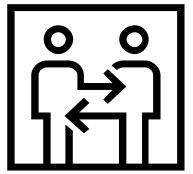
Attendance at Clinical Team Meetings

Lead Role in CHN Management Structure

Chronic Disease Management





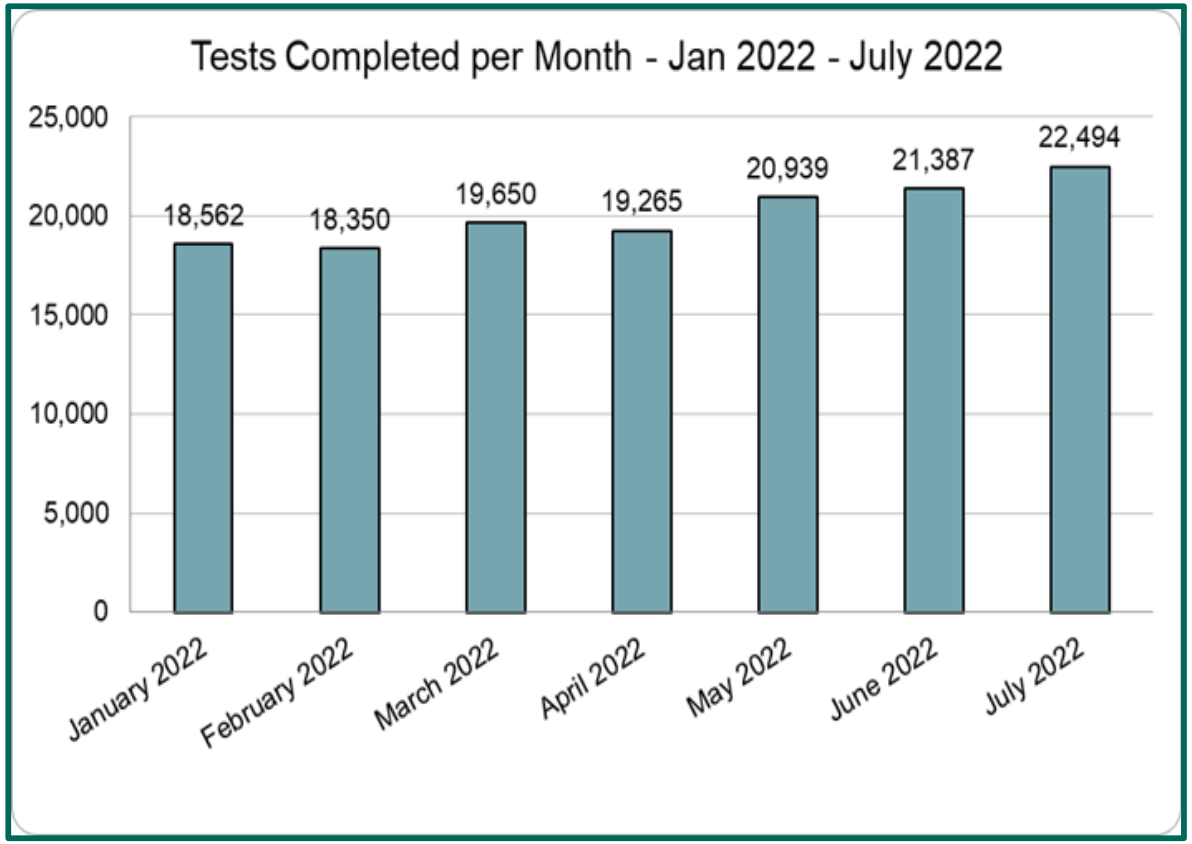


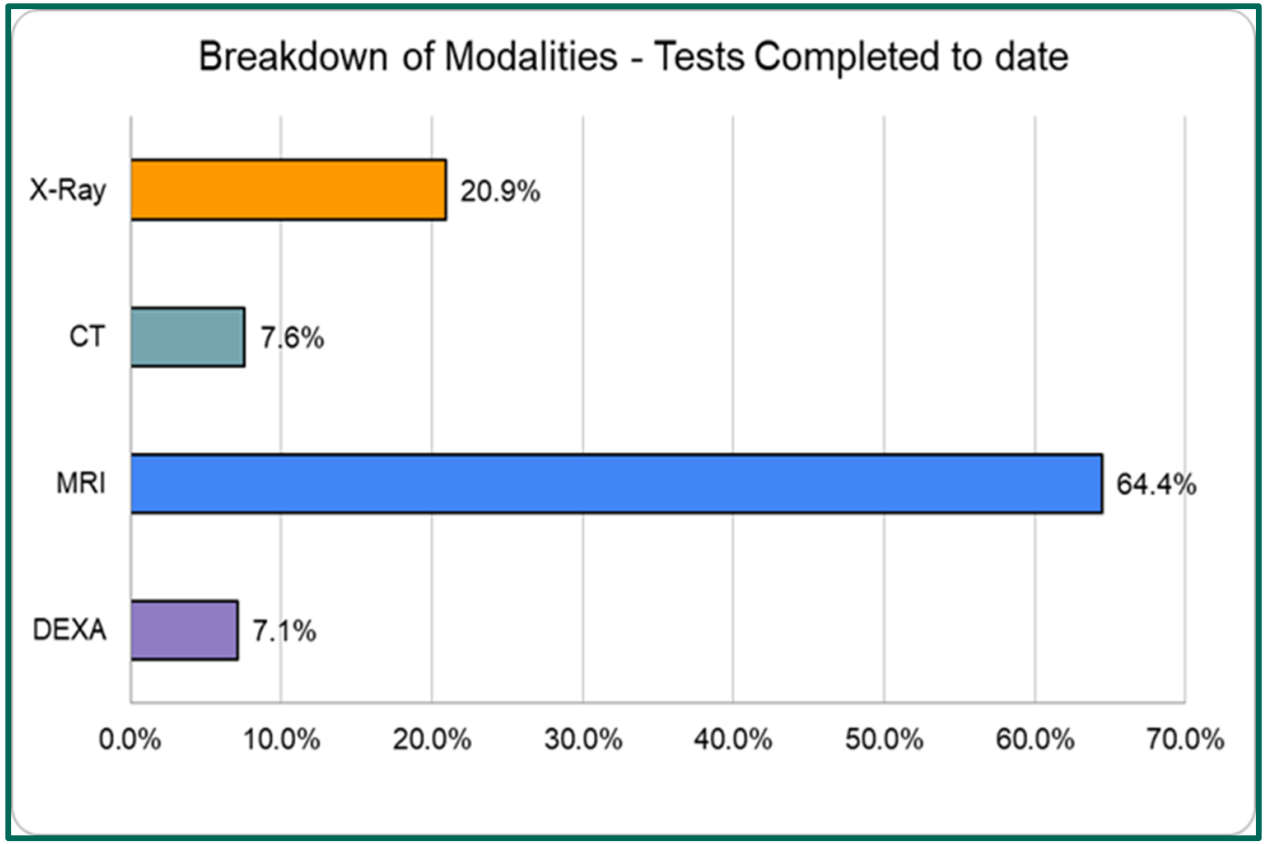
c.2,500 GPs signed

300,000 reviews in past 12 months

GP Access to Community Diagnostics: A Key Enabler

