Setting the context;

Challenges to implementing Integrated Care for older persons in Ireland

Mr. PJ Harnett (MBS, MSc, RMN), National Programme Manager, Integrated Care Programme, Older Persons

8.5.17
Figure 1.1.1 Irish Health System: Inflection point and consequences

- Self-sustaining improvements
- Simultaneous improvements in quality access and cost
- Safety and quality catastrophe, higher costs, damaged reputation

Inflection Point

[Graph showing data from 2011 to 2022 with different age groups (65-69, 70-74, 75-79, 80-84) and markers indicating inflection points and trends.]
- 4% of older people in NH
- 5% in receipt of HCP
- Majority live independent lives
PROPORTION RATING HEALTH AS GOOD/VERY GOOD

TOTAL
84%

BY AGE
15-24 year olds: 93%
25-34 year olds: 91%
35-44 year olds: 90%
45-54 year olds: 82%
55-64 year olds: 78%
65-74 year olds: 71%
75+ year olds: 58%

PROPORTION WITH POSITIVE MENTAL HEALTH
(% with an EVI score equal to or over one standard deviation of the mean)

Total 13%
15-24 year olds: 20%
25-34 year olds: 17%
35-44 year olds: 14%
45-54 year olds: 14%
55-64 year olds: 14%
65-74 year olds: 15%
75+ year olds: 10%

PROPORTION WITH NEGATIVE MENTAL HEALTH
(% with a MHI-5 score of 56 or lower)
5 Integrated Care Programmes

These five areas will allow us to tackle the most pressing challenges in our health and social care systems, and improve outcomes and experiences for the greatest number of patients.

ICP for Prevention and Management of Chronic Disease

ICP for Older Persons

ICP for Patient Flow

ICP for Children

ICP for Maternity (on hold)
Aims and Objectives of the Programme

The aim of the Integrated Care Programme for Older Persons is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care.
Typical team

Consultant Geriatrician
2 X Case managers
2 X AHP
1 X Admin

Catchment area
(50-100K)
## Risk Stratification Based on Frailty Prevalence Data From Wave 1 of TILDA

<table>
<thead>
<tr>
<th>Risk</th>
<th>Minimal risk</th>
<th>At risk</th>
<th>High risk</th>
<th>Very High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frailty State</td>
<td>Fit (Non-frail)</td>
<td>Mild frailty (Pre-frail)</td>
<td>Moderate Frailty (Frail)</td>
<td>Severe Frailty (Frail)</td>
</tr>
<tr>
<td><strong>Age ≥50 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% (n)</td>
<td>60.7 (4,963)</td>
<td>25.4 (2,080)</td>
<td>10.0 (814)</td>
<td>3.9 (318)</td>
</tr>
<tr>
<td>†% (95% CI)</td>
<td>59.8 (58.5-61.0)</td>
<td>25.4 (24.4-26.3)</td>
<td>10.4 (9.6-11.1)</td>
<td>4.0 (5.0-6.1)</td>
</tr>
<tr>
<td><strong>Age ≥65 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% (n)</td>
<td>44.3 (1,555)</td>
<td>33.3 (1,168)</td>
<td>15.6 (546)</td>
<td>6.9 (242)</td>
</tr>
<tr>
<td>†% (95% CI)</td>
<td>42.1 (40.2-44.0)</td>
<td>33.0 (31.4-34.7)</td>
<td>16.5 (15.1-17.9)</td>
<td>8.3 (7.2-9.5)</td>
</tr>
<tr>
<td><strong>Age ≥75 years</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% (n)</td>
<td>31.8 (430)</td>
<td>36.4 (495)</td>
<td>20.5 (277)</td>
<td>11.3 (153)</td>
</tr>
<tr>
<td>†% (95% CI)</td>
<td>30.1 (27.4-32.8)</td>
<td>35.6 (32.9-38.3)</td>
<td>21.0 (18.7-23.4)</td>
<td>13.2 (11.1-15.4)</td>
</tr>
</tbody>
</table>

* Frailty Index (FI) score cut-offs from study of 516,000 individuals aged 65-95 in UK (Clegg et al. Age Ageing 2016)
† Weighted prevalence estimates with 95% Confidence Intervals.
Older persons: some key Irish statistics

**NEED**

2011 – 2026

>65 yrs population  \(\uparrow\) +60%

>85 yrs population  \(\uparrow\) +100%

(Source: CSO)

**LIFE EXPECTANCY 1993 - 2013**

>75 yrs increase  \(\uparrow\) +29%

>75 yrs increase  \(\uparrow\) +39%

75 female
75 male

(Source: Eurostat 2014)

**INPATIENT DISCHARGES 2015 - 2021**

>75 yrs will increase  \(\uparrow\) +28%

(Source: HIPE)

**ACCESS**

**ADMISSION RATE**

>75 yrs  48%

>95 yrs  64%

(Source: SDU 2016)

**PET TIMES**

PET times increase with age.

