Integrated Healthcare Conference:
Shifting Care to the Community

Liffey Hall A, Convention Centre Dublin
4 September, 2025. 14:25- 15:40

Rialtas na hÉireann
Government of Ireland

Welcome & Introduction

Pat Healy
National Director, National Schemes & Services

Enhanced Community Care: Creating the Conditions for Access and Integration, Wexford

ICPCD Wexford
CHNs Wexford

Wexford Population Health Demographics

County Wexford, home to over 163,000 people, has a notably high proportion of disadvantaged individuals, with elevated levels of disability, poor health, and limited education compared to national and regional averages.

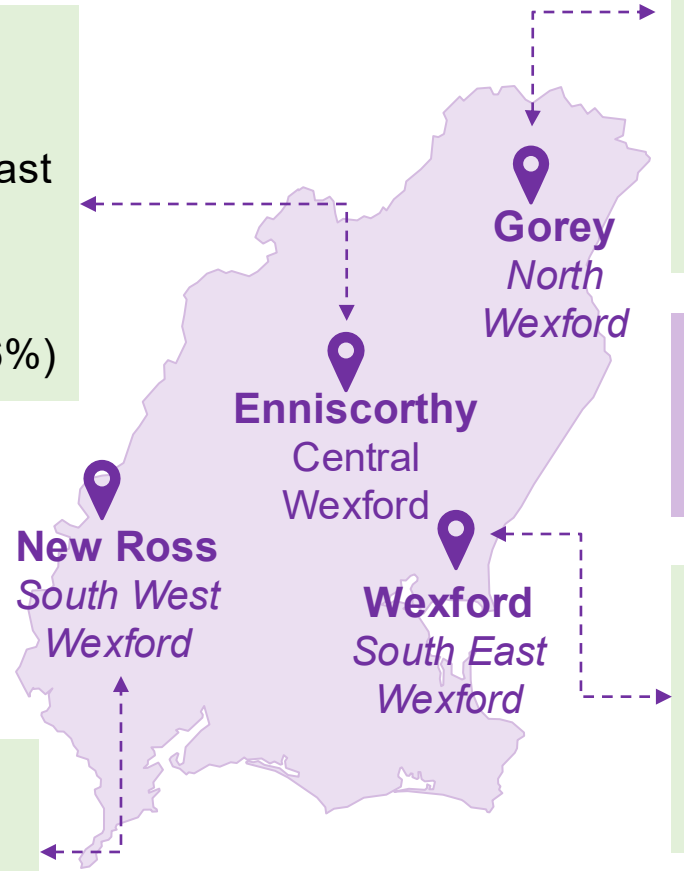
Central Wexford

- Total Population: 42,033
- Highest deprivation score in Dublin South East REO at 14.4%
- Traveller population represent 1.4% of the population, double the national average (0.6%)

County Wexford has a high representation of Traveller, Roma and Ukrainian populations compared to national averages

South West Wexford

- Total Population: 35,429
- High deprivation score at 12.5%



Wexford North

- Total Population: 38,874
- Second fastest growing CHN nationally

9% Increase in total population County Wexford (2016 vs 2022)

South East Wexford

- Total Population: 48,788
- High proportion of people aged 65% compared to national average

The Enhanced Community Care Model – Wexford

Shift left of Resources & Activity

COMMUNITY DIAGNOSTICS

Early Supported Discharge/ Admission avoidance

- Community Intervention Team (CIT)
- Frailty at the Front Door
- Bespoke Specialist Pathways
- Palliative/End of life care
- Rehab / Intermediate care Beds
- Respite/Residential care

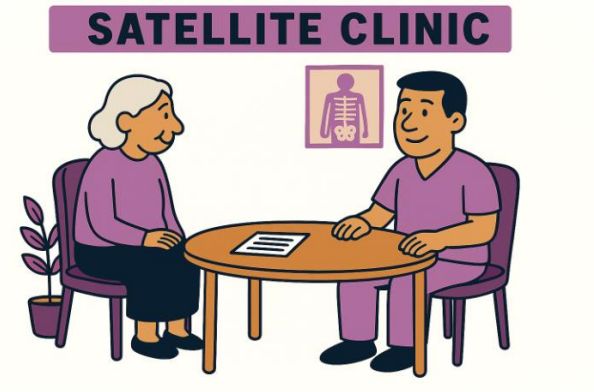
ALONE – YOU'RE NOT ALONE

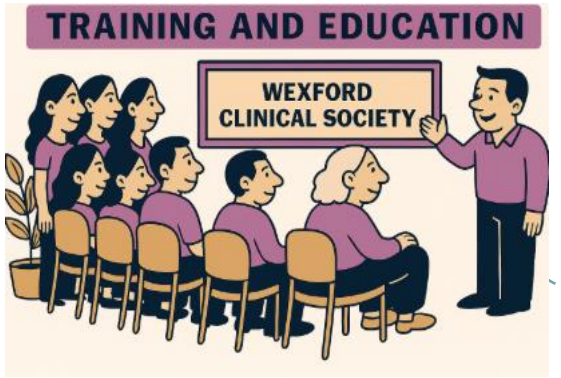
MAKING EVERY CONTACT COUNT

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

Key Enablers for Service Integration

Several key enablers and integration initiatives across CHN have enabled Wexford to further enhance the ECC model to better support the population and services across County Wexford.





Patient Centred Care

Wexford CHN Initiatives

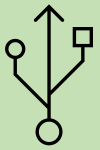
Community Healthcare Networks throughout Wexford have pinpointed key enablers to effectively support initiatives that cater to the unique needs of County Wexford's population, ensuring timely and needs-based access to care.

Multi Visit Patients (MVPs):

Early Identification & Management enabled by Technology

- Use of iPMS to identify multi visit patients (MVPs).
- Use of CTM and tailored Care Plans for MVPs to be managed within the community
- This approach was identified through the Rapid Improvement Event (RIE) with WGH and Wexford ICPOP

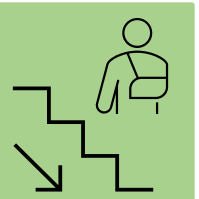
Formalised Decision Tree Support To Referral Into Community Pathways



Decision Trees were developed and extensively communicated.

- Feedback during the RIE from services highlighted knowledge gaps in community referral pathways.
- Facilitates hospital avoidance
- Reduction of service duplication

Waitlist Initiative Physiotherapy Services



Introduced a central targeted approach for Waitlist Management.

- Additional funding was agreed to seek additional capacity.
- Facilitates hospital avoidance
- Reduction of service duplication

Right Path First Time for Children Services in County Wexford

Implementation of integrated working groups between CDNT and Primary Care for children services specific to each CHN.

- The integrated communication between teams supported by senior paediatric clinicians.
- Decisions are communicated to the child's parent/guardian and referrer in a timely manner.

Technology Advances across Wexford

To successfully scale across various initiatives, Wexford's services are successfully leveraging new and pre-existing technology to increase service and operational efficiency and improve patient outcomes.

National Shared Care Record

Support clinicians to have rapid access to patient data resulting in timely clinical decision making and more effective case management.

Microsoft Power Apps

Pilot in progress to streamline Physiotherapy Register workflows. This includes the generation of national & clinician specific KPIs.

Attend Anywhere

Leveraged to support with virtual consultation delivery across the Wexford services

InterRai

Clinical Coordinators access InterRai to upload WexIPOP client CTM notes, enhancing clinical information sharing and client outcomes.

iPMS

Leveraged in the identification of Multi-Visit ED patients, for discussion at the CTM and management.

Bulk SMS Texting

Leveraged to support patient consultation reminders and is associated with significant reduction in DNA rates.

Navigating Challenges & Solutions

The CD Wexford Hub has actively identified challenges and embraced innovation within existing service constraints to boost productivity and efficiency, delivering timely, needs-based access to care.

Integrated Model of Care for the Prevention and Management of Chronic Disease (HSE 2020)

The Model outlines five levels of service essential for providing comprehensive, end-to-end care for chronic conditions.

Challenges & Solutions

Limited integration between teams

- Established a Working Group
- Emphasis on cross collaboration projects
- Clinical governance led by Integrated Consultants

Resources & Infrastructure Constraint

- Expanded services to satellite clinics
- Proposal advanced for an ECC wide physical premise including diagnostics services.
- Additional admin resource sourced

Process Enhancement

- Creation of Standard Operating Procedures
- Creation of a Central Referral System, to enable prompt response to Healthlink referrals
- Re-validation of waiting lists

Limited use of technology

- Virtual appointments introduced to augment pathways
- Utilisation of real time patient monitoring (SMILE2)

Leveraging Technology to Enhance Productivity

In April 2025, the CD Wexford Integrated Cardiology Service recognised the unsustainability of the first-come, first-serve model amidst a growing waitlist, leading to the development of an innovative Waitlist Action Plan.

Patient requires referral to ECC Cardiology Services

Incoming HealthLink referral via GP

Patient referral received and triaged in an MDT Setting across 7 distinct pathways

** The seventh pathway is redirection to acute care services*

1 Virtual CNS Clinic

Video consultation with nurses via Attend Anywhere

2 MDT Clinics

F2F consultations for less complex patients

3 1:1 CNS Clinics

F2F consultations for complex patients

4 Urgent Appointments

F2F consultations for urgent needs within 4 weeks

5 Direct Investigations

Diagnostic test access with consultant approval

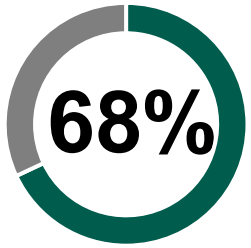
6 Virtual GP Support

Virtual GP support provided by ICPCD consultant

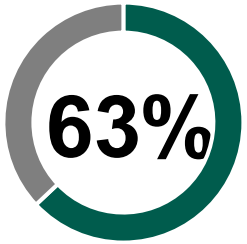
Impact of the Waitlist Action Plan

The Waitlist Action Plan yielded profoundly positive outcomes and impact for both patients and healthcare staff, underscoring the strategic utilisation of technology to drive innovation and optimisation within existing resource and operational constraints.

- Enhanced clinical productivity and operational efficiency.
- Integrating new ways of working via technology
- Overwhelmingly positive patient feedback received for virtual appointments

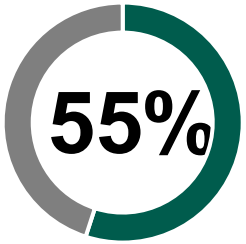


Reduced clinical time



Waitlist reduction

Increase in CNS capacity



Reduced DNA rates

Virtual Appointments - Patient Feedback

Integrated Service Improvement Initiatives

Additional service improvement initiatives are taking place across CD Wexford Hub utilising technologically enhanced new ways of working to improve service efficiency and productivity.

Lipid Integrated Management

Integration with WGH

Development of a lipid management pathway delivered by the Cardiac Rehabilitation Programme.

68% of patients hit LDL-C targets by end of study.

Early identification of patients requiring add-on therapy reducing risk of subsequent cardiac events

SMILE 2 – Integrated Virtual Case Management of Patient with Multimorbid Chronic Disease

Virtual case management service for people with multi comorbidities.

60 to 80% reduction of in-person clinic visits for select patient cohorts.

50% + referrals to SMILE to date have come from Wexford.

Continuous glucose monitoring (CGM) in the Frail Adult with Type 2 Diabetes (T2DM)

Integration with WGH

Use of CGM to identify patients at risk of adverse / hypoglycaemic events.

100% of patients required medications adjustment based on CGM data.

Only **7** of **25** reported symptoms.

Self Management of Blood Sugar Level Monitoring (BSL) via Technology

App based platform to store BSL readings that can be accessed by clinical teams

Patients can share their data with their healthcare professional remotely.

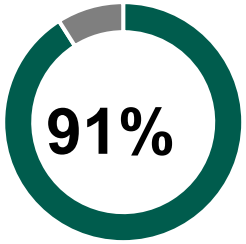
Wireless data capture of BSL readings with analytics to support patient / clinicians to identify trends

Service Delivery Feedback

To evaluate the ongoing service improvement initiatives, a robust feedback loop was established. The questionnaire captured insights and improvement opportunities, providing crucial feedback.

Patient Feedback

To evaluate the service improvement initiatives, a patient feedback and experience survey was piloted during June 2025 with a total of 68 responses.



91% of respondents rated their experience as excellent

100% of respondents felt supported

99% of respondents were clear on next steps

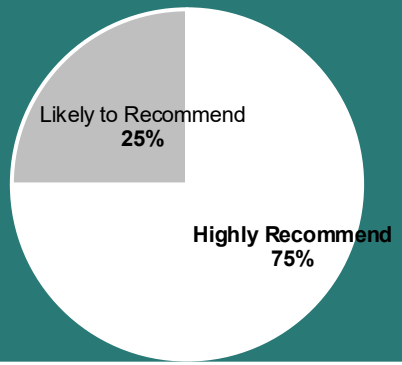
General Practitioner Feedback

To evaluate the service's impact, specifically the Cardiology Service a GP survey was conducted over three weeks in September 2024.

Overview of GP Feedback & Opportunity for Improvement:

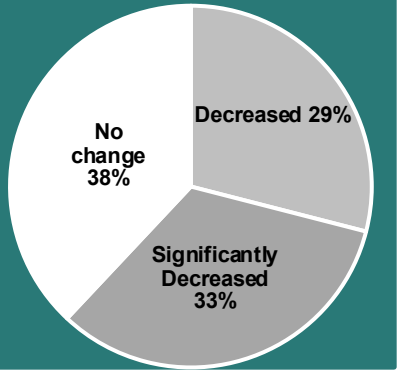
- Efficient Access
- Staffing optimisation
- ED Avoidance
- Virtual support

How likely are you to recommend Wexford CDM?



How would you rate your overall experience ?

Has the new pathways impacted your workload



Embedding New Ways of Working

After reviewing feedback from service improvement initiatives, the CD Wexford Hub has pinpointed key areas for enhancing productivity and scaling community services across County Wexford.