- **In 2021, Community Diagnostics facilitated + 139,000 scans**
- **To date in 2022, 140,647 radiology tests were reported as completed between January and July 2022**





GP Access to Community Diagnostics: Impact

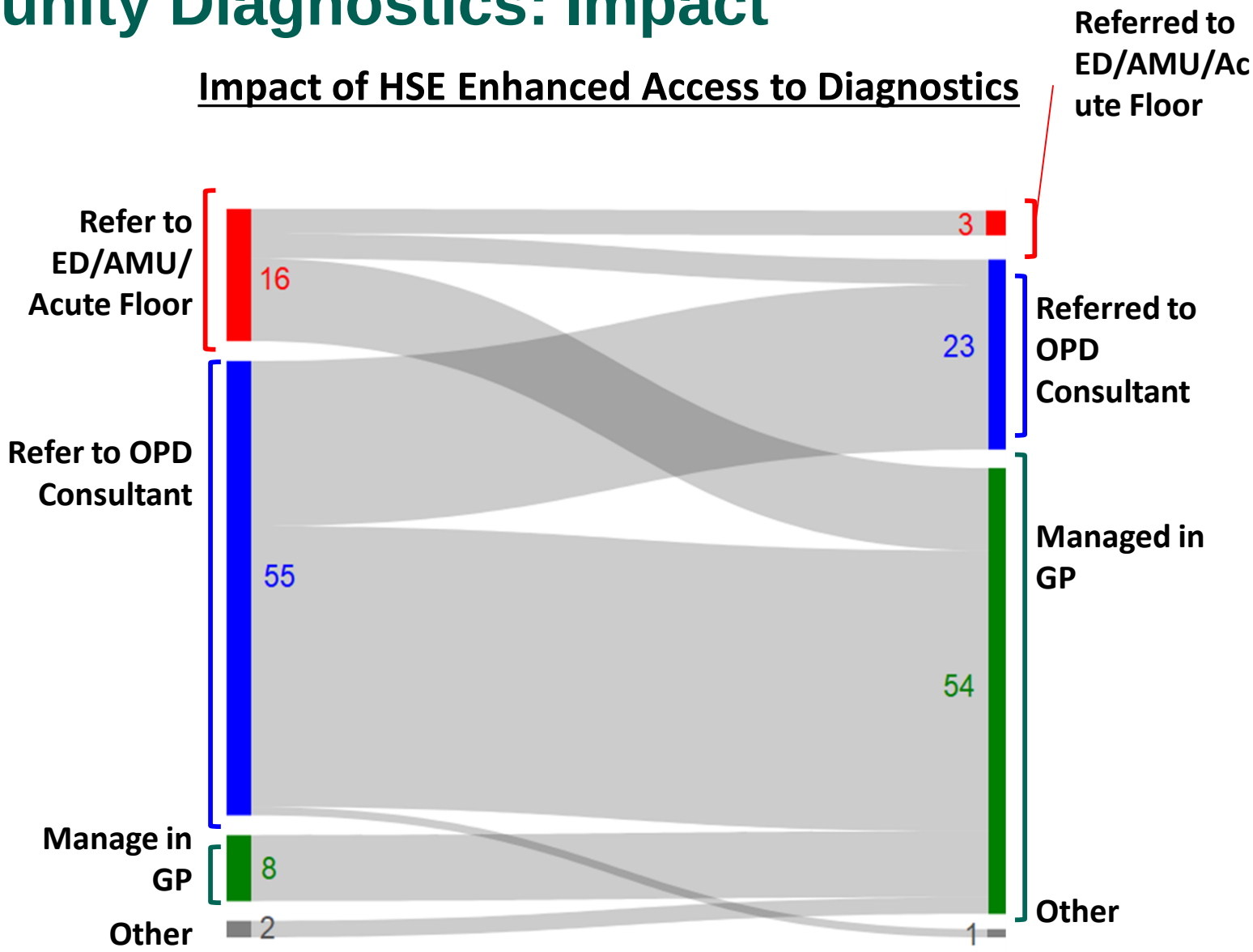
Review of 81 imaging studies arranged by GPs in 2021 highlighted the impact of timely access to diagnostics:

86% of GPs reported that the initiative improved patient care

81% reduction in referrals to Emergency Departments / Acute Medical Units

58% reduction in referrals to outpatient clinics / consultants

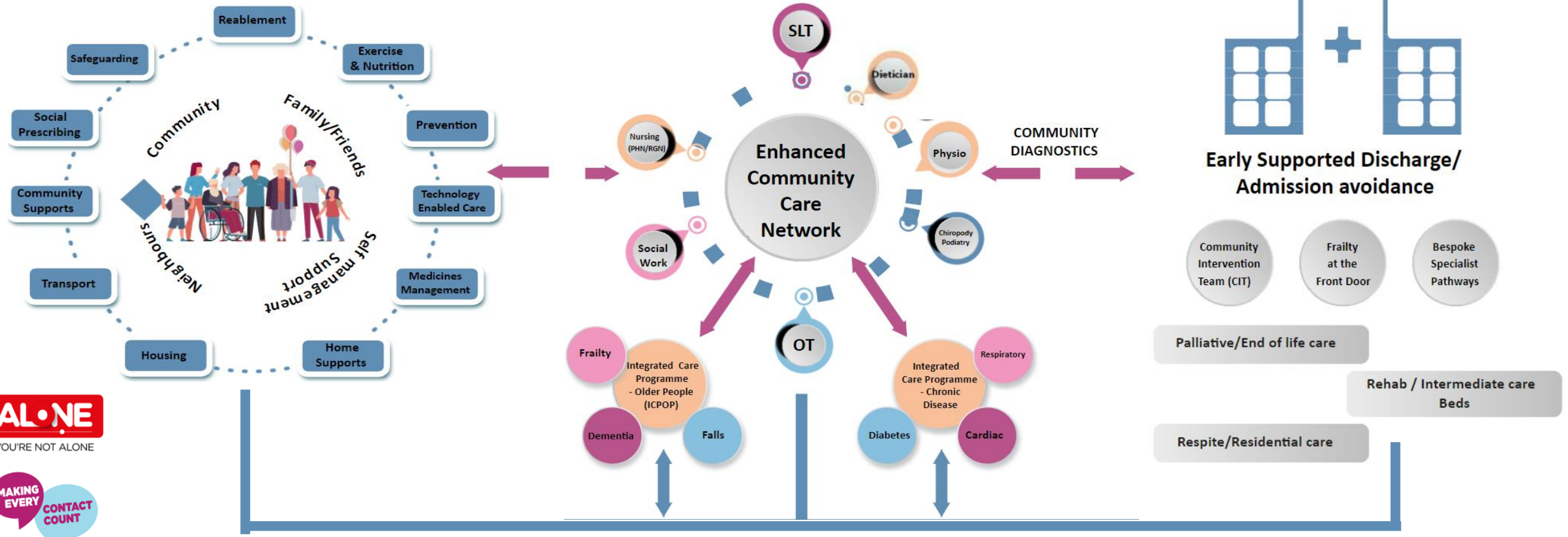
Impact of HSE Enhanced Access to Diagnostics



*This Graph shows **on the left what would have happened** without access to diagnostics*
***The right side shows what happened** due to enhanced community access to diagnostics*