30-50% of all 24 Hr breaches are >75yrs (BIU 2016).

**DEMENTIA IN IRELAND**

50k with dementia

4k new cases every year

100k cases by 2026 (Source: ICGP 2014)

**RESOURCE**

**NHSS** - €940 net

Home Care
16,750 HCP
10.5m HH Hours
130 iHCP

€373 million

**TRANSITIONAL CARE FUNDING**

7,342 approvals (2016)
(152/week Avg)

All acute hospitals

**PUBLIC BEDS (LONG STAY & SHORT STAY)**

5,088 LS
1,918 SS

(Source: SCD Operational Plan 2017)
<table>
<thead>
<tr>
<th>Metric</th>
<th>Age band</th>
<th>2016</th>
<th>2021</th>
<th>2026</th>
<th>% increase to 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>75-79</td>
<td>112,245</td>
<td>139,500</td>
<td>171,555</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>80-84</td>
<td>78,663</td>
<td>90,093</td>
<td>114,951</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>85-90</td>
<td>45,101</td>
<td>53,578</td>
<td>63,888</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>90+</td>
<td>24,772</td>
<td>31,462</td>
<td>40,206</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>Total 75+</td>
<td>260,751</td>
<td>314,633</td>
<td>390,800</td>
<td>50%</td>
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<tr>
<td><strong>Expected ED attendance</strong></td>
<td>75-79</td>
<td>49,563</td>
<td>61,360</td>
<td>75,935</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>80-84</td>
<td>44,341</td>
<td>50,850</td>
<td>64,669</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>85-90</td>
<td>30,519</td>
<td>36,278</td>
<td>43,284</td>
<td>42%</td>
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<tr>
<td></td>
<td>90+</td>
<td>15,547</td>
<td>19,545</td>
<td>24,933</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Total 75+</td>
<td>139,880</td>
<td>168,033</td>
<td>208,852</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Expected ED admissions</strong></td>
<td>75-79</td>
<td>25,588</td>
<td>31,643</td>
<td>39,218</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>80-84</td>
<td>24,739</td>
<td>28,379</td>
<td>36,074</td>
<td>46%</td>
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<tr>
<td></td>
<td>85-90</td>
<td>18,286</td>
<td>21,741</td>
<td>25,951</td>
<td>42%</td>
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<tr>
<td></td>
<td>90+</td>
<td>9,976</td>
<td>12,630</td>
<td>16,121</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>Total 75+</td>
<td>78,588</td>
<td>94,393</td>
<td>117,363</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Expected BDUs</strong></td>
<td>75-79</td>
<td>236,973</td>
<td>292,502</td>
<td>363,418</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>80-84</td>
<td>259,508</td>
<td>297,851</td>
<td>378,028</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>85-90</td>
<td>214,082</td>
<td>254,605</td>
<td>304,094</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>90+</td>
<td>122,381</td>
<td>154,804</td>
<td>197,495</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Total 75+</td>
<td>832,943</td>
<td>999,762</td>
<td>1,243,035</td>
<td>49%</td>
</tr>
</tbody>
</table>
Funding required to match population growth.

**HOMECARE FUNDING RATES €M ACTUAL VS IF FUNDING WAS MAINTAINED IN LINE WITH OVER 65 POPULATION INCREASES FROM 2011**

- **Over 65 Population '000 (based on HSE Planning for Health Document 2016)**
- **Home Care Total - Actual €m**
- **Home Care Funding from 2011 if maintained in line with annual population increase €m**

**Notes:**
- HCP Funding figure includes €27m of funding which was utilised by Primary Care since 2008
- 2016-2017 HCP funding includes €3m Atlantic Philanthropies funding for IHCP
POSITIVE AGEING – STARTS NOW!