Scale current service improvement initiatives	Resourcing Enhancements	Digitisation of Services	Expansion of Service Offerings	Research, Innovation & Professional Development
Ongoing Hospital Waitlist Reduction Initiatives	Stand up Respiratory services within CD Wexford	Scale Virtual Appointments for Waitlist Management service wide	Expand Psychological Interventions	Foster a culture of research across services County Wexford wide (i.e. WGH, ECC)
Strengthen and increase collaboration between care settings to ensure we are meeting needs of the local population.	Supplement diabetes resourcing to enable the provision of full diabetes services	Strengthen data capture tools to enable tracking of outcomes, service performance and impact	Respiratory Services Cardiology Services Diabetes Services	Continue to embrace and support teams to trial technological solutions to optimise service delivery

Lessons Learned

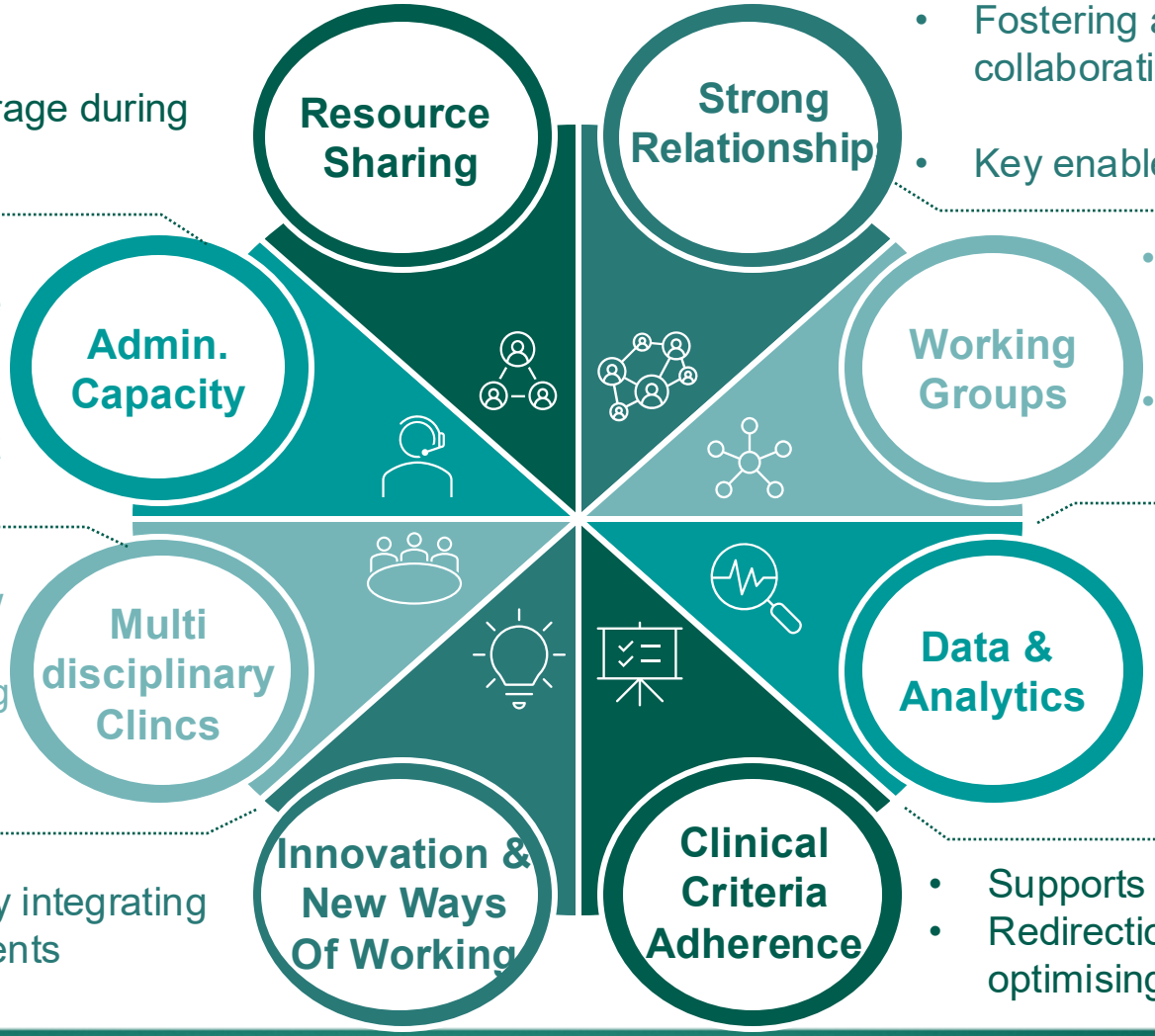
Establishing robust feedback mechanisms and capturing lessons learned are essential for continuous improvement and informed decision-making.

- Efficient operation relies on shared administrative resources and coverage during absences

- Skilled resourcing allows service expansion i.e. new clinics and care pathways.
- Pivotal in coordination and efficient use of clinical resources

- MDT Clinics streamlines patient flow
- Increases efficiency by consolidating specialist input in a single setting

- Embedding new ways of working by integrating new pathways i.e. virtual appointments



- Fostering a vital ecosystem of trust and collaboration across services
- Key enabler for integration initiatives

- Consistent platform for decision-making, and collaborative issue resolution.
- Fosters continuity and transparency for ongoing initiatives

- Supports in model validation
- Aids funding bids, and service expansion

- Supports targeting suitable patients
- Redirection to appropriate support, optimising efficiency

Enhanced Community Care Reference Posters

Title: Lived Patient Experiences

Authors

- Martina Carroll
- Alison Whelan

Title: Integrated Virtual Case Management

Authors

- Dr Orlaith O Reilly
- Margaret Curran
- Mary Burke
- Patricia McQuillan
- Aideen Byrne
- Ashleigh Farrell
- Dr Maria O'Brien
- Liz Murphy

Title: Reducing Waitlists and Enhancing Productivity

Authors

- Elizabeth Murphy

Title: Continuous glucose monitoring

Authors

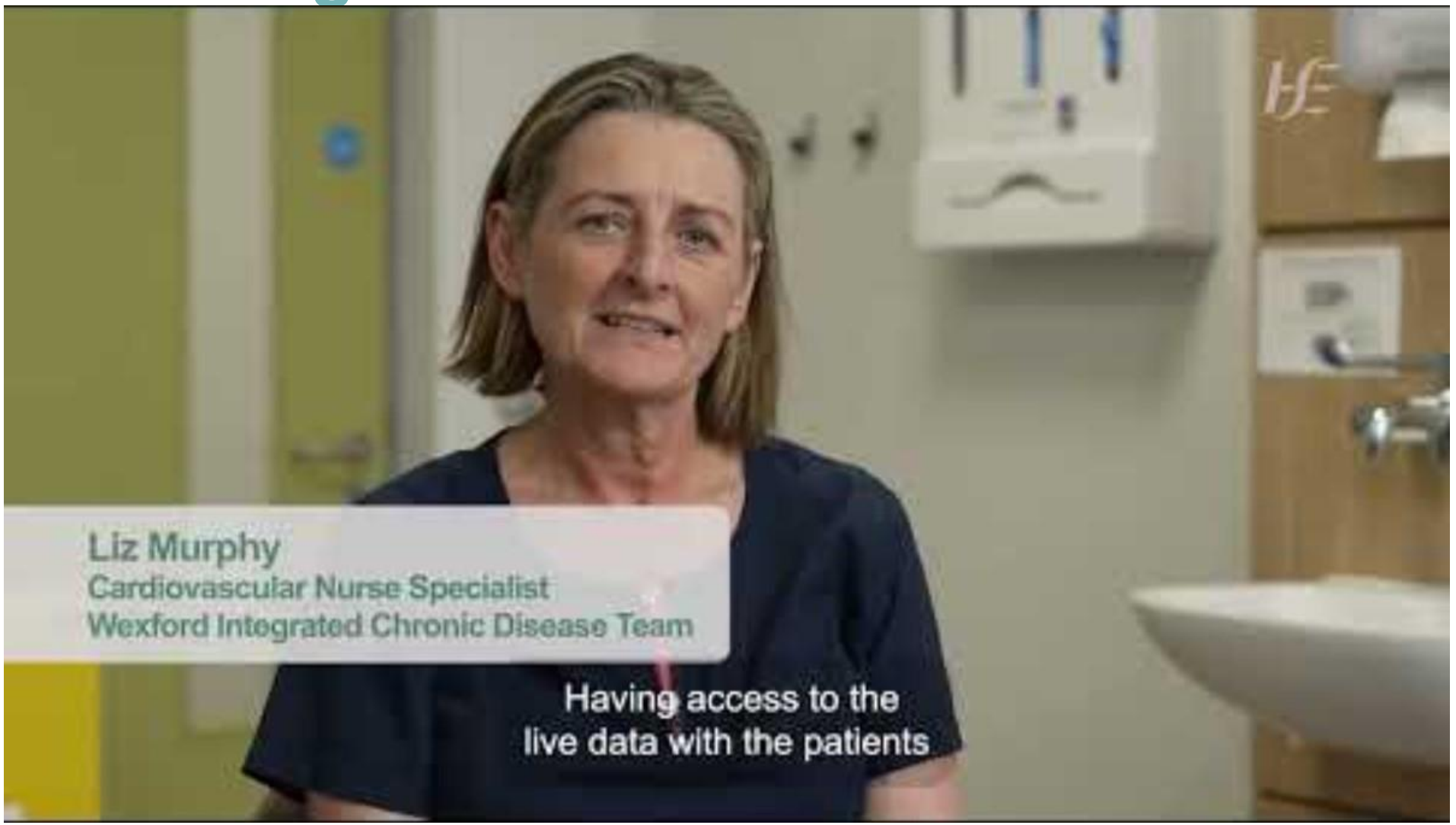
- Dr. Nicholas Ng Khay Jin
- Mairead Fenlon
- Professor John Nolan

Title: Optimising Older Person Pathways

Authors

- Eleanor Carpenter
- Siobhan O'Hanlon
- Olivia Cadogan
- Marian Flynn

SMILE Programme

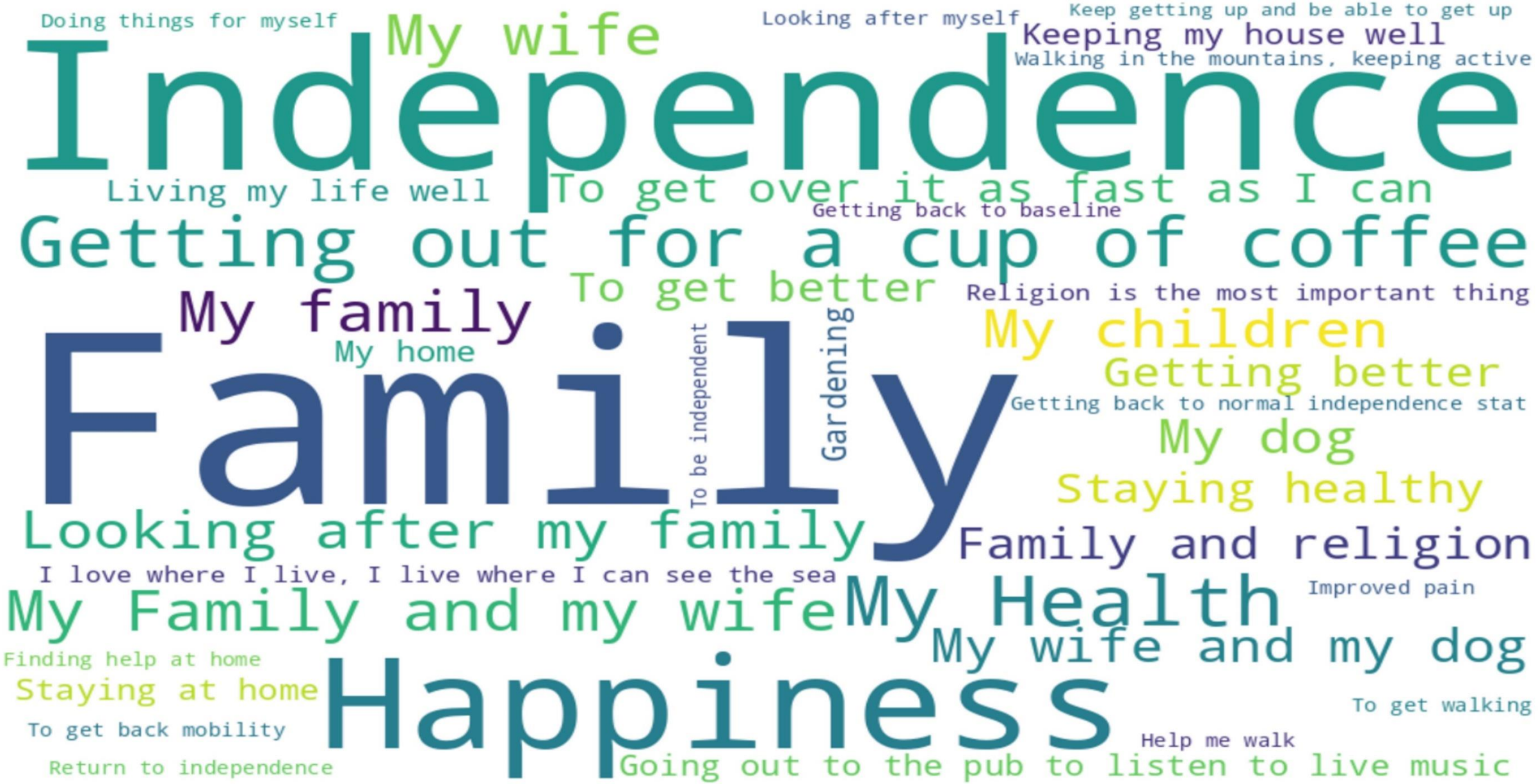


Link here

ECC ICPOP and Virtual Care in the Community

Dr. Emer Ahern, NCAGL, Older Persons
Dr. Rory Nee, Consultant Geriatrician


“I want to be included in decisions about my health & life with better access to coordinated care closer to home and use technology to support communication & safer care”


Doing things for myself
My wife
Looking after myself
Keep getting up and be able to get up
Keeping my house well
Walking in the mountains, keeping active
Independence
Living my life well
To get over it as fast as I can
Getting back to baseline
Getting out for a cup of coffee
To get better
Religion is the most important thing
My family
My children
My home
Gardening
To be independent
Family
Getting better
Getting back to normal independence stat
My dog
Staying healthy
Looking after my family
Family and religion
I love where I live, I live where I can see the sea
Improved pain
My Family and my wife
My Health
My wife and my dog
Finding help at home
Staying at home
Happiness
To get walking
To get back mobility
Help me walk
Return to independence
Going out to the pub to listen to live music