Enhanced Community Care – Home First

Shift left of Resources & Activity



ALONE
YOU'RE NOT ALONE

MAKING EVERY CONTACT COUNT

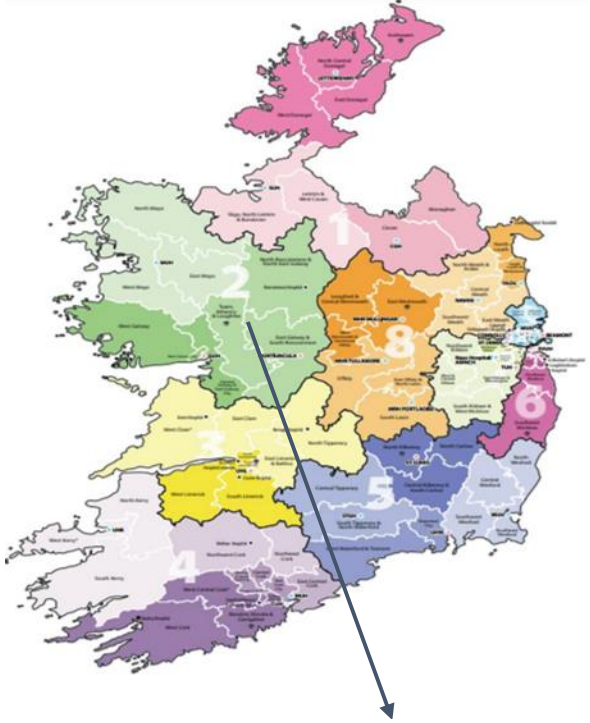
LIVING WELL AT HOME — ENHANCED COMMUNITY CARE - CHNS - ICPOP - CDM — ACUTE CARE

Mapping Example: CHO2

Mapping has been completed for the 96 CHNs

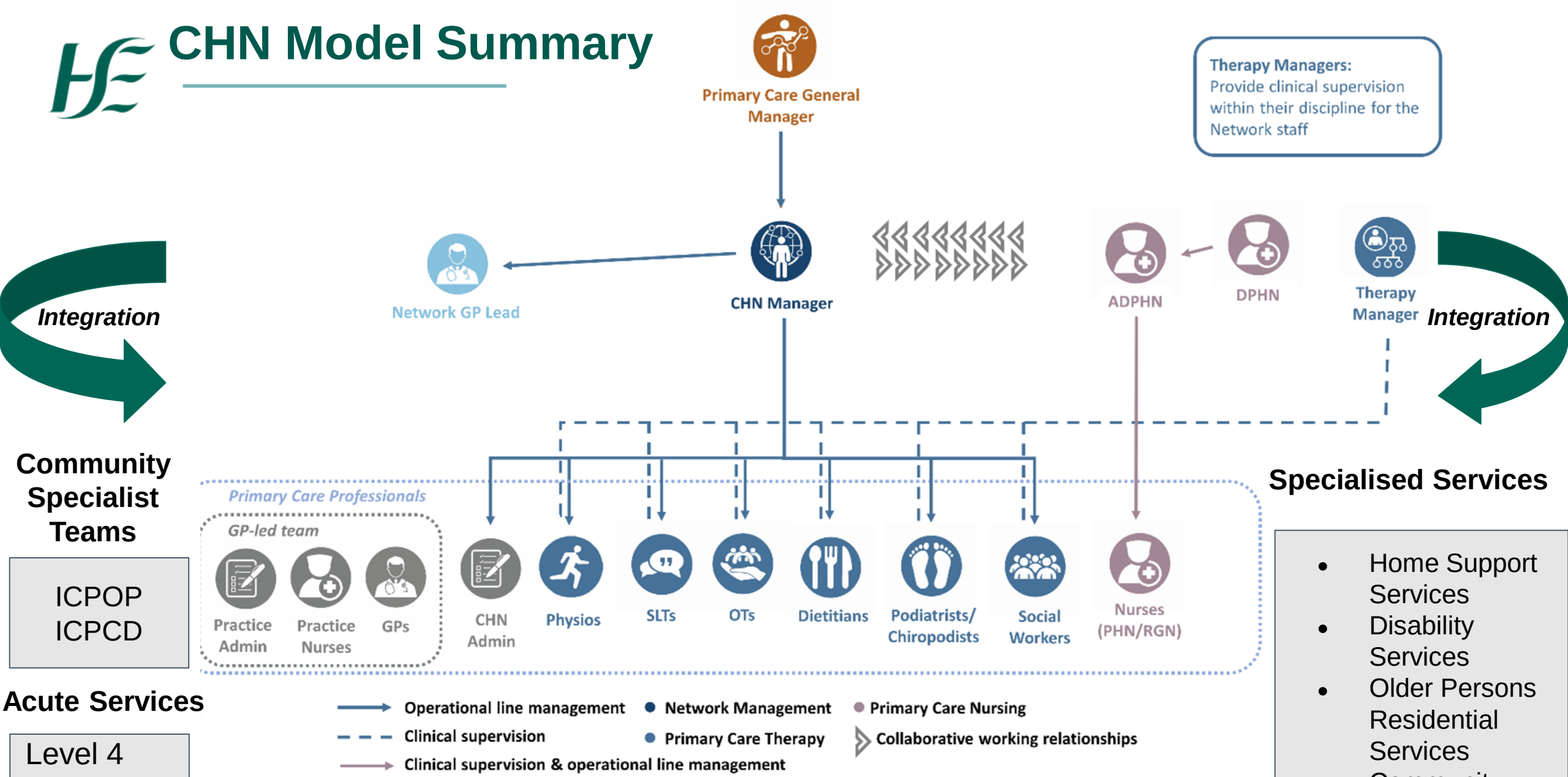
Community Specialist Teams serving populations of 150,000, equating on average to 3 CHNs

Chronic Disease and Older Persons Community Specialist Teams ideally collocated, aligned to acute hospitals, with services being provided to local communities



CHO	ECC Networks		CHN Population Source: CSO Census 2016	CST Population	Aligned Acute Hospital
CHO 2	1	North Mayo	46,516	130,507	Mayo University Hospital (Castlebar)
	2	East Mayo	49,031		
	3	West Mayo	34,960		
	4	West Galway	38,532	163,942	Team 1 University Hospital Galway
	5	West Galway City	57,110		
	6	Central Galway and East Galway City	68,300		
	7	Tuam, Athenry, and Loughrea	55,350	158,660	Team 2 University Hospital Galway
	8	East Galway and South Roscommon	49,259		
	9	North Roscommon and North East Galway	54,051		

CHN Model Summary



Community Specialist Teams

ICPOP
ICPCD

Acute Services

Level 4
Level 3
Level 2

Specialised Services

- Home Support Services
- Disability Services
- Older Persons Residential Services
- Community Mental Health

CHN Model Implementation in Operation

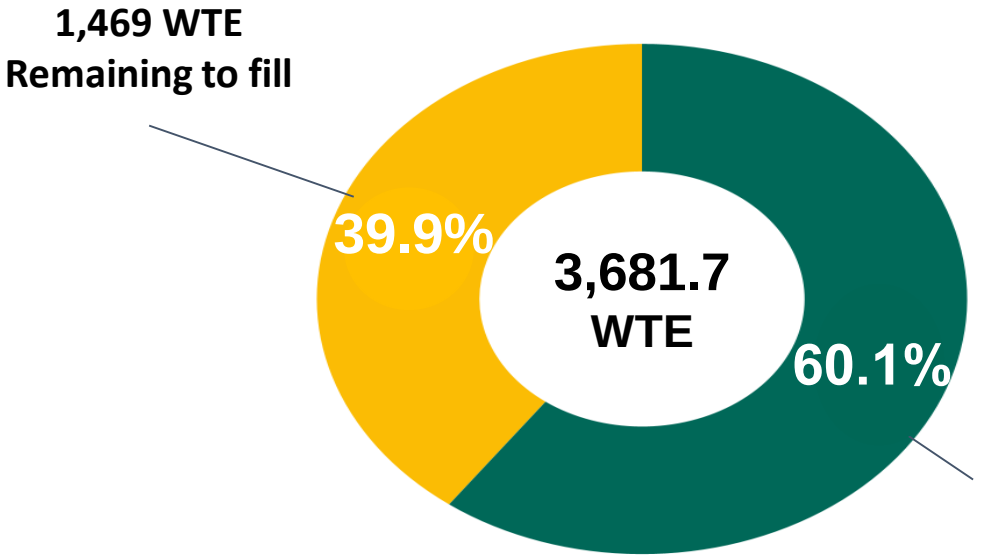
1	CHN Manager Role: Providing multidisciplinary management in the network.	✓
2	GP Lead Role: Supporting development and maintenance of relationships between GPs and Primary Care Professionals	✓
3	ADPHN Role: Supporting Community Nursing by working collaboratively with CHN manager and other colleagues	✓
4	Network Management Team and Clinical Team meetings operational	✓
5	Therapy Manager Role: Providing Clinical Supervision and Professional Governance arrangements	✓
6	Clinical Coordinator & Key Worker Role: Facilitate multidisciplinary working	✓
7	New development posts will provide additionality to existing resources within the CHNs	✓
8	Linkages in place with ALONE Health Promotion and Improvement Officers active in CHNs	✓