THE NATIONAL POSITIVE AGEING STRATEGY

An Roinn Sláinte
DEPARTMENT OF HEALTH

Department of Health
Statement of Strategy
2016 – 2019

Ireland:
A great country in which to grow old

Age Friendly Ireland’s Statement of Strategy
2015 - 2017
Towards 2026
A Future Direction for Irish Healthcare

Recommendations

1. Healthcare is about me
   A truly patient-centred system
   The future health system must put patients and people at its centre in a meaningful way.
   This means listening to the patient voice in the planning, design and implementation of services; supporting open and honest public debate on how services are provided; and building a sense of partnership between the people who use services and those who provide them.
   "If older people are afraid of going to hospitals then the services are wrong and they need to change."
   (Patient and carer forum, Towards 2026)
   It also means understanding population need and the needs of groups with specific vulnerabilities, and designing services to respond to that need. In the coming years this will mean a particular focus on the needs of an increasing population of older people.
   We must champion the fundamental principle that the healthcare system is owned by the patient and is accountable to the people it serves.

2. Keeping people well
   Stemming the tide of preventable health conditions
   Unless action is taken to keep people well, our health system will be overwhelmed by the rise in long-term diseases, such as diabetes.
   There must be sustained cross-governmental and cross-sectoral commitment to reduce ill-health through addressing lifestyle trends and inequalities in health outcomes.

3. Funding and expectations
   Time for public dialogue
   Clarity is needed on what can reasonably be expected from the health service, what funding is to be allocated to meet those expectations, and how decisions are made to benefit the greatest number of people in a fair and transparent way.
   Fundamentally, we must support the principle that people should be able to access healthcare on the basis of clinical need, not ability to pay. Central to this debate will be the issue of what society is prepared to invest in its health service.

4. Using data to plan
   Joining the dots between population needs and frontline decisions
   Healthcare policies, strategies and plans should use research evidence and relevant data to make clear connections between population needs assessment and frontline planning decisions. Of crucial importance is the alignment of capacity with demand through the use of data and evidence. Much of the current visible dysfunction in the system is a result of demand grossly exceeding capacity.

5. Joined up care
   Delivering seamless care across various settings
   Care pathways should be built around the needs of the patient, not the system. We need to provide care that is joined up from the patient perspective, through the design and implementation of patient-centred, clinically led, evidence-informed integrated models of care. Patient outcomes and safety measures, costing and funding models, workforce plans and data and system requirements must all be built into these integrated models of care. Funding must be allocated to facilitate and incentivise joined up care, and to avoid fragmented care.

6. Hospital without walls
   "Hospital" services in the community
   Service delivery should be oriented around the service itself rather than buildings and institutions or legacy arrangements. This includes the concept of a hospital without walls, where many services delivered in hospitals can and should be delivered in the community, with greater collaboration across hospital, primary care and community care settings. Strengthening capacity in primary and community care will be crucial to achieve this. There should be less focus on the "place" and more on the "service."

7. Building for accountability
   Responsibility, authority and accountability from the ground up
   We need a governance system that applies at every level, from service delivery upwards, and is grounded in the principle that the healthcare system is owned by and accountable to the people. This requires clearly identified responsibility, authority and accountability at all levels of the health service from ward level right up to the Department of Health.

8. Supporting healthcare staff
   Without people, there is no healthcare system.
   Major, sustained emphasis is needed on strengthening and supporting the people who deliver care, and on rebuilding trust and confidence among the workforce.
   Successful organisations recognise the importance of the people who work for them: they try to recruit the best; ensure they are enabled to perform to their best; are involved appropriately in decision-making; are trusted; and are provided with development opportunities. This is what we should aspire to for our health service.

9. Developing healthcare leaders
   Great leaders bring about great change
   Only strong leadership at local, regional, national and institutional levels can overcome the lack of trust in the system and bring about the kind of change needed to return the health system to its core purpose. It must be recognised that there is a crisis in leadership at all levels, and that there has been a lack of support for leadership development.
   Clinical leadership roles and managerial leadership capability should be developed and supported at all levels in the system.