HSE Corporate Plan 2025-2027

Your Health, Our Mission – Shaping Care Together

Integrated care *is about continuity and coordination of care to deliver outcomes that matter to people and communities*

Dr N. Lennox-Chhugani, IFIC

Evidence-base for virtual care for older adults

Effectiveness and clinical outcomes
- CHF, DM – self-management, disease tracking and adherence to treatments
- Post-discharge follow up – reduce readmission rate in older adults with chronic conditions

Access and equity
- Accessibility boost – homebound or rural living
- Scheduling flexibility
- Lower exposure risks

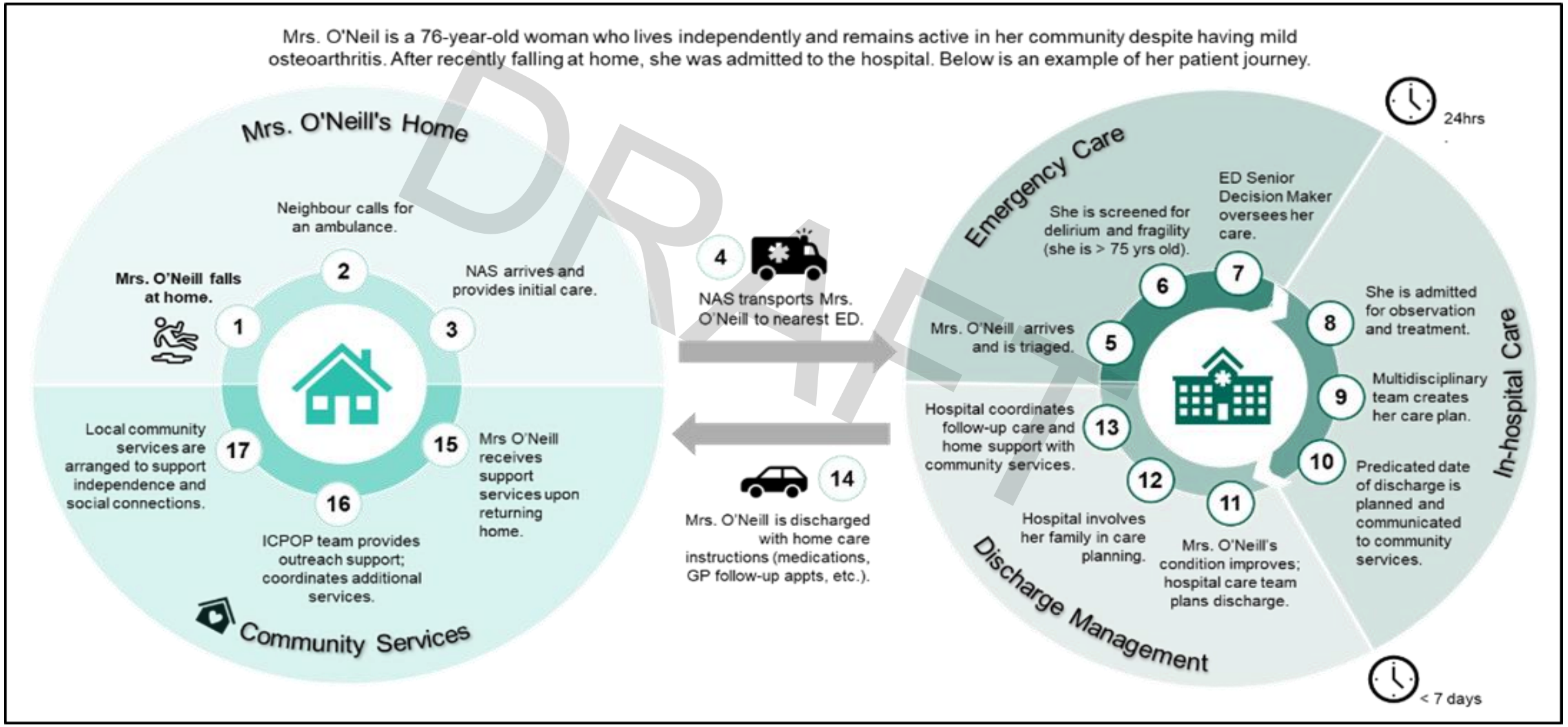
Patient experience and satisfaction
- High satisfaction
- Technical challenges

Conditions
- Low-moderate complexity needs: Routine care, chronic condition management, mental health services, medication reviews
- Limitations for complex case

Cost-effectiveness
- Potential savings – transportation needs, carer distress, hospital re-admissions – results vary

Implementation factors
- Support services matter – training, user-friendly technology, carer support, clear protocols
- Hybrid models work best – yield the best outcomes

Mrs. O'Neill

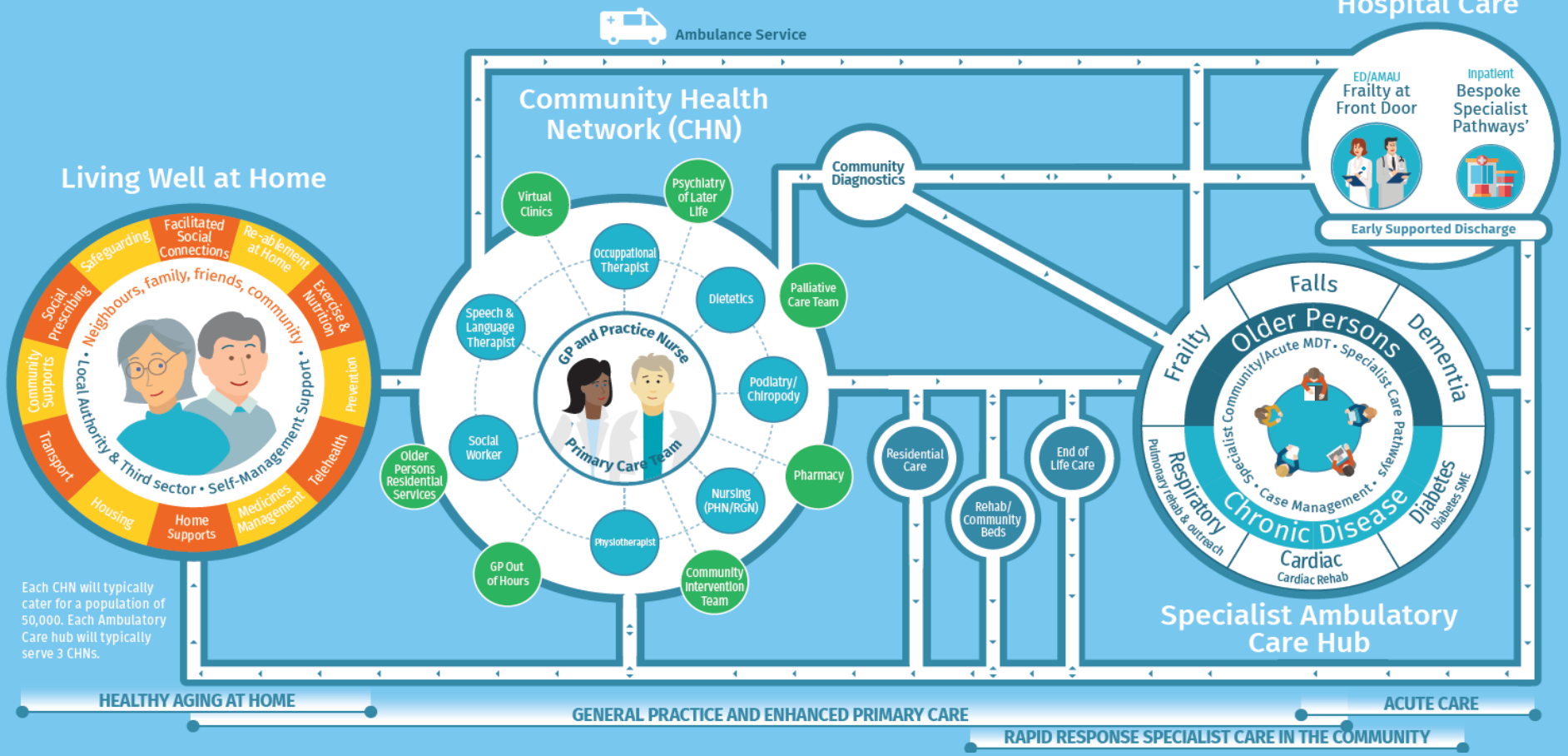

Mrs. O'Neil is a 76-year-old woman who lives independently and remains active in her community despite having mild osteoarthritis. After recently falling at home, she was admitted to the hospital. Below is an example of her patient journey.
Mrs. O'Neill's Home
Mrs. O'Neill falls at home.
1
Neighbour calls for an ambulance.
2
NAS arrives and provides initial care.
3
4
NAS transports Mrs. O'Neill to nearest ED.
Emergency Care
24hrs
ED Senior Decision Maker oversees her care.
She is screened for delirium and fragility (she is > 75 yrs old).
6
7
Mrs. O'Neill arrives and is triaged.
5
8
She is admitted for observation and treatment.
In-hospital Care
9
Multidisciplinary team creates her care plan.
10
Predicated date of discharge is planned and communicated to community services.
Hospital coordinates follow-up care and home support with community services.
13
12
11
Hospital involves her family in care planning.
Mrs. O'Neill's condition improves; hospital care team plans discharge.
Discharge Management
14
Mrs. O'Neill is discharged with home care instructions (medications, GP follow-up appts, etc.).
Local community services are arranged to support independence and social connections.
17
15
Mrs O'Neill receives support services upon returning home.
16
ICPOP team provides outreach support; coordinates additional services.
Community Services
< 7 days
DRAFT

Older Adult Service Model

What Matters

Mobility

Medication



Mind

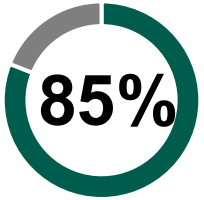
National Impacts and Outcomes

In providing multidisciplinary specialist care, ICPOP teams (27 of 30 teams operational) are adopting new ways of working, facilitating the shift left from acute to community. ICPOP teams are seeing more complex, more frail patients at a quicker rate than ever before. Some key programme impacts to date include;

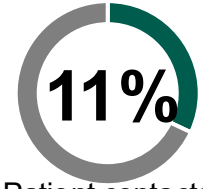
72,728

ICPOP CST Patient contacts in June 2025 YTD

14% of patients reviewed the same day / next day of referral

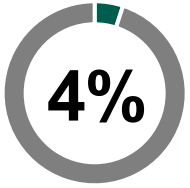


85% of patients discharged home



Patient contacts increased by 11% in 2025 YTD compared to 2024 YTD

Patients seen with Clinical Frailty score 5-9 vs target 55%



Only 4% of accepted patients discharged to acute hospitals

Virtual Care in the Community Model Service Integration

Maximising the above VCIC applications involves leveraging the existing local strengths and opportunities and enhancing collaboration and communication with other older adult services, such as:

Overview of Supporting Services:

- NAS (National Ambulance Service)
- Alternate Acute Pathways
- General Practice
- Community Healthcare Networks & ICPCD CSTs.
- CIT (Community Intervention Team)
- ALONE
- Community Diagnostics
- Bespoke innovations like the Data Demonstrator Analytics Project (Predictive Models).

ECC Virtual Care in the Community Model Initiative

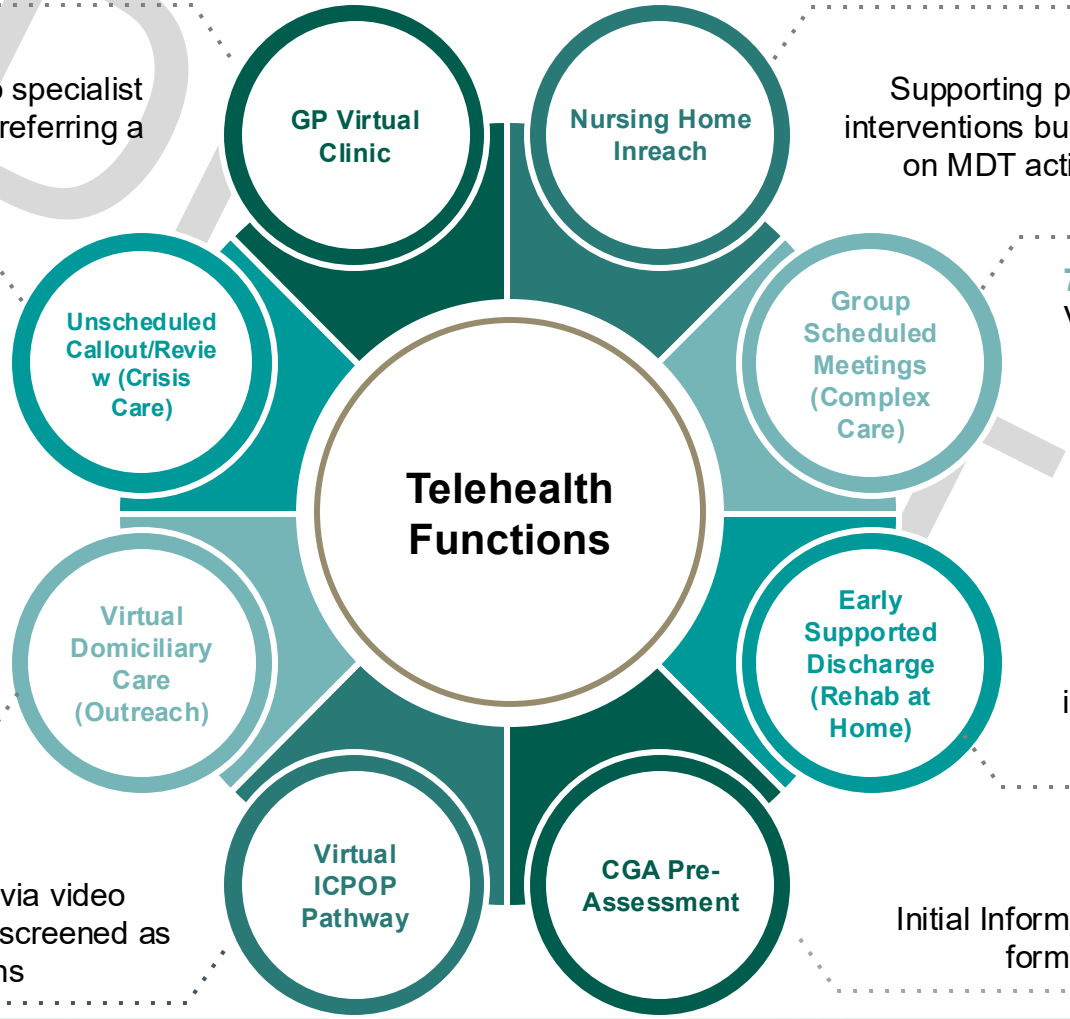
- The ECC programme has collaborated with Tech & Transformation, National Clinical Leads and ECC Consultants and Geriatricians to develop an initiative to enable ECC teams, including ICPOP teams, to provide virtual care.
- This model is designed to emphasise the use of **existing resources and technology** within the system, streamline healthcare delivery, improve staff productivity and patient outcomes across all primary care and ECC settings.
- Virtual care encompasses any remote interaction between patients and clinicians or between clinicians, facilitated by information technologies. These virtual models of care ensure that appropriate care is provided at the right time and in the right place.