ECC Programme - *Progress to date as at 26th July 2022*

ECC Teams Status

Team	Teams Target	Teams In place
CHN	96	87
CST ICPOP	30	21
CST ICPCD	30	14
CIT	21 - Full National Coverage	

Recruitment



2,213 WTE
Onboarded / At an Advanced Stage*

Target: 3,681.7WTE
(*includes Community Diagnostics*)

* At an advanced stage of recruitment - the status of the post is either one of the following: a) Post at Offer Stage b) Post Accepted, or c) Recruitment Complete

ECC Teams Status by CHO

ECC Implementation - Progress per CHO

	Number of Teams					
	CHNs		ICPOP		ICPCD	
CHO	*Target*	*Actual*	*Target*	*Actual*	*Target*	*Actual*
CHO1	8	8	3	3	3	3
CHO2	9	8	3	2	3	3
CHO3	8	6	2	2	2	1
CHO4	14	14	4	3	4	1
CHO5	11	8	4	3	4	2
CHO6	8	7	2	1	2	2
CHO7	14	14	4	2	4	2
CHO8	12	12	4	1	4	0
CHO9	12	10	4	4	4	0
Total	**96**	**87**	**30**	**21**	**30**	**14**

Other Key Deliverables

- Health & Wellbeing services: **1 Health Promotion and Improvement (HP&I) Officer** allocated to each CHN
- The community and voluntary **ALONE type model** will enable coordination of voluntary and community supports and will be rolled out across each CHN.
- **Dementia Advisors** providing country wide cover being implemented in conjunction with Alzheimer's Society of Ireland
- Full alignment with the GP Agreement 2019 including **€80m for CDM in General Practice**
- **Community Diagnostics** Programme being successfully rolled out - **€26m budget**