10. Shared vision and political consensus
    Long term vision, and the political drive and courage to deliver it.
    A shared vision and long-term strategic plan with cross-party political support is essential. Frequent changes in direction are fundamentally destabilising and undermining for the health service.
    Crucially, it must be recognised that to have a meaningful impact, there must be sustained political commitment to long-term policies and strategies. Cross-party political consensus and longer-term collaborative planning are necessary to support a commitment that spans multiple government terms and composition.
    The establishment of the cross-party Oireachtas committee in 2016 is a necessary and practical political development to set a direction for the health service. The challenge to all stakeholders will be to support the output of the committee.
    The challenge for the committee will be to outline a direction that all stakeholders can commit to.

11. e-Health now!
    e-Health supporting and enabling joined-up care
    The individual health identifier and electronic health record must be implemented. The advent of the eHealth Strategy provides an opportunity to adopt a long-term strategy to underpin joined-up care across community, primary care, acute hospitals, and mental health, and to simultaneously enable effective population needs analysis, planning, outcome measurement, and performance accountability at local and national levels.

12. Implementing change
    A major implementation strategy to deliver change
    These recommendations represent an enormous challenge. Failure to successfully implement changes has been a recurrent and debilitating feature of the health service for many years. There must be significant, targeted and sustained investment into making these changes happen.
    This will require a high level expert group that reports to the Oireachtas on progress and that has the mandate and authority to hold all parts of the system to account for making the changes happen. Change will not happen without a plan, neither will it happen without determined and consistent leadership, from the highest level of government.
Foreword

It is widely acknowledged that our health services model as it currently exists is no longer fit for purpose. Health and social care provision in Ireland is unsustainable and without strong political consensus on a new way forward, that fully takes into consideration the reality of delivery, staffing and cost pressures, the provision of healthcare services will continue to worsen.

Health services currently neither have functional capacity nor structural capability to meet current and future needs. The balance of health and social care services needs to shift away from an over-reliance on acute hospital services towards stronger primary and community services. Poor orientation to primary care and underdevelopment of eHealth infrastructure mean the starting point for our goal of building a sustainable service model capable of meeting unmet need together with increasing demand is weak.

We often talk about future challenges posed by things such as increasing levels of frailty as people live longer, new technologies, drugs and devices and increases in chronic disease. While future challenges are real and undisputed, the fact is these are not only future challenges for the health service in Ireland. They are challenges that we are currently experiencing and have been, year on year, for quite some time. We have been responding to these challenges at every level of the healthcare system without the political, financial, strategic, structural and service levers or controls to address the substantive issues. During this time we have been attempting to meet service
# Health Atlas Ireland

Supports the quest for better health for patients, their families & the public by exploiting the quality assurance, health mapping & research potential of available data.

## Finder

*Available to all Atlas users*

- Find an address or service site - and the Eircode
- Profile the demography of catchment areas
- Map sites and boundaries, show population density or deprivation

## Username & password required to access the following

### Health Service Data

- **Hospital Emergency Care**
- **Hospital KPIs (CompStat)**
- **Community Healthcare**

### NQAIS Clinical

**National Quality Assurance Intelligence System**

- **Acute Coronary Synd**
- **Endoscopy**
- **Radiology**
- **Acute Medicine**
- **Histopathology**
- **Surgery - All**
- **IRIS**
- **Hospital Mortality**
- **Surgery - Elective**

### Emergency

- **Aero-Medical**
- **E Zone**

### Analyser

- **Atlas Analyser**
- **Resource Profiler**
- **Smap**

### Directories

- **Geo Reference**
- **Service Directory**
- **Service Lists**
- **Estate Directory**
CSO Census 2011 (Final) - 65 years+
Primary Care Team Area (PCT): North Kerry 2 & 3.

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>Area</th>
<th>Area change (since 2006)</th>
<th>Ireland</th>
<th>Ireland change (since 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>3,530</td>
<td>16.5</td>
<td>+407</td>
<td>+13.0</td>
</tr>
<tr>
<td>85+</td>
<td>404</td>
<td>1.9</td>
<td>+60</td>
<td>+17.4</td>
</tr>
<tr>
<td>80-84</td>
<td>482</td>
<td>2.2</td>
<td>+23</td>
<td>+5.0</td>
</tr>
<tr>
<td>75-79</td>
<td>696</td>
<td>3.2</td>
<td>+61</td>
<td>+9.6</td>
</tr>
<tr>
<td>70-74</td>
<td>839</td>
<td>3.9</td>
<td>+67</td>
<td>+8.7</td>
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<tr>
<td>65-69</td>
<td>1,109</td>
<td>5.2</td>
<td>+196</td>
<td>+21.5</td>
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DEPRIVATION LEVEL - HP INDEX

