#HSEConference2026

# Integrated Healthcare Conference

## Delivering Integrated Care Together

### Supporting Older Adults through Integrated Care

**Liffey A, Convention Centre Dublin**

**3 September, 11:30 – 12:55**

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Welcome and Introduction

Sandra Broderick
REO, HSE Mid West

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Home Supports

## Delivering Integrated Care Together


Patricia Whelehan

Assistant National Director, Older Persons Services, Access and Integration


ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# HSE Home Support Services

- **Home Support Services** aim to enable individuals to continue to, or to return to, live in their own homes and communities with confidence, security and dignity, providing the 'right care, in the right place, at the right time,' in accordance with assessed needs and available resources.

- **Service snapshot**

➢ **25.55m** Home Support Hours delivered in 2025 , an increase of **1.78/+7.5%** on 2024. **60,463** services users in receipt of service as at 31st December 2025.

➢ **15.63m** hours delivered July 2026 YTD, with 62,681 service users in receipt.

➢ Continued growth in delivery of Home Support – **5m hrs/+24.8%** increase at end Dec 2025 vs Dec 2021

# National Home Support Programme

- The HSE have established the **Reform of Home Support Services and Establishment of a Statutory Home Support Scheme Programme** as the central point for strategic planning and decision making within the HSE to ensure a standardised approach in the preparation for the pending regulation of the home support service and the establishment of a future statutory home support scheme (SHSS).
- This Programme is overseeing the delivery of the following **three key elements** that will enable the HSE health regions to meet future regulatory compliance and provide a high quality home support service.
    - Development of a standardised operating model for regulated home support services using the digital interRAI Home Care Assessment.
    - Design and delivery of a digitally enabled and data driven home support service and replacement of existing Nursing Home Support Scheme (NHSS) system.
    - Significant national and regional communication and change management.

# The Home Support Regulatory Framework

- **Health (Amendment) (Home Support Providers) Act 2026** (enacted on the 1st July 2026) - establishes a mandatory national framework for the registration and inspection of home support services delivered to older persons and individuals with disabilities in private dwellings.

- This Act and when the regulation of services commence it will:
  - make it an offence for an organisation to provide a Home Support service without being registered with HIQA
  - ensure that registered home support providers will not be permitted to operate below the standard set out in the regulations
  - give the HIQA and the Chief Inspector the authority to grant, amend and cancel registration if home support providers fail to meet minimum requirements as set out in the regulations
  - enable HIQA to monitor and assess compliance with regulations and HIQA national standards

This Act applies to all individuals/populations in receipt of home support services and to all home support providers.

You can access further information here; https://www.oireachtas.ie/en/bills/bill/2025/84/

# Anticipated Regulatory Timelines

## Year 1 - Commencement Period

- The commencement period is anticipated to run for 1 year (July 2026 – July 2027)
- Includes the finalisation of the necessary secondary legislation to support the implementation of the Act (the regulations) and finalisation of HIQA national standards for home support providers to include guidance material for service users and providers to ensure the scope of regulation and responsibilities for relevant stakeholders is clearly set out.

## Year 2 – Bill Commenced /Transitional Period

- Within 3 months of the commencement order, date TBC, being signed by the Minister (anticipated October 2027), existing providers must notify the Chief Inspector that they are providing a home support service, and that they intend to apply for registration.
- The Chief Inspector will maintain a register of existing providers who will be subject to the submission of information requirements as set out in the primary and secondary legislation.
- HIQA to gather data necessary for the development of the register and inspection process in addition to sectoral level data on home support providers to inform service delivery and policy development.

## Year 3: End of Transitional Period

- Existing providers must apply for registration no later than 2 years from the date of the Commencement Order and may continue to operate pending the grant or refusal of their application by HIQA.

# Home Support in a regulated home support environment

- Home support providers will be required to adhere to and meet the minimum requirements as set out under the Ministerial regulations expected to be published mid 2027

- The HIQA National Standards for Home Support will ensure that people receiving care at home experience a safe, high-quality service that promotes their rights and independence.

- The HSE's vision for the home support service is that of an equitable, person-centred, enabling, regulated home support service with enhanced service user, carer and staff experiences. It will deliver person centred support through a human rights-based approach, promote safety and wellbeing while being responsive and accountable.


HIQA National Standards Principles

# Meeting the Needs of the Older Adult Population