CHNs: Key Enablers and Standardisation of Processes

Evaluation and Learnings

Population Health Profiling

Centralised Referrals

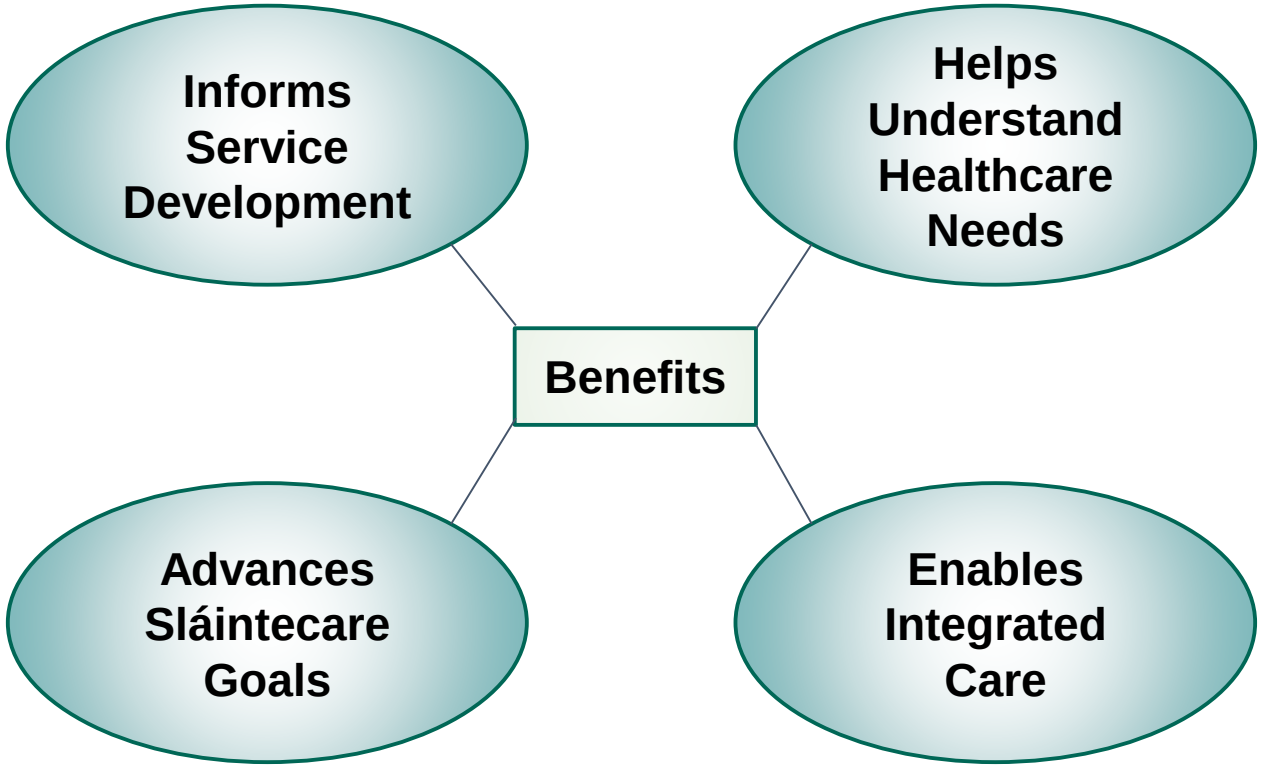
Population Segmentation

Experience of implementing processes

CHN Integrated Case Management

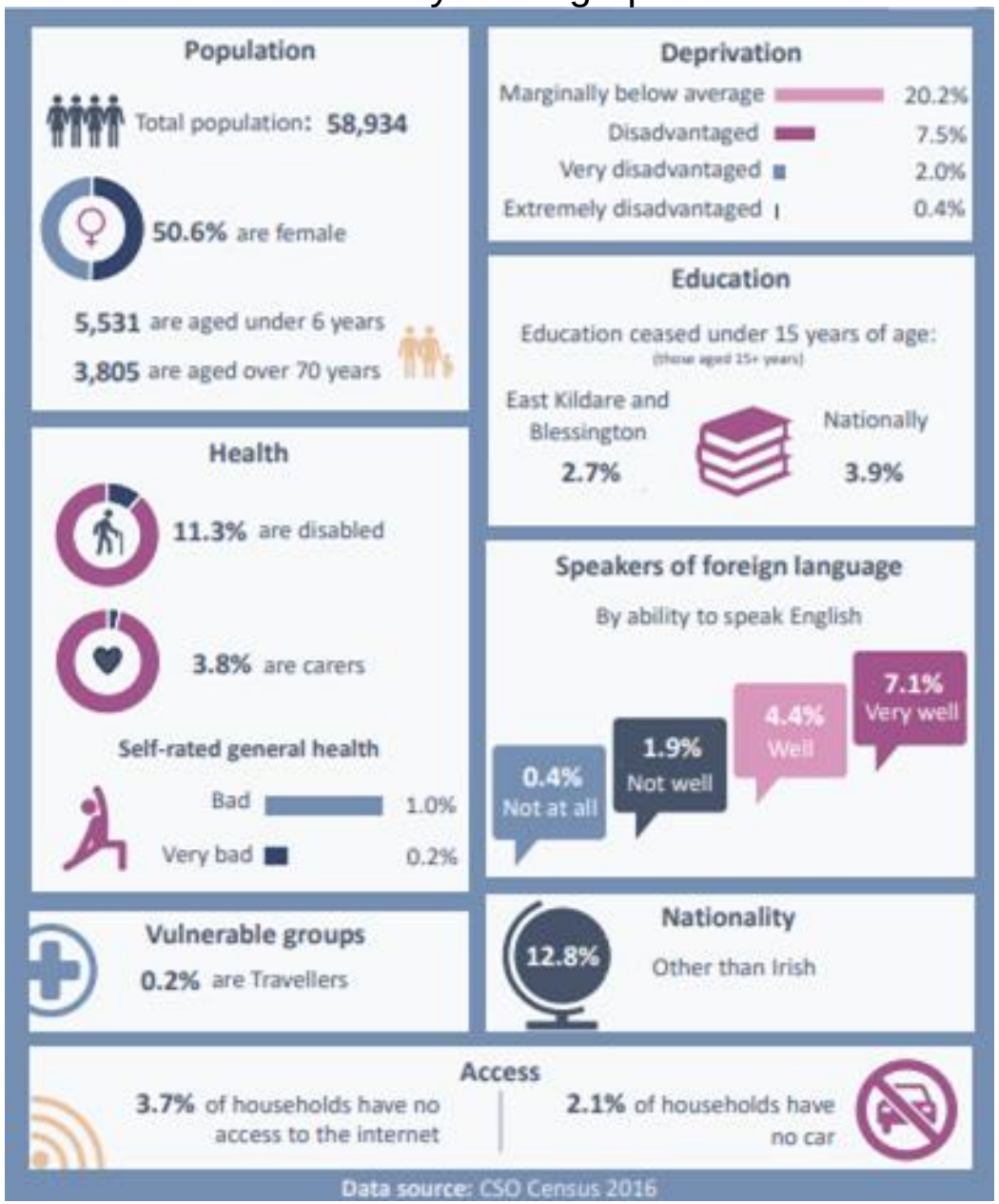
Population Health Profiling

Population health profiling is the collection of relevant information about your service users



96 CHN Population Health profiles are available at: https://www.hseland.ie/dash/Hub

East Kildare and Blessington
Summary Demographics



Enablers: Centralised Referrals Process

Centralised Referrals Process as an enabler for CHN implementation:

- **Centralised referrals**
- **Single point of contact**

ICT Solution

- **Electronic Referral System (Interim)**
- **Integrated Community Case Management System (Long-Term)**

- **Single Referral Template for all types of referrals**

- **Complex case discussion**
- **Clinical Team Meeting**

CHN Communications and Engagement - Ongoing Focus

1. **Support the ECC programme roll-out with two-way communications**
2. **Keep our staff and teams informed of progress, learning and engagement**
3. **Ensure patients and families have services they can access**
4. **Keep the public informed on progress through advocates, partners and public representatives**

CÚRAM SLÁINTE POBAIL
CORCAIGH CIARRAÍ
CORK KERRY
COMMUNITY HEALTHCARE

Enhanced Community Care (ECC)

ECC Conference:
Enhanced Community Care Initiative
Proof of Concept

Priscilla Lynch, Head of Primary Care, Cork Kerry Community Healthcare
Mari O'Donovan, CHN Manager Network 8
Dr John Sheehan, GP Lead Network 8