<table>
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<th>Deprivation Level</th>
<th>Area</th>
<th>Area change (since 2006)</th>
<th>Ireland</th>
<th>Ireland change (since 2006)</th>
</tr>
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<tbody>
<tr>
<td>Extremely affluent</td>
<td>4</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Very affluent</td>
<td>47</td>
<td>0.2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Affluent</td>
<td>276</td>
<td>1.3</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Marginally above average</td>
<td>821</td>
<td>3.8</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Marginally below average</td>
<td>1,186</td>
<td>5.5</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Disadvantaged</td>
<td>839</td>
<td>3.9</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Very disadvantaged</td>
<td>295</td>
<td>1.4</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Extremely disadvantaged</td>
<td>60</td>
<td>0.3</td>
<td>n/a</td>
<td>n/a</td>
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HP INDEX DETERMINANTS

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<th>Ireland</th>
<th>Ireland change (since 2006)</th>
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<tbody>
<tr>
<td>Age dependency (elderly) - males</td>
<td>1,642</td>
<td>7.7</td>
<td>+213</td>
<td>+14.9</td>
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<tr>
<td>Age dependency (elderly) - females</td>
<td>1,888</td>
<td>8.8</td>
<td>+194</td>
<td>+11.5</td>
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</table>

HEALTH INDICATORS

<table>
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<th>Health Indicator</th>
<th>Area</th>
<th>Area change (since 2006)</th>
<th>Ireland</th>
<th>Ireland change (since 2006)</th>
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<tr>
<td>Disabled</td>
<td>1,282</td>
<td>5.9</td>
<td>+358</td>
<td>+39.3</td>
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Data Sources, Integration and Infrastructure Enablers

Shared Record Phase 2

Phase 1
- Clinical portal – national views
- User access and desktop / mobile infrastructure
- Communication tools to plug IT system gaps

Phase 2
- Patient portal – patient views
- Care plans & assessments to plug IT system gaps
- SATIS
- ePrescribing
- Patient portal – carer views
- GP PMS
- GP out-of-hours systems

Shared Record

Community Operational Systems
- GP Systems
- Pharmacy

Acute Operational Systems
- Private Hospitals

Integration

Individual Health Identifier

One Project (Digital Identity)

Phase 1
- National Integration Platform
- Leverage Healthlink messaging
- PAS
- RIS/ PACS
- LIS
- MN-CMS
- eReferrals
- ED
- Clinical Document Systems

Phase 2
- National condition specific EPRs
- Endoscopy
- MOCIS
- Cardiology investigations
- Ambulance EPR

DRAFT FOR DISCUSSION
The Changing Workforce

New Roles
- Peer Support Workers
- Community Navigators

Essential Shared Capabilities

- Nurse
- Dietician
- Social Worker
- Community Pharmacist
- Physiotherapist
- GP
- Geriatrician

Adopted from Mental Health International Networks for Developing Services
Ideological challenges

Complex and often poorly defined

Working across traditional boundaries (agencies)

Integration needs to be wider than health and social care

Designed ‘with’ rather than ‘for’

New roles and ways of working

Different values, mindset and approach
(population v disease, interprofessional, shared decision making).

Longitudinal and difficult to show ‘evidence’

More a mission than a programme
### Operational Challenges

<table>
<thead>
<tr>
<th>Theme</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Incentivising a population-health mind set focus</strong></td>
<td>Understanding the health needs of communities</td>
</tr>
<tr>
<td><strong>3 Operationalizing Personalised care co-ordination</strong></td>
<td>The ability to design, plan and organise services effectively around people’s needs</td>
</tr>
<tr>
<td><strong>4 Effective ICT systems</strong></td>
<td>Collect use and share existing and potential data sources to support decision-making</td>
</tr>
<tr>
<td><strong>5 An integrated delivery system</strong></td>
<td>Lack of co-terminosity between providers and alignment of service delivery, duplication of effort.</td>
</tr>
<tr>
<td><strong>6 Building social capital and collaborative capacity to change</strong></td>
<td>Promoting shared values and common understanding to engage and trust the change process in context of austerity hangover.</td>
</tr>
<tr>
<td><strong>7 Local capacity to deliver change</strong></td>
<td>Local improvement capacity (new roles and structures yet to embed)</td>
</tr>
<tr>
<td><strong>8 Dedicated transformation funding</strong></td>
<td>Appropriate funding and or incentives to</td>
</tr>
<tr>
<td><strong>9 Translational research and evaluation</strong></td>
<td>Measuring, monitoring and responding to evidence to judge or benchmark care quality and outcomes is essential to improving quality of care through integration</td>
</tr>
<tr>
<td><strong>10 Workforce</strong></td>
<td>New structures in CHOss and HGs - yet to become established Roles that work across boundaries</td>
</tr>
</tbody>
</table>
Opportunities