Key Impacts of Model Implementation:

- Decrease in Did Not Attend (DNA) rates
- Facilitates an increased level of early supported discharge
- Enhances ability to reduce Primary Care Waiting lists
- Enablement of new models of care

Applications of Telehealth for ICPOP Teams

Attend Anywhere is being introduced to streamline and enhance various processes and functions. By facilitating virtual consultations and meetings it enhances **access** for patients and reduces the dependency on physical presence. Some of the key scheduled and unscheduled applications include;



1. GP Virtual Clinic
Empowering the GP through the access to specialist advice from an ICPOP Consultant prior to referring a patient to ICPOP services.

2. Unscheduled Callout/Review (Crisis Care)
Crisis Care patient/family can contact staff (within the appropriate hours) and engage as appropriate

3. Virtual Domiciliary Care (Outreach)
Clinical staff conducts home visit and engages with staff in hub via video

4. Virtual ICPOP Pathway
Face to face appointment conducted via video consultation for patients who have been screened as suitable for virtual consultations

5. CGA Pre Assessment
Initial Information gathering and pre-assessment for a formal CGA to be conducted via video

6. Early Supported Discharge (Rehab at Home)
Outreach support for patients who requires interventions but not acute care. Eg those that require follow on MDT activity but can do not require an acute bed

7. Group Scheduled Meetings (Complex Care)
Virtual meetings to support engagement between ECC CHN / ICPOP / MDT or Care planning meetings.

8. Nursing Home Inreach
Supporting patients within nursing homes who require interventions but not acute care. Eg those that require follow on MDT activity but can do not require an acute bed

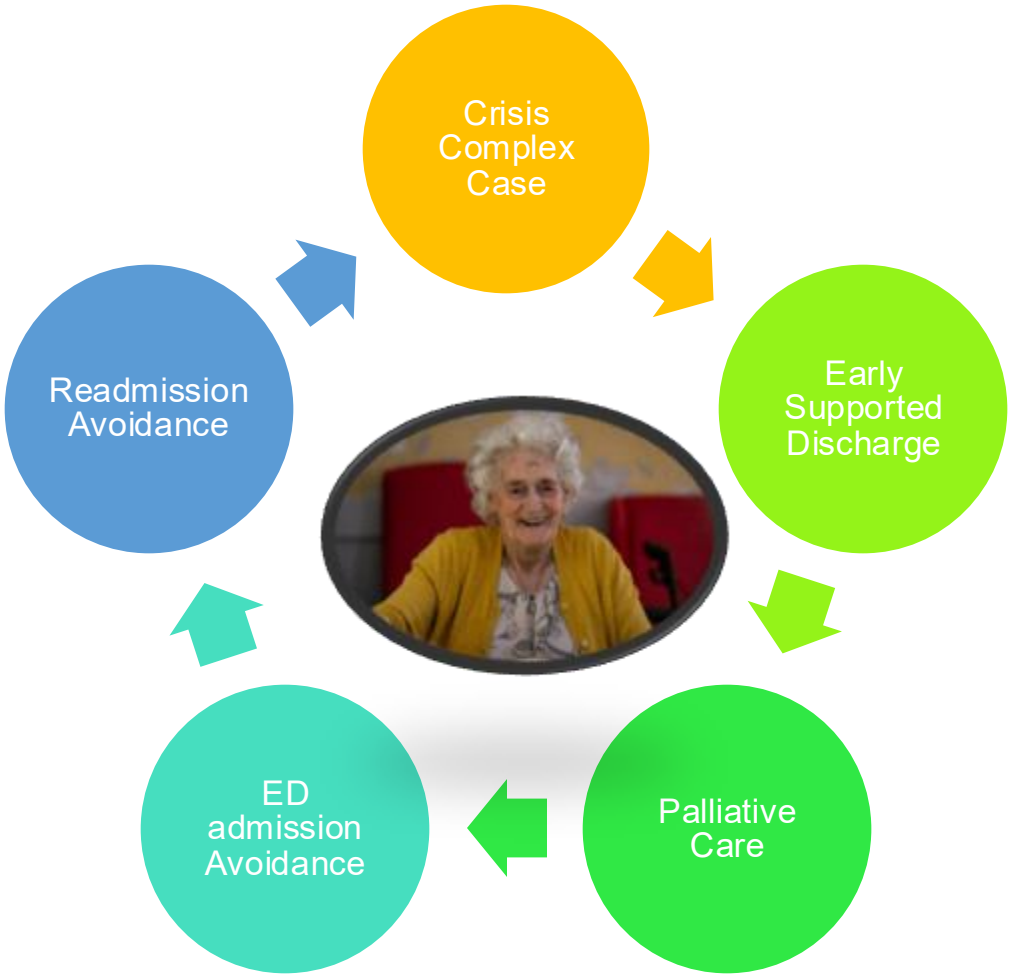
INTEGRATED CARE

Admission to the ICPOP Community Virtual Ward

Referral from Acute and Community Services

Consultant Triage

Streamed to appropriate virtual bed



INTEGRATED CARE

Supporting the Pillars of Unscheduled care

Hospital Avoidance

- Crisis Case Management
- Palliative Care
- Frailty Hotline
- Attend Anywhere Virtual Care
- 7/7 HCSA service

ED Operations

- Consultant Geriatrician in ED
- Direct and Immediate Access to ICPOP team
- Admission Avoidance
- 7/7 HCSA service

In Hospital Care Delivery

- In reach and Outreach
- ED avoidance admission when necessary
- Inpatient Consult

Discharge Management

- Readmission Avoidance
- Early Supported Discharge Rehabilitation and Delirium
- 7/7 HCSA service

What Matters to Me

Bi-Directional Patient Centred Integrated Care

INTEGRATED CARE

Supporting the Pillars of Unscheduled care

Hospital Avoidance

- Crisis Case Management
- Palliative Care
- Frailty Hotline
- Attend Anywhere Virtual Care
- 7/7 HCSA service

What Matters to Me

Bi-Directional Patient Centred Integrated Care

Hospital Avoidance

- **Mr BC**

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Hospital Avoidance

- Mr BC
- **75 yr old gentleman**

iHeartCraftyThings.com

INTEGRATED CARE

Hospital Avoidance

- Mr BC
- 75 yr old gentleman
- **GP referral**

iHeartCraftyThings.com

INTEGRATED CARE

Hospital Avoidance

- Recent falls
- Difficulty in managing
- Now housebound
- Alcohol Misuse

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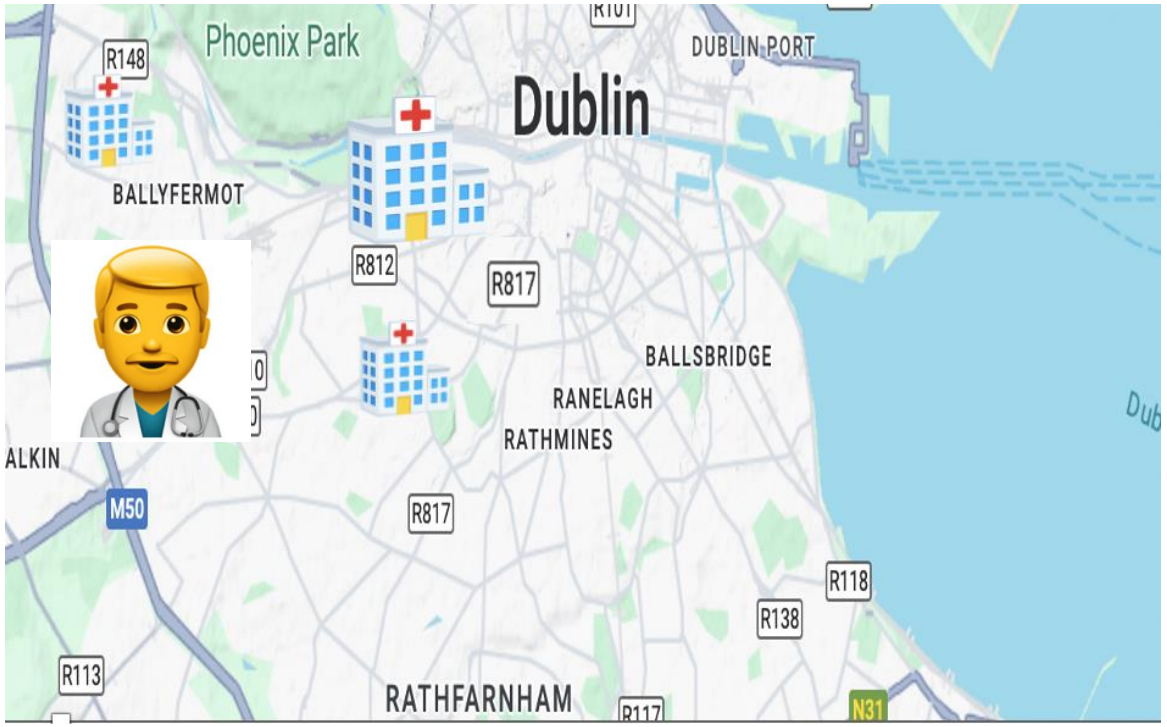
INTEGRATED CARE

Hospital Avoidance

Consultant Triage



INTEGRATED CARE

Hospital Avoidance

Consultant Triage

NIMIS
The National Integrated Medical Imaging System

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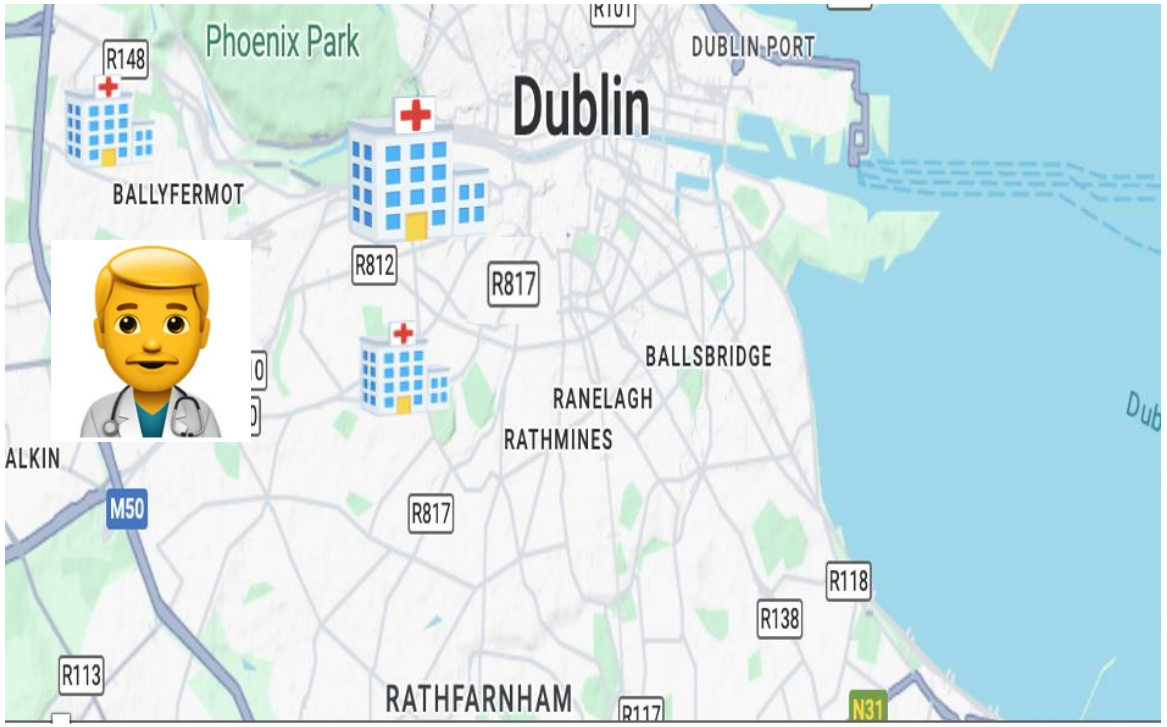
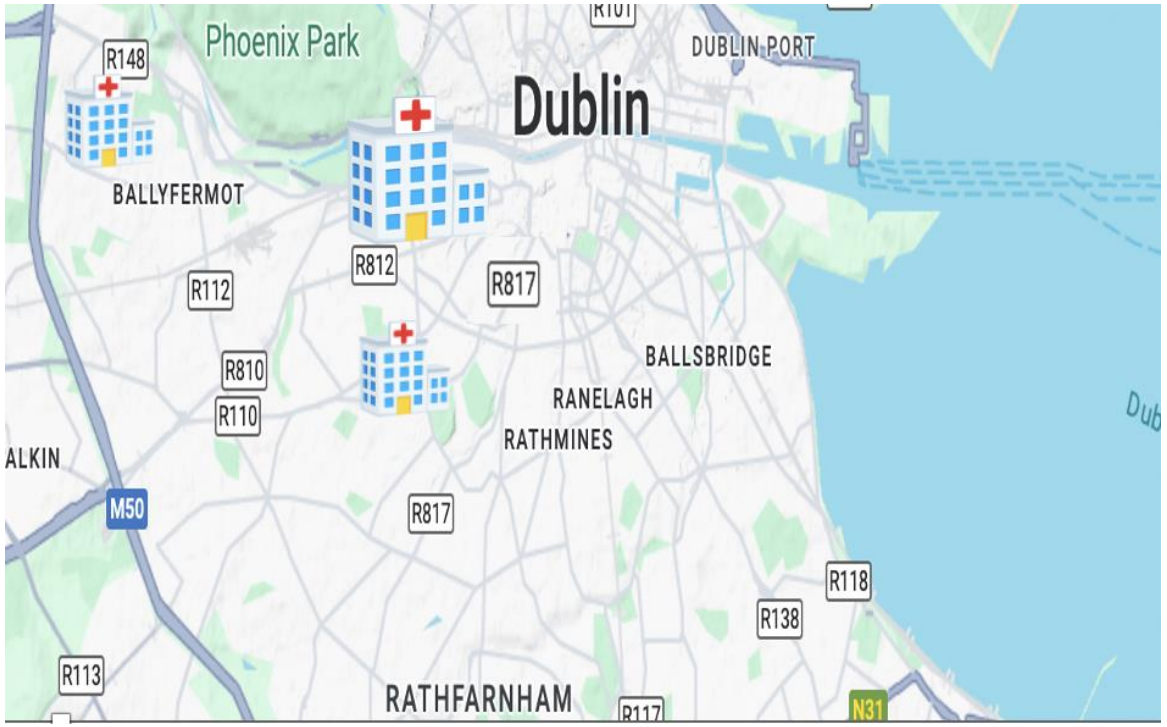