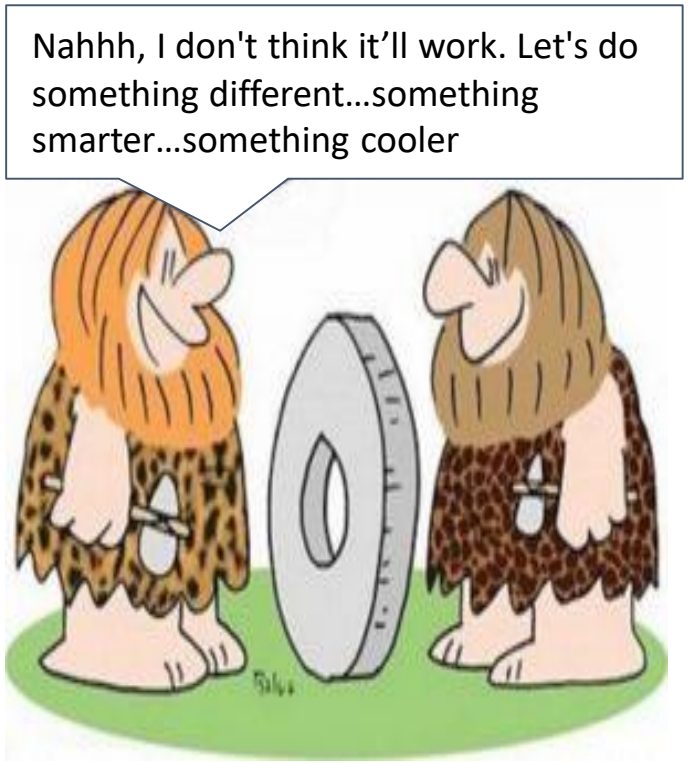
Thursday, 1st September 2022

Concept of the Program

Focused approach to population segmentation with 6 CHNs in Cork adjacent to CUH / MUH

Project Goal

Demonstrate a way of working with Community Healthcare Network Teams that will result in a reduction in the number of preventable, unplanned attendances at the Emergency Department.

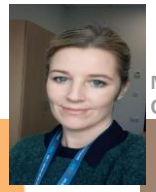


The key to ensuring the success of this initiative is continuing to work on the trusted relationships built with the GPs to develop & enable pathways for their patients in partnership with the Network Managers to utilise all of the great services available.

Community Healthcare Networks & Managers

Miriam O'Sullivan
CHN 1

1 - Listowel, Castleisland (pop. 46, 371)



Martina Corkery
CHN 9

9 -Blarney, Sunday's Well, City Centre, Farranree, Gurranabraher, Knocknaheeny (pop. 50, 257)

Niamh Lordan
CHN 4

4 Charleville, Buttevant, Kanturk, Mallow, Millstreet, Newmarket (pop. 60,382)

Ina McGrath
CHN 2

2 - Tralee, Dingle (pop 43,000)

Claire McSweeney
CHN 3

3 - Iveragh, Kenmare, Sneem, Killorglin, Killarney (pop. 56, 326)

Emer Shanley
CHN 10

10 - West Cork (pop. 59,444)

Claire McCarthy
CHN 12

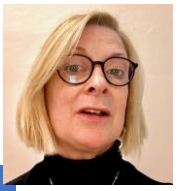
12 - Ballincollig, Bishopstown, Macroom (pop. 66, 943)

13 - Bandon, Kinsale, Carrigaline, Passage West (pop 64, 644)

Deirdre Cullen
CHN 13/Learning Site

Colette McSweeney
CHN 14

14 - Turners Cross, Grange, Frankfield, Togher, Ballyphe, Greenmount, The Lough (pop. 42, 206)

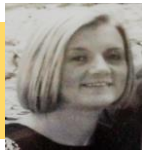


Claire 'Donovan
CHN 5

5 - Castlelyons, Fermoy, Mitchelstown (pop. 32, 3444)

Mari O'Donovan
CHN 8

8 -Mayfield, Montenotte, Tivoli, The Glen,Blackpool, Carrignavar, St. Patricks(pop.32,059)



Michelle Kiely
CHN 6

6 - Midleton, Youghal (pop. 45, 441)