- Align with emerging local innovation (e.g. Leitrim Day Care model)
- Build on existing infa-structure/resources (e.g. CHO5/WUH)
- Tap into latent professional capacity (e.g. CHO 9/Beaumont)
- Develop expanded and new roles (e.g. ANP)
- Test ICT innovations (e.g. Health Innovation Hub)
# Appendix 1: Benefits of Implementing the Integrated Care Programme for Older Persons

## Situation
An aging population with increased prevalence of frailty

Unplanned care for older people with complex care needs

## Priority areas
- Focus on frailty
- Population planning
- Bespoke pathways
- MDT community teams
- Case management approach

## Inputs
- National Integrated Care Programme for Older persons team set up, governance, work streams and framework
- Population planning approach using Information on local population in the development of plans for services at Pioneer sites
- MOC, pathways, assessment and referral models spanning both community and acute hospital
- Recruitment of staff and new ways of working for existing staff to deliver services in accordance with the moc/pathways/framework
- Operational hub for MDT working at Pioneer sites
- Established mechanism for engaging Service users/patients and analysing patient feedback and experience at Pioneer sites

## Deliverables
- National Integrated Care Programme for Older persons team set up, governance, work streams and framework
- Formalised Governance at Pioneer sites
- Population planning approach using Information on local population in the development of plans for services at Pioneer sites
- Information on community, social, ambulatory acute and voluntary services used in the development of plans for services at Pioneer sites
- Recruitment of staff and new ways of working for existing staff to deliver services in accordance with the moc/pathways/framework
- Operational hub for MDT working at Pioneer sites
- Established mechanism for engaging Service users/patients and analysing patient feedback and experience at Pioneer sites

## Engagement
- 12 Teams
- 8 CHOs
- Case Managers
- AHPs
- Geriatricians
- GPs
- CNMs/CNSs
- Home Care Co-ordinators
- Admin. staff
- ED staff
- Social Care/Primary Care/Mental Health and Wellbeing
- Hospital groups
- Voluntary sector
- Community supports for older people and carers to live well in the community

## Changes
- Move from hospital centric care to community care model
- Population approach to service planning
- Single point of contact for older persons for timely access to services in community
- Clearly defined pathways across primary, acute and social care settings (MDT working)
- Supported self management at home
- Measurement/technology/education enablers - national roll out
- Holistic needs of patient addressed

## Benefits
- Improved Health Outcomes
- Reduced time in ED (>24 hr PET in >75 yrs)
- Reduced unscheduled admissions/Readmission
- Reduced hospital bed use (ALoS for >75s)
- Reduced Delayed discharges
- Reduced institutional care
- Improved Quality and patient experience of care
- Improved carer support/satisfaction
- Improved staff satisfaction

## HSE Corporate Goals
- Promote health and wellbeing as part of everything we do
- Provide fair, equitable and timely access to quality, safe health services
- Foster a culture that is honest, compassionate, transparent and accountable.
- Engage, Develop and value our workforce
- Manage resources in a way that delivers best health outcomes, improves people’s experience of using the service and demonstrates value for money.

## Enablers
- Funding
- ICT
- Improvement support
- National governance
- Guidance
- Population Planning
- Data Analytics
- Evaluation
- Networking
- Education
- Comms
- HR

## ICT
- Measurement & Evaluation
- Workforce & Education

## Enabling activities

## External factors on outcomes
10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   Frailty Prevalence
   - 11% Severely Frail (Very High Risk)
   - 21% Moderate Frailty (High Risk)
   - 36% Mild Frailty (At risk)
   - 32% Fit (Minimal risk)

3. Map Local Care Resources

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

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
Thank You

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