INTEGRATED CARE

Hospital Avoidance

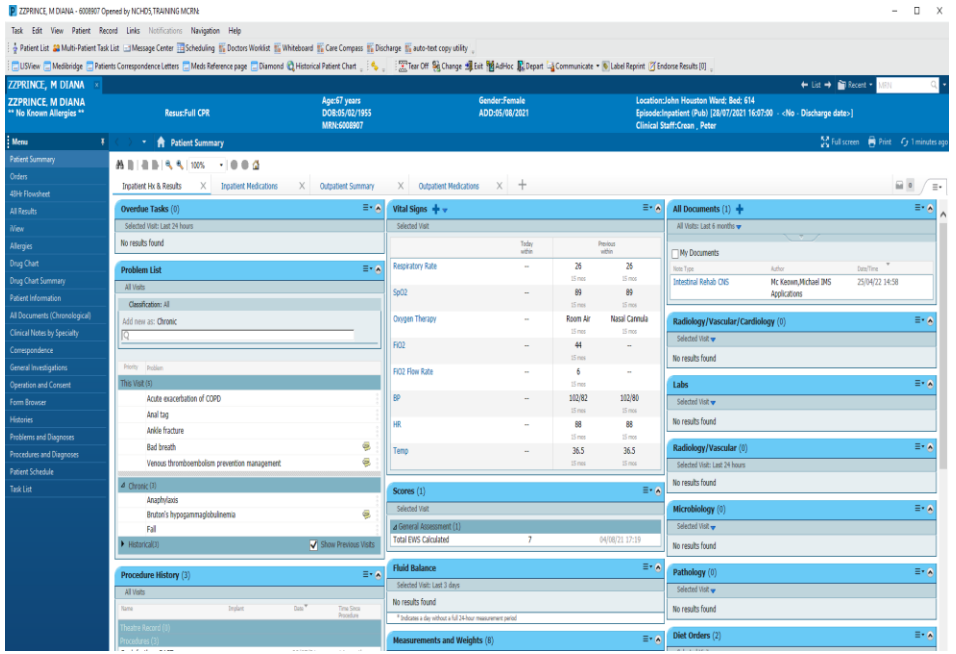
Domiciliary Comprehensive Geriatric Assessment



INTEGRATED CARE

Hospital Avoidance

Domiciliary
Comprehensive Geriatric
Assessment



INTEGRATED CARE

Hospital Avoidance

Domiciliary Comprehensive Geriatric Assessment

- **OT review**
- Disorientated
- Squalor/incontinence
- Low mood and poor engagement
- Pain

INTEGRATED CARE

Hospital Avoidance

Treatment, monitoring and Provision of care

- **Nursing review**
- Pain
- Infected pressure areas
- Skin breakdown
- Poor bed mobility

INTEGRATED CARE

Hospital Avoidance

Treatment, monitoring and Provision of care

Hb 5.7

Na 121

CRP 65

INTEGRATED CARE

Hospital Avoidance

Treatment, monitoring and Provision of care

Consultant review

“What Matters To Me”

BC had capacity to refuse hospital admission

INTEGRATED CARE

Hospital Avoidance

Treatment, monitoring and Provision of care






Treatment

- **Care**
- Analgesia
- Antibiotics
- Multivitamins
- MDT

INTEGRATED CARE

Hospital Avoidance

Treatment, monitoring and Provision of care







Treatment

- Care
- Analgesia
- Antibiotics
- Multivitamins
- **MDT**

INTEGRATED CARE

Hospital Avoidance

Rapid Coordination of Supports

Primary Care

INTEGRATED CARE

Hospital Avoidance

Rapid Co-ordination of Supports

Primary Care

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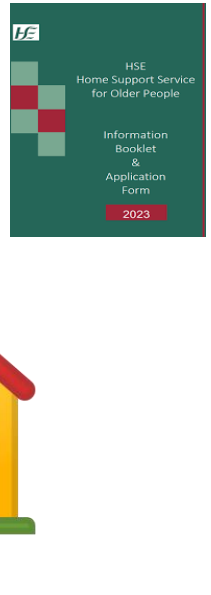
EMPOWERING PEOPLE IMPROVING EXPERIENCES WORKING TOGETHER

INTEGRATED CARE

Hospital Avoidance

Rapid Co-ordination of Supports

Primary Care



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EMPOWERING PEOPLE IMPROVING EXPERIENCES WORKING TOGETHER

INTEGRATED CARE

Hospital Avoidance

Rapid Co-ordination of Supports

Primary Care

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INTEGRATED CARE

Hospital Avoidance

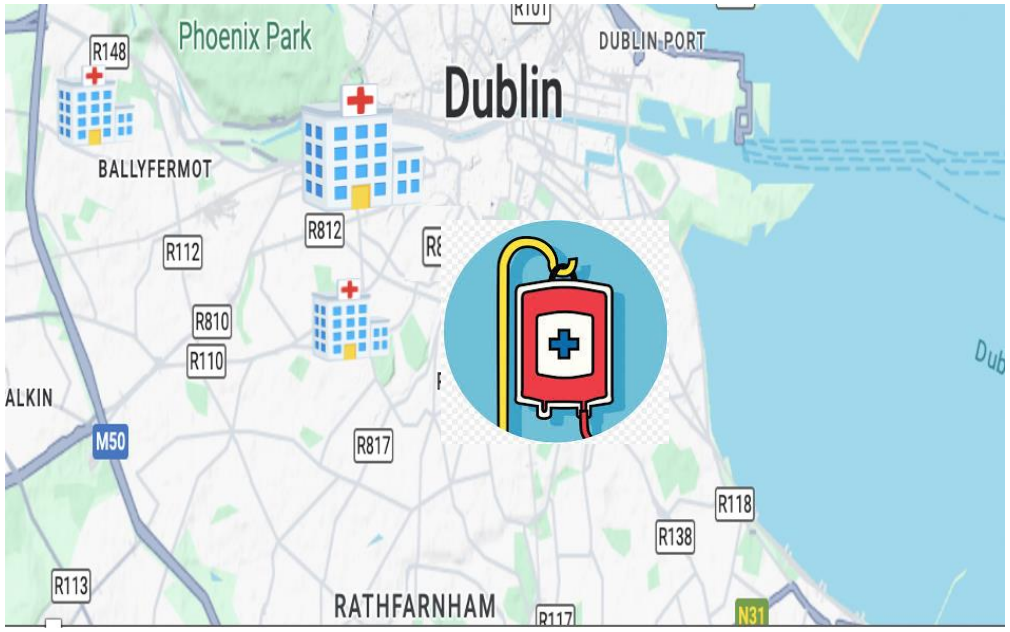
Rapid Co-ordination of Supports

EMPOWERING PEOPLE IMPROVING EXPERIENCES WORKING TOGETHER

INTEGRATED CARE

Hospital Avoidance

Rapid Co-ordination of Supports



EMPOWERING PEOPLE IMPROVING EXPERIENCES WORKING TOGETHER

Hospital Avoidance

Outcome

- Walked into the hub
- CPM
- Reduced HCP
- Discharged from CVW

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INTEGRATED CARE

Supporting the Pillars of Unscheduled care

In Hospital Care Delivery

- In reach and Outreach
- ED avoidance admission when necessary
- Inpatient Consult

Discharge Management

- Readmission Avoidance
- Early Supported Discharge Rehabilitation and Delirium
- 7/7 HCSA service

What Matters to Me

Bi-Directional Patient Centred Integrated Care

Discharge Management In Hospital Care delivery

- **Ms NW**

INTEGRATED CARE

Discharge Management In Hospital Care delivery

- Ms NW
- **73 yr old lady**

INTEGRATED CARE

Discharge Management In Hospital Care delivery

- **Ms NW**
- 73 yr old lady
- **Explained fall 15th August**

INTEGRATED CARE

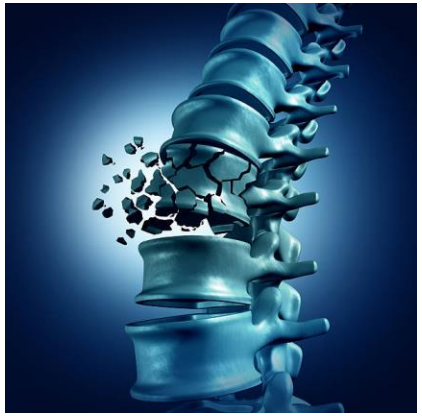
Discharge Management + In Hospital Care delivery

- **Hip Fracture**

INTEGRATED CARE

Discharge Management + In Hospital Care delivery

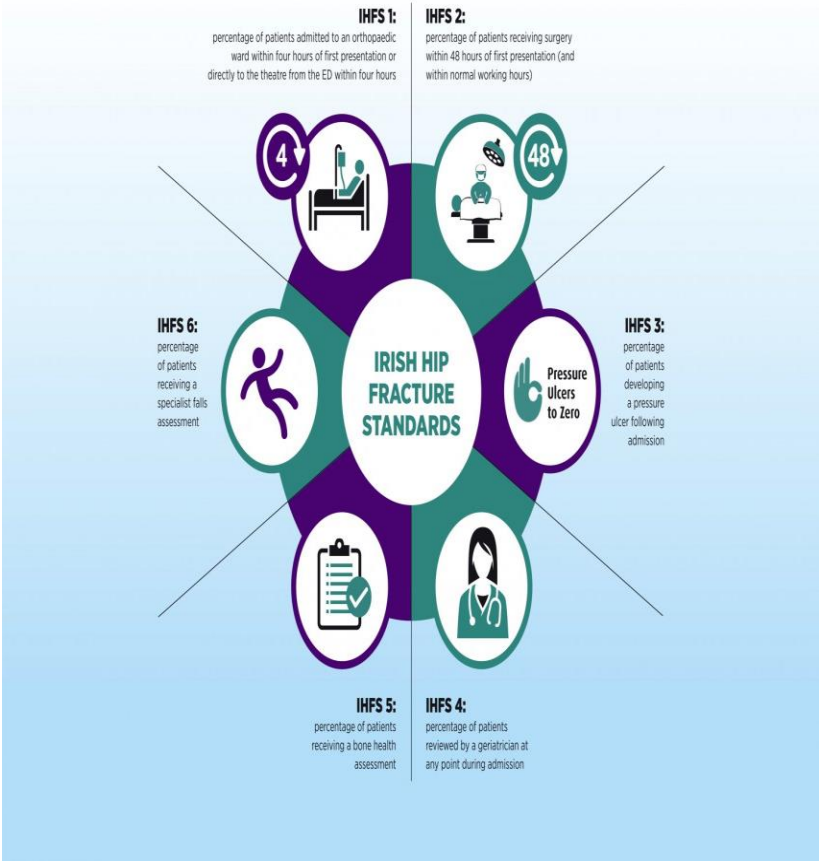
- Hip Fracture
- **And**
- **Spine Fracture (L3)**



INTEGRATED CARE

Discharge Management + In Hospital Care delivery

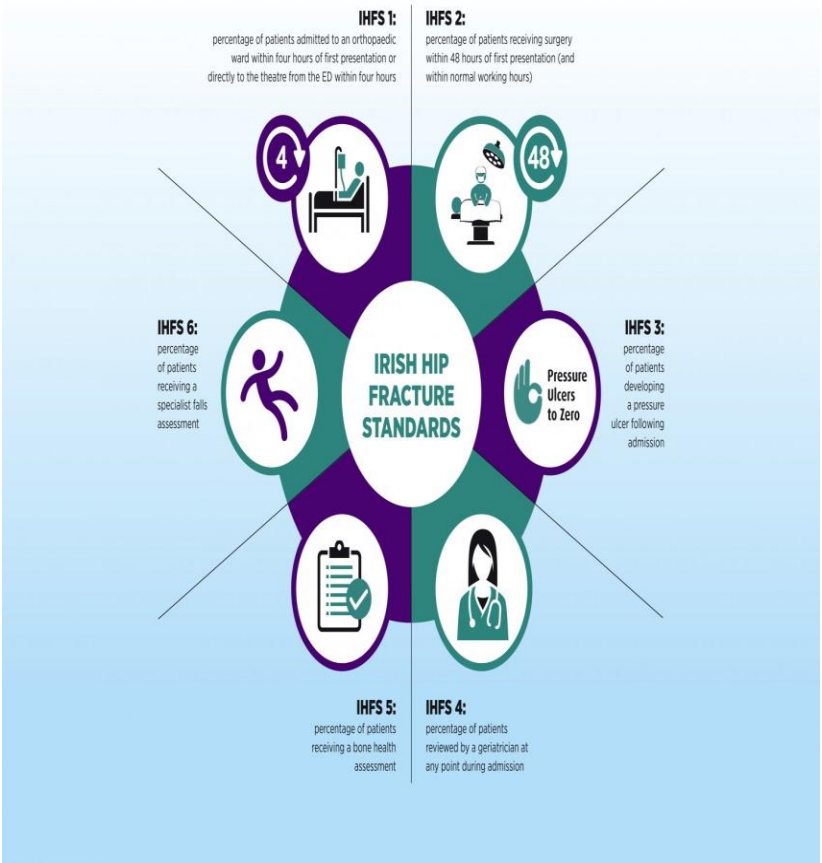
- **ED < 4 hrs**



INTEGRATED CARE

Discharge Management + In Hospital Care delivery

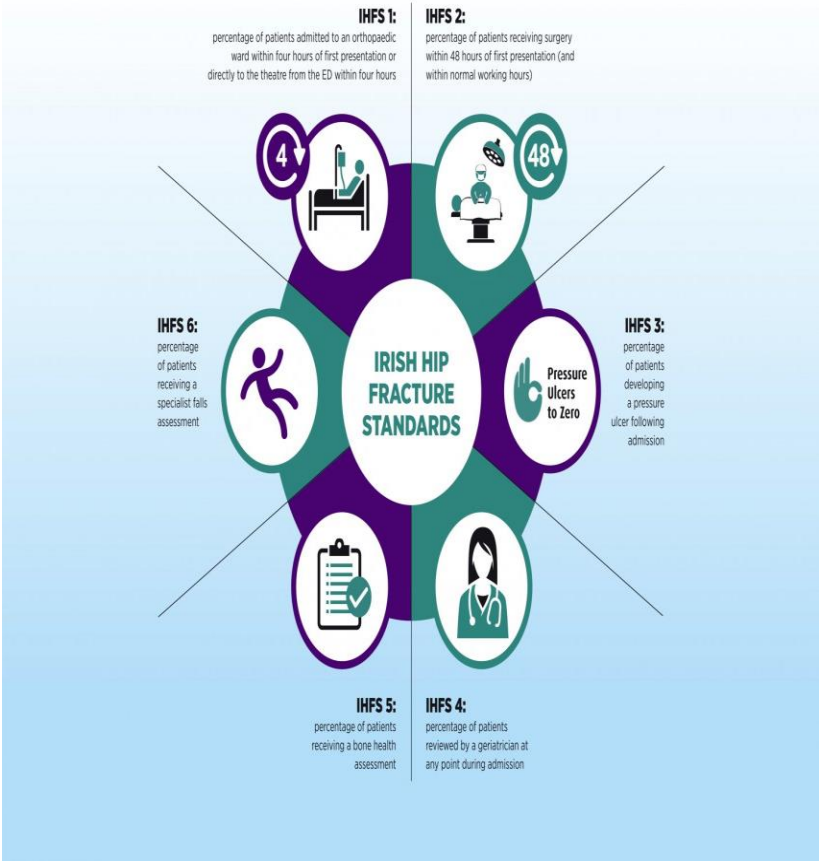
- **ED < 4 hrs**



INTEGRATED CARE

Discharge Management + In Hospital Care delivery

- ED < 4 hrs ✓
- **Theatre < 48 hrs**



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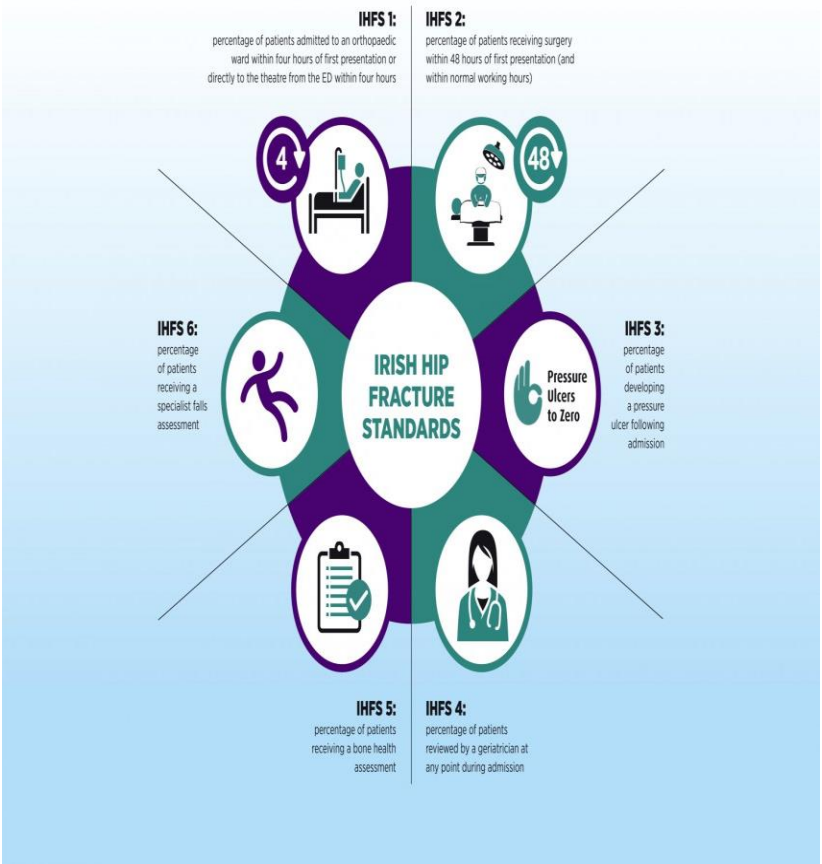
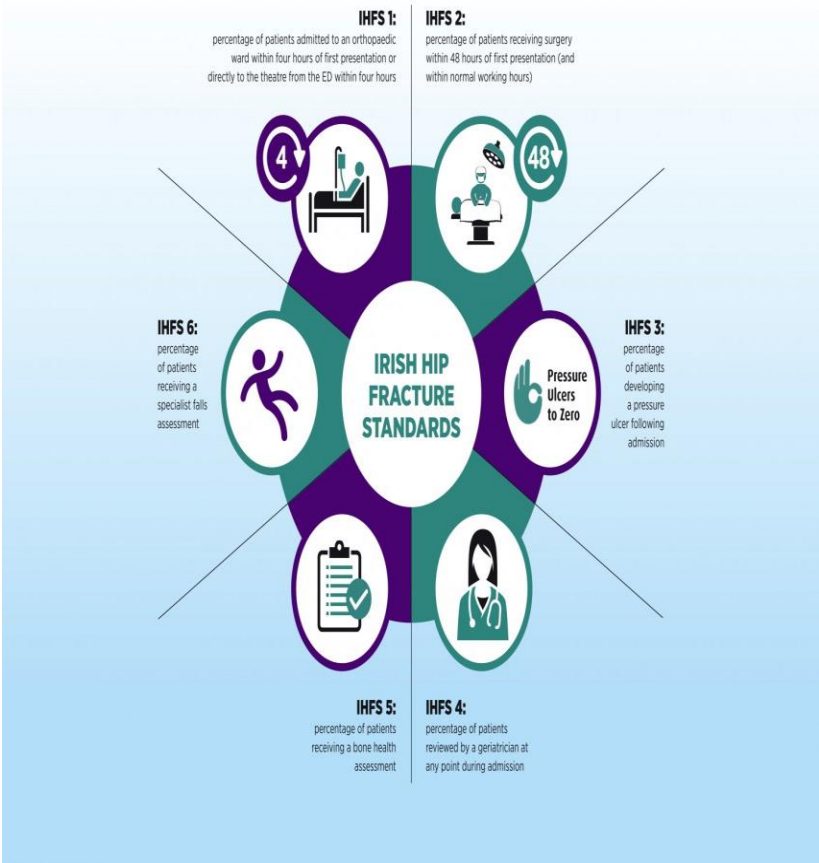


INTEGRATED CARE

Discharge Management + In Hospital Care delivery

- ED < 4 hrs ✓
- Theatre < 48 hrs ✓
- **1st day mobilisation**



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Discharge Management + In Hospital Care delivery

- ED < 4 hrs ✓
- Theatre < 48 hrs ✓
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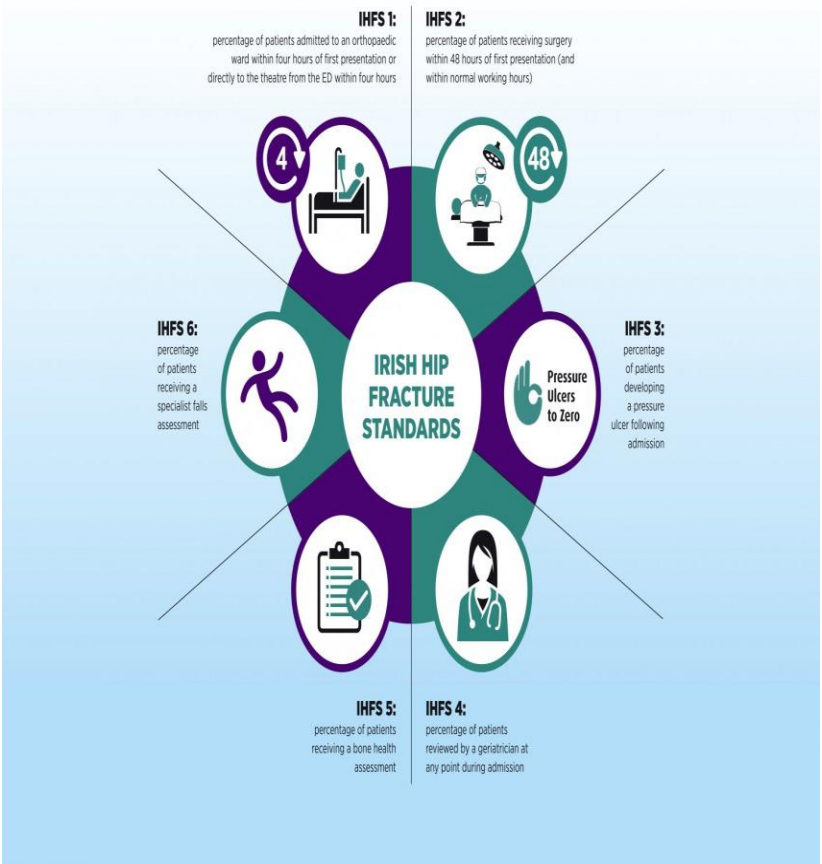
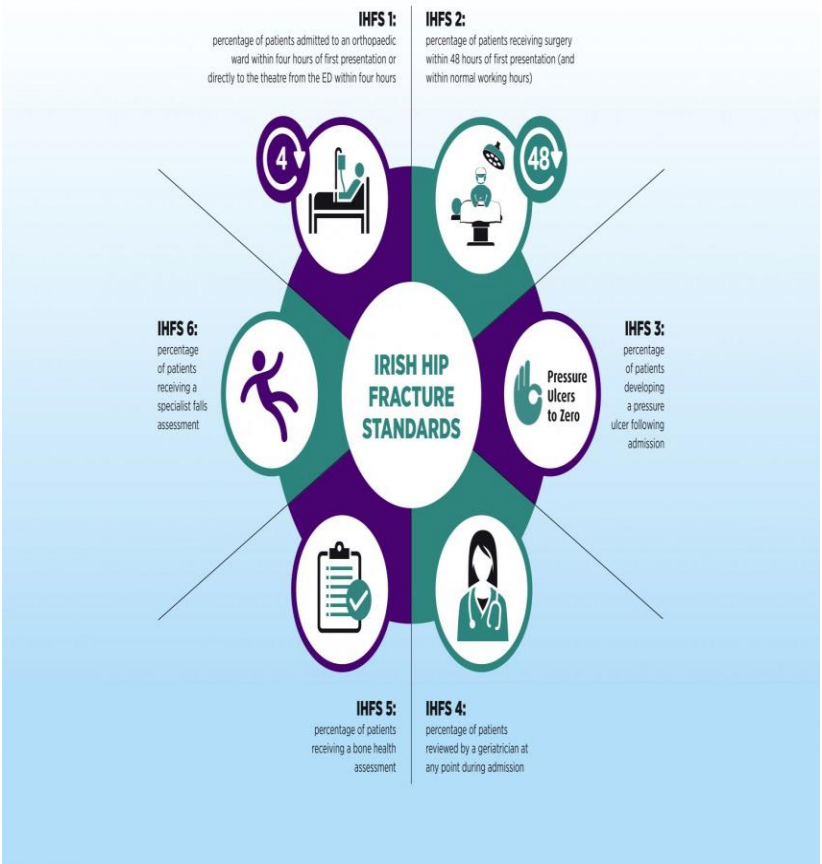


INTEGRATED CARE

Discharge Management + In Hospital Care delivery

- ED < 4 hrs ✓
- Theatre < 48 hrs ✓
- 1st day mobilization ✓
- **Bone Health**



INTEGRATED CARE

Discharge Management + In Hospital Care delivery

- ED < 4 hrs ✓
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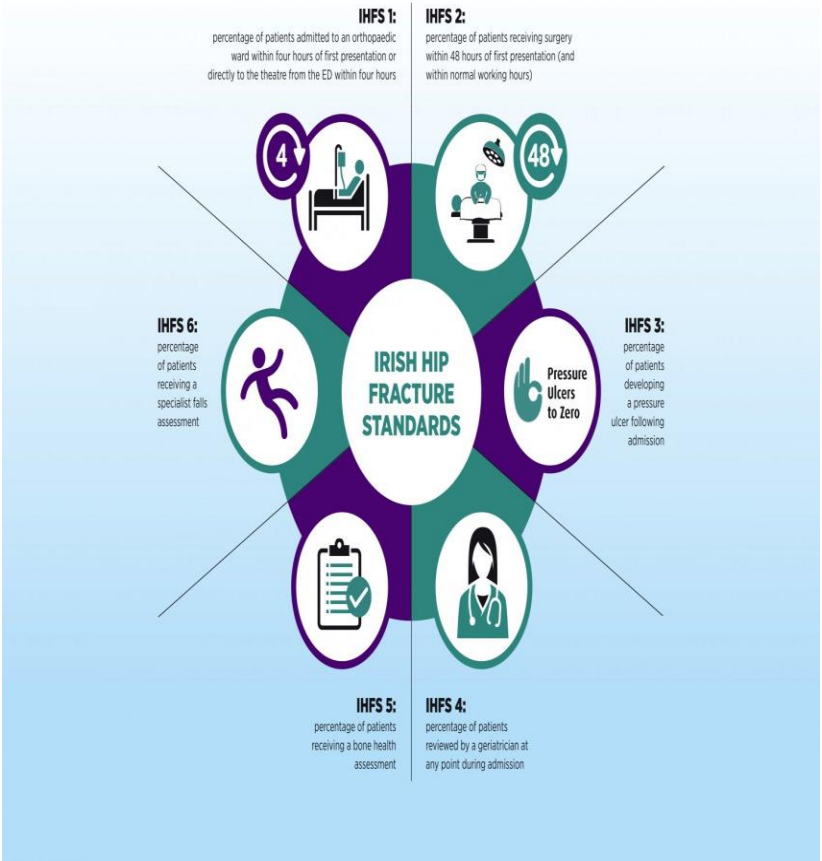
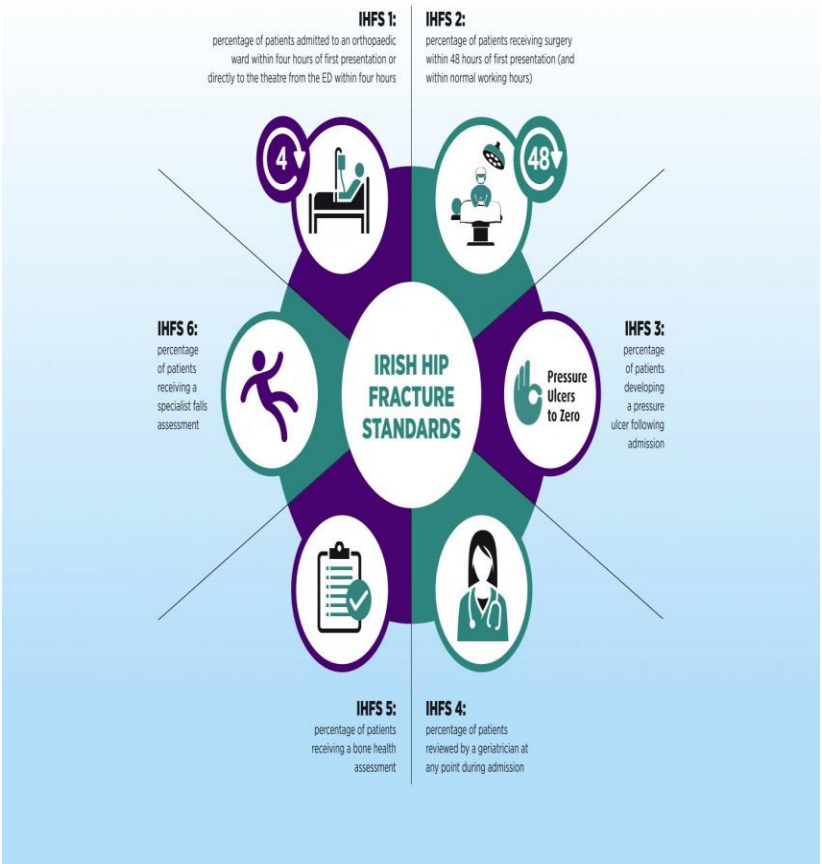


INTEGRATED CARE

Discharge Management + In Hospital Care delivery

- ED < 4 hrs ✓
- Theatre < 48 hrs ✓
- 1st day mobilization ✓
- Bone Health ✓
- **No pressure sore**



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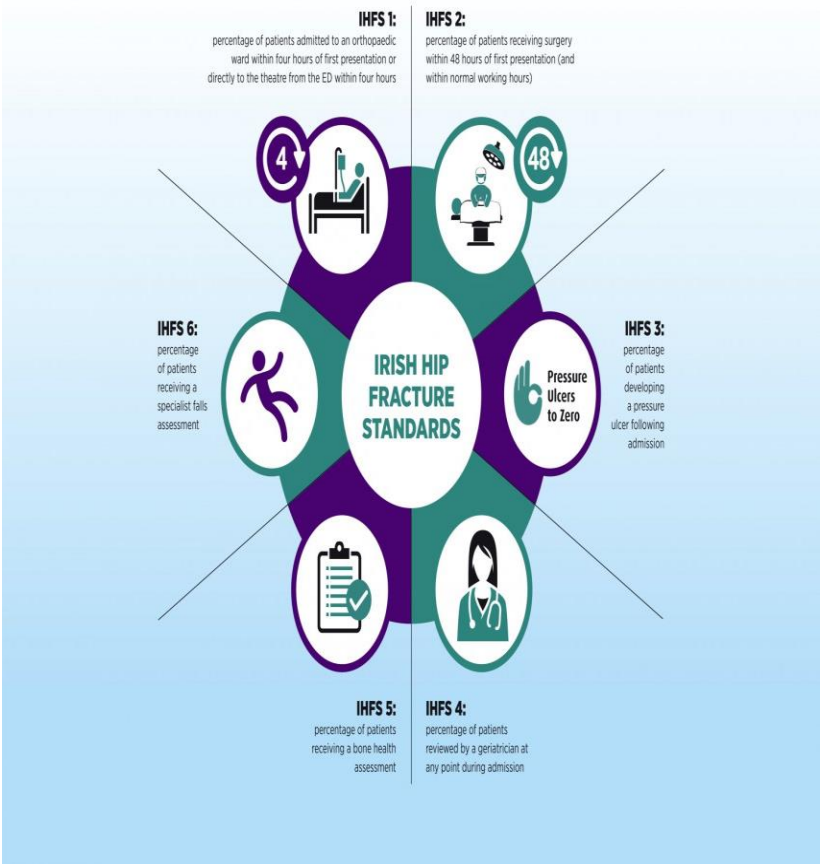

INTEGRATED CARE

Discharge Management + In Hospital Care delivery

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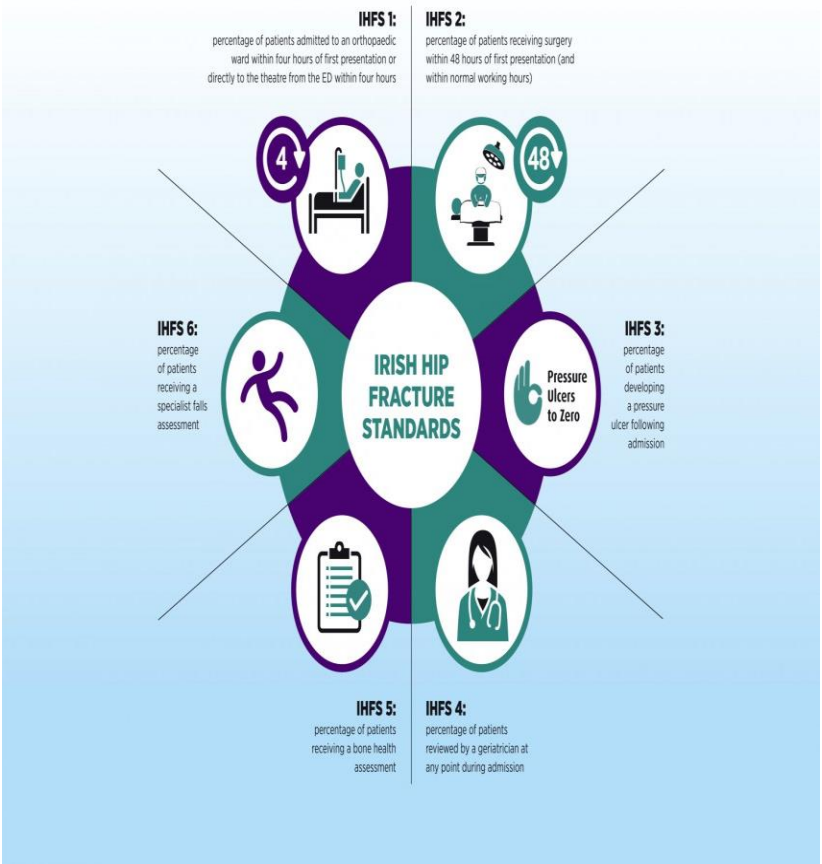
- 1st day mobilization ✓
- Bone Health ✓
- No pressure sore ✓
- **Falls Assessment**



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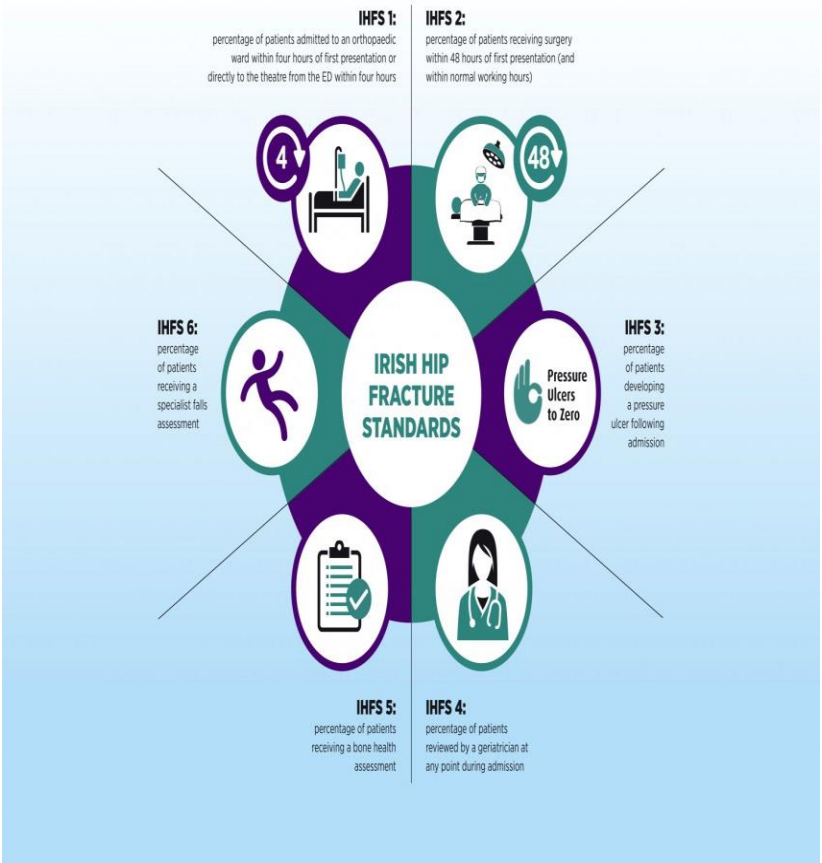

INTEGRATED CARE

Discharge Management + In Hospital Care delivery

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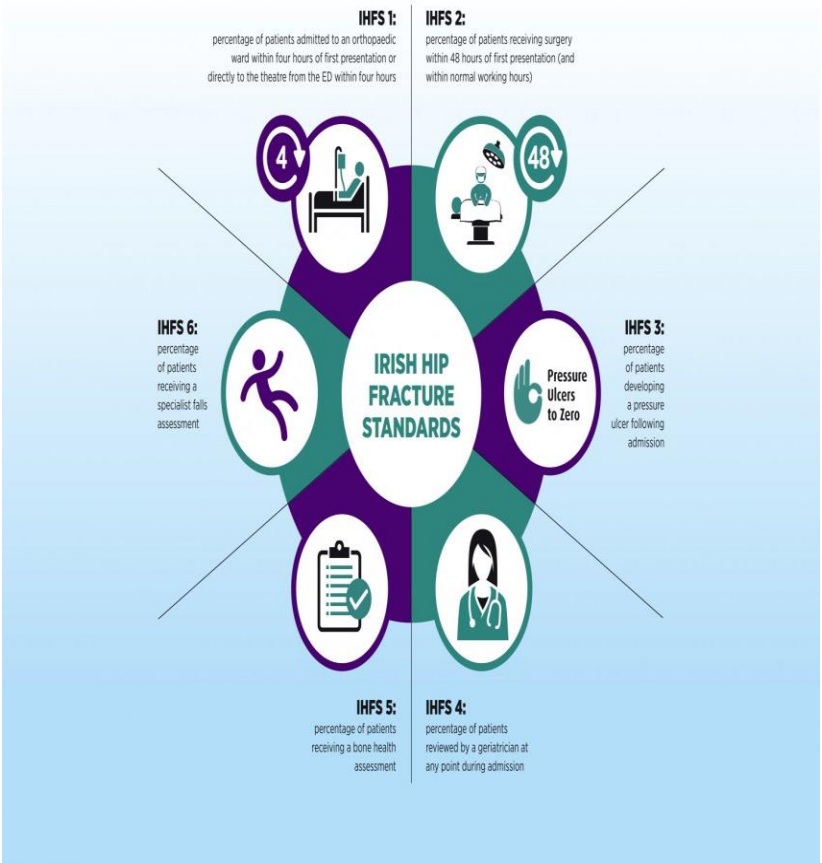
- Bone Health ✓
- No pressure sore ✓
- Falls Assessment ✓
- **Geriatrician review**



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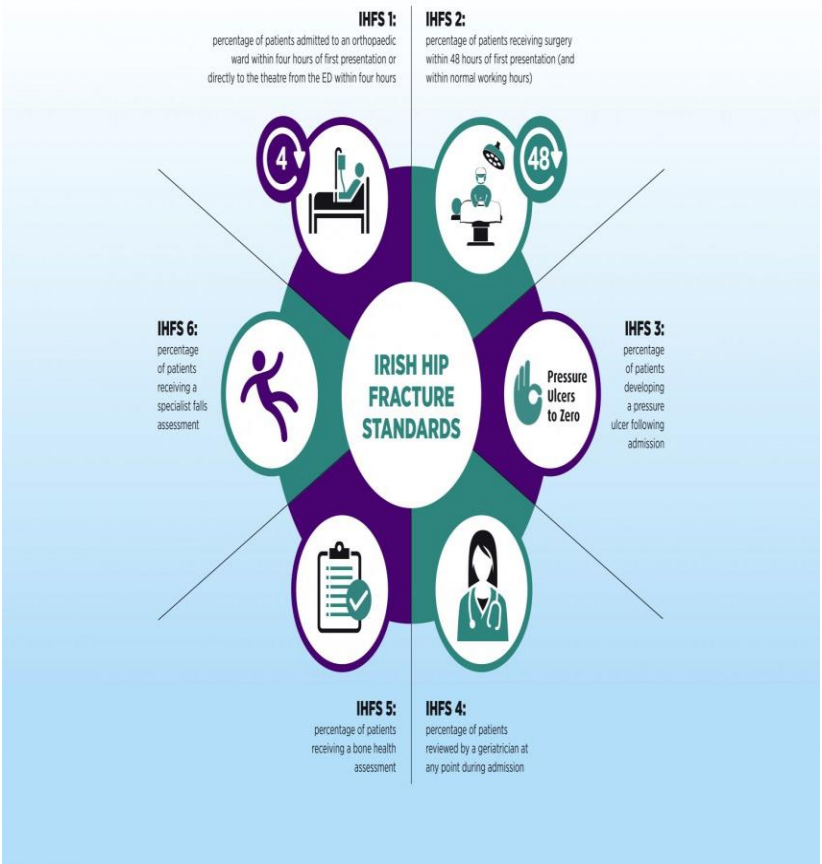

INTEGRATED CARE

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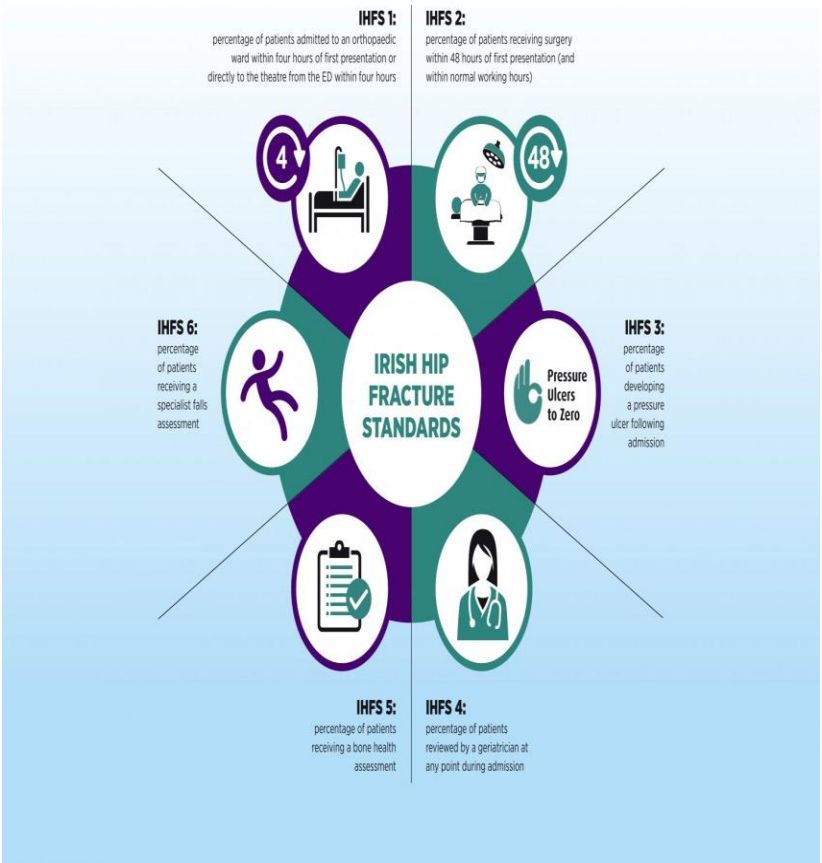

Early Supported Discharge day 13

Early Supported Discharge day 13

Early Supported Discharge day 13

- **What Matters**
  - **Regain independence**
  - **Return driving**

Early Supported Discharge day 13




- **What Matters**
  - **Regain independence**
  - **Return driving**

Early Supported Discharge day 13





- **What Matters**
  - **Regain independence**
  - **Return driving**

Early Supported Discharge day 13






- **What Matters**
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Early Supported Discharge day 13






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Early Supported Discharge day 13

- **What Matters**
  - **Regain independen**
  - **Return driving**

Early Supported Discharge day 13






- **What Matters**
  - **Regain independen**
  - **Return driving**


INTEGRATED CARE

Supporting the Pillars of Unscheduled care

ED Operations

- Consultant Geriatrician in ED
- Direct and Immediate Access to ICPOP team
- Admission Avoidance
- 7/7 HCSA service

What Matters to Me

Bi-Directional Patient Centred Integrated Care

ED
Operations

- Mr J O'K

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ED
Operations

- Mr J O'K
- 95 yr old gentleman

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ED
Operations

- Mr J O'K
- 95 yr old gentleman
- **ED presentation**

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ED Operations

- **Recent falls**

ED
Operations

INTEGRATED CARE

- Recent falls
- **Confused**

ED Operations

- **ED consultant review**

ED Operations

- **ED consultant review and workup**







INTEGRATED CARE

ED Operations

- ED consultant review and workup
- **Frailty @ Front Door**








INTEGRATED CARE

ED Operations

- ED consultant review and workup
- Frailty @ Front Door
- **ED Consultant Geriatrician review**









ED
Operations

- **ED environment unsuitable**

ED
Operations

- **ED environment unsuitable**

INTEGRATED CARE

ED
Operations

- ED environment unsuitable
- **Care planning meeting**

INTEGRATED CARE

ED
Operations

- ED environment unsuitable
- Care planning meeting

- **What Matters**

INTEGRATED CARE

ED Operations

- **Home w ICPOP**
  Delirium Early
  Supported Discharge

INTEGRATED CARE

ED
Operations

- Home w ICPOP
  Delirium Early
  Supported Discharge

- **Next day cANP review**

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INTEGRATED CARE

ED Operations

- Home w ICPOP Delirium Early Supported Discharge
- Next day cANP review
- **Next day ICPOP consultant virtual review**

ED
Operations

- **Ongoing delirium**



ED
Operations

- Ongoing delirium
- **Unmet needs**



INTEGRATED CARE

ED Operations

- Ongoing delirium
- **Unmet needs**
  - **Nutrition**

ED Operations

- Ongoing delirium
- **Unmet needs**
  - Nutrition
  - **Medications**

ED
Operations

- Ongoing delirium
- Unmet needs
  - Nutrition
  - Medications
  - **Personal cares**

ED Operations

- Ongoing delirium
- Unmet needs
  - Nutrition
  - Medications
  - Personal cares
- **Home falls assessment**







ED
Operations

- **cANP Delirium Management**

ED
Operations

- **cANP Delirium Management**

ED
Operations

- **cANP Delirium Management**

ED
Operations

- **cANP Delirium Management**

ED
Operations

- **cANP Delirium Management**

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ED
Operations

- **cANP Delirium Management**

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ED
Operations

- **cANP Delirium Management**

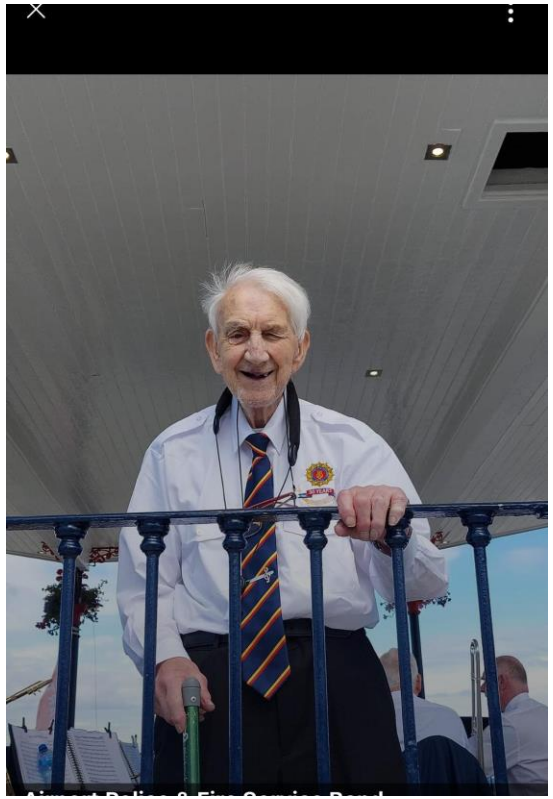
INTEGRATED CARE

ED
Operations

- **Outcome**

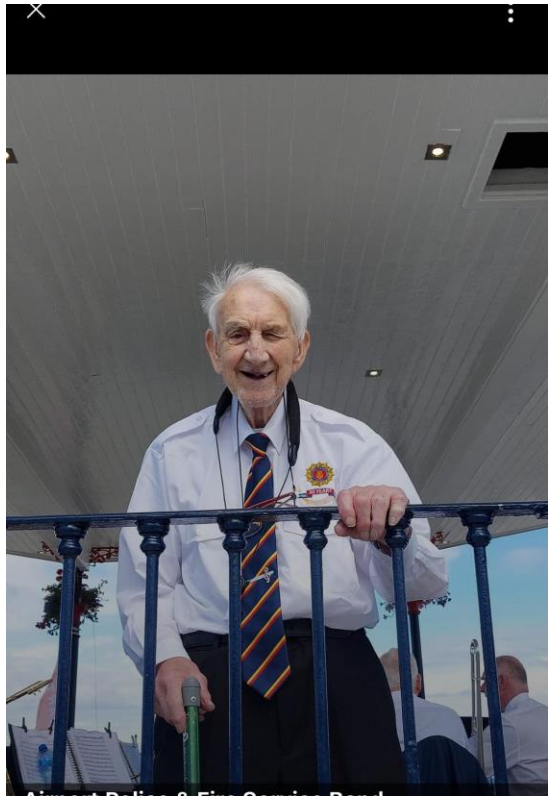
ED
Operations

- **Outcome**



ED
Operations

- **Outcome**



INTEGRATED CARE

Supporting Unscheduled Care Direct SJH

From 2024 to 2025

Hospital re-admission avoidance – complex case	
To May 2025	60
2024	138
2023	58

7% increase

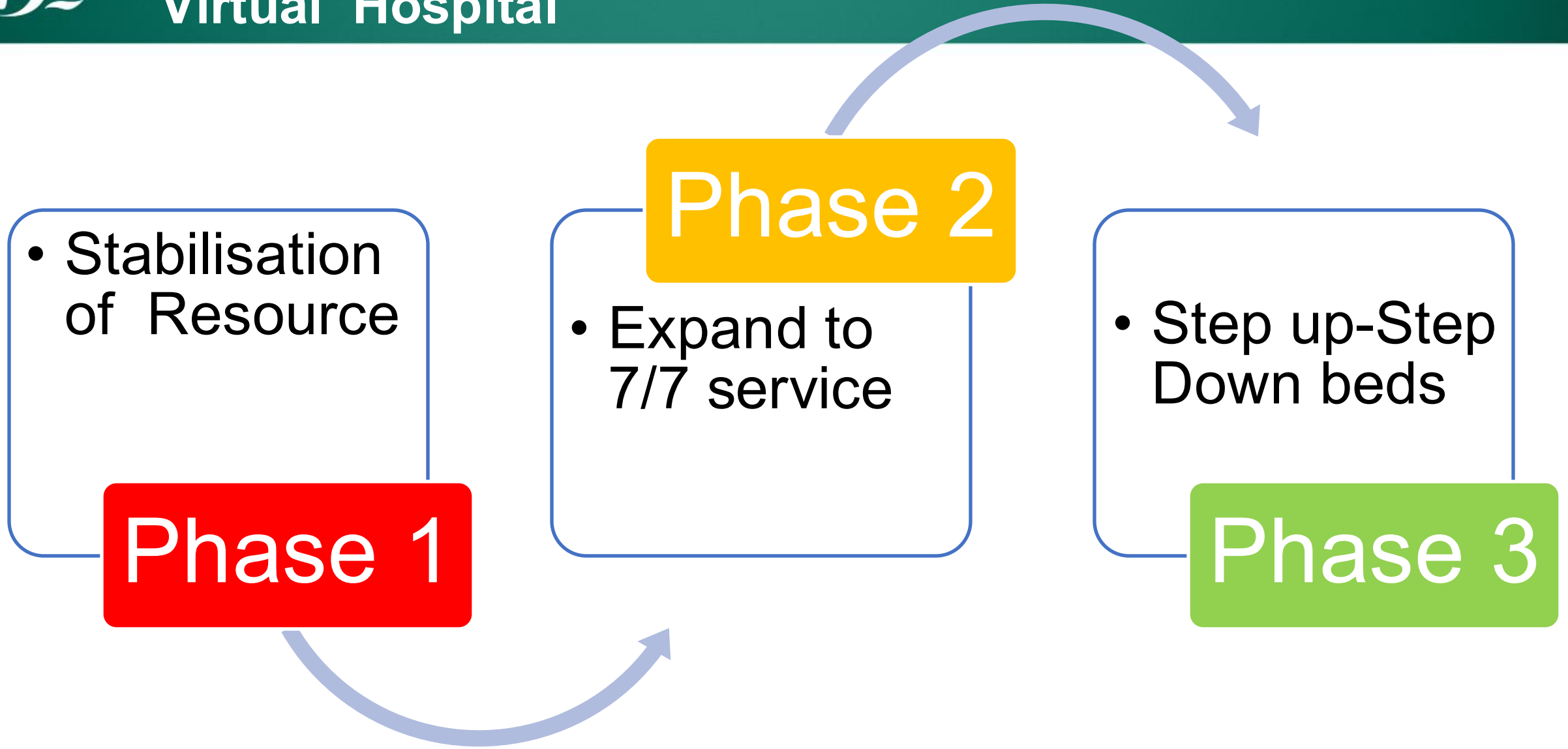
ED Frailty @ Front Door	
To May 2025	40
2024	39
2023	25

105 % increase

Early Supported Discharge Rehab	
To May 2025	22
2024	56
2023	30

0 % increase

Realistic ambition…. From Virtual Care to Virtual Hospital



Community Virtual Care Patient and Carer Feedback

INTEGRATED CARE

Very restrictive in hospital environment, much more happy to be at home.
Home exercise is much better for someone like me.

The team was so knowledgeable and helpful , Mum is a tricky character but I felt really supported

Staff in hospital were very nice but I was anxious to get home.
Felt like I could do more walking and exercise at home than in hospital.
Free to get up and move at home when I want to, in hospital felt like I was on a schedule.

I was very nervous about going home initially, I'm delighted to be home now though.

They were out so quickly to se me, I thought I would be waiting ages

I felt really listened to, I have also learned that I need to take care of myself

Top of the Range Service

INTEGRATED CARE

Go raibh míle maith agaibh

Panel Discussion

Martina Queally (REO)
Prof. Áine Carroll (Prof. Integrated Care and Improvement, UCD and NRH)
Prof. Breda Cushen (Cons Respiratory Physician, Beaumont Hospital) and;
Dr Richard Lewanczuk (Senior Medical Director of Health System Integration at Alberta Health Services)

Closing Remarks

Geraldine Crowley
Assistant National Director of the Enhanced Community Care Programme