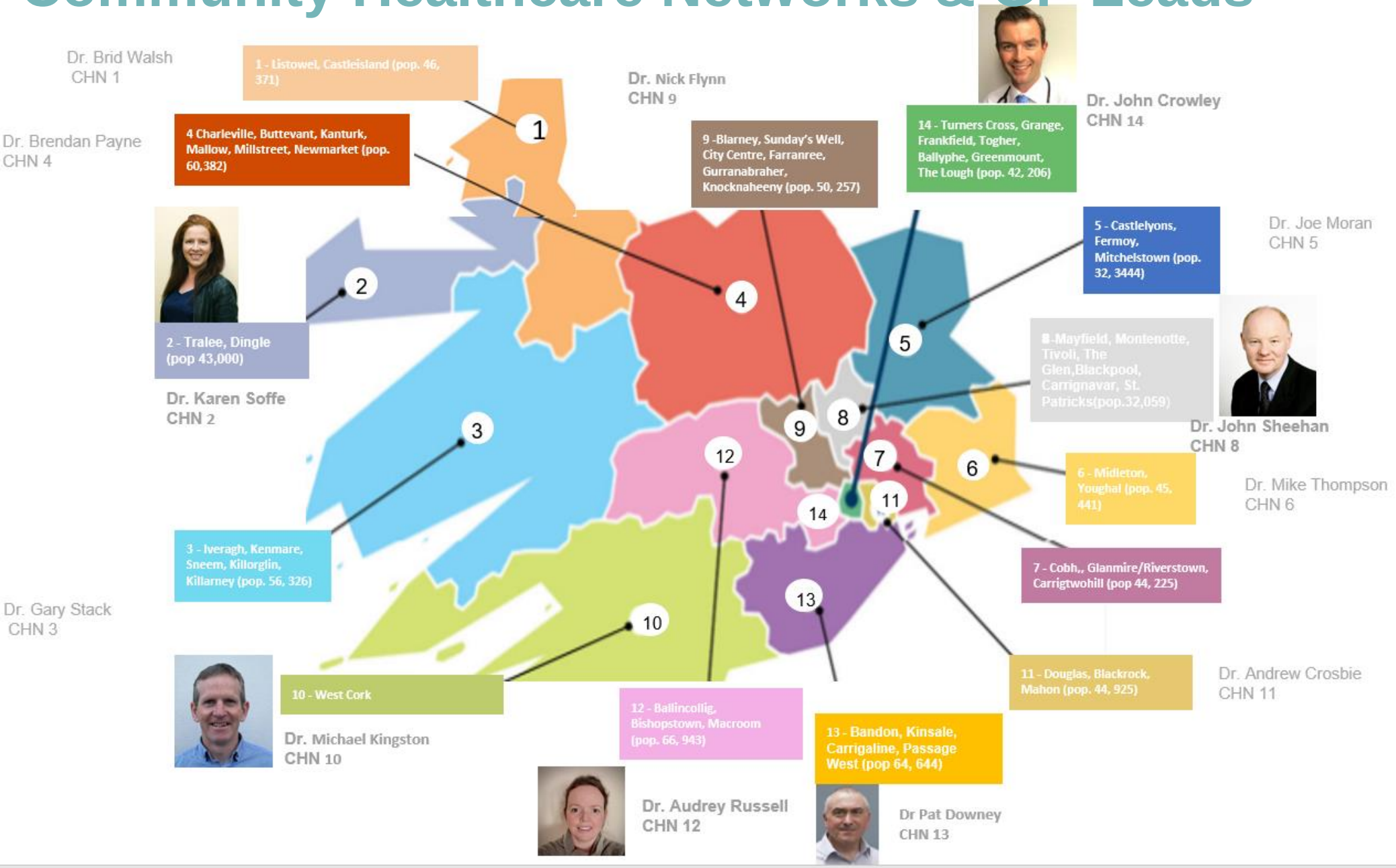
Judith Purkiss
CHN 7

7 - Cobh,Glanmire/Riverstown, Carrigtwohill (pop 44, 225)

11 - Douglas, Blackrock, Mahon (pop. 44, 925)

Breda O'Donovan
CHN 11

Community Healthcare Networks & GP Leads



CHN Integrated Case Management: Proof of Concept

CHN Integrated Case Management: Proof of Concept

Engaging GPs:
Integrating Care for Patients with Particular Focus on Avoidance of ED Attendance

Leveraging **ECC & GP Agreement 2019**, GPs in each CHN proactively identify patients likely to have a **preventable, unplanned attendance at the ED**.

Objective: Provide a **safe alternative** to attending ED by maintaining people in their homes through **prevention and interventions**, including **Community Specialist Teams** where appropriate

GPs, based on their **clinical judgment**, are requested to **identify 5 Patients** who through this early intervention, may be prevented from unplanned attendance in the ED and / or receive targeted intervention from services.

Subgroups from Proof of Concept

Comms

- GPs
- Primary Care
- Acute Services Posters, Handbook, YouTube videos of staff

KPIs

Qualitative and quantitative

Mapping

End to end Process mapping

Pathways

- Primary Care,
- Acute Services,
- CIT,
- CSTs (ICPOP & ICPCD)
- Respite, Home Support,
- Community/ Vol sectors

ICT

- HealthLink,
- Patient Tracker &
- IPMS

Proof of Concept: CKCH Networks 8, 9, 11, 12, 13, 14

Network Area	Area Information		Contacting GPs			Nominating Patients				
	No. of GPs	No. of Practices	Phone Calls Recorded	Practices Contacted	Practices Contacted (%)	Patient Nominations	Practices w/Patients Nominated	Practices w/Patients Nominated (%)	Outstanding Practices w/Appointment Scheduled	Outstanding Practices w/Appointment Scheduled (%)
Bandon/Carigaline/Kinsale	43	17	86	16	94%	19	7	41%	8	47%
Central Cork	22	11	136	11	100%	20	7	64%	2	18%
North Cork City and Blarney	32	15	138	12	80%	23	7	47%	4	27%
South Cork City	27	11	129	11	100%	35	10	91%	0	0%
Southeast Cork City	31	12	51	12	100%	24	7	58%	5	42%
West Central Cork	49	21	239	21	100%	68	15	71%	1	5%
Total	204	87	779	83	96%	189	53	62%	20	23%

Proof of Concept: Story so far…

c.300k
Population included in the 6 participating CHNs

204 GPs
(in 87 practices)
In the 6 PoC CHNs

62% Practices have nominated patients for discussion

189
Patients have been nominated for discussion

c.5%
of referrals received were unknown to the service

96%
Of patients referred were aged >65

34%
Of patients referred were aged >85

Proof of Concept: Examples of Patient Experience

- ✓ **Proof of Concept: Integration and collaboration between services**
- ✓ **Young Chronic Sick – Self Management of Care**
- ✓ **Capacity and Advocating for Service Users**
- ✓ **On-site Clinical Team Meeting – value to Service User and Health Services**

Proof of Concept: Benefits

Before:

- Varied levels of
  - **GP awareness** regarding available services
  - **GP engagement** at clinical team meetings
- **No feedback** provided to GPs on Primary Care services
- **Multiple referral forms** required for different disciplines

After:

- **Educational sessions** being progressed with GPs about Primary Care services and pathways
- **CHN Clinical Teams enhancing collaboration with GPs**
- **Plan of Action** circulated to GPs who nominate patients
- **Single Referral Form** in development to further reduce the administrative burden

Embedding CHN Integrated Case Management

01 Time efficient CTMs chaired by Clinical Coordinators

02 GP Engagement

03 Central Point of Contact for each CHN

04 Central Point of Referral in time

05 Patients being triaged and interventions applied based on need

06 Plan of Actions – generated from CTM & circulated to GPs & Primary Care team

07 Better integration and collaboration between services (GPs, Primary Care, Mental Health, Community work Dept, Voluntary Org)

08 Appointment of Social Prescribers & Social Workers progressing

09 Better Service User engagement and care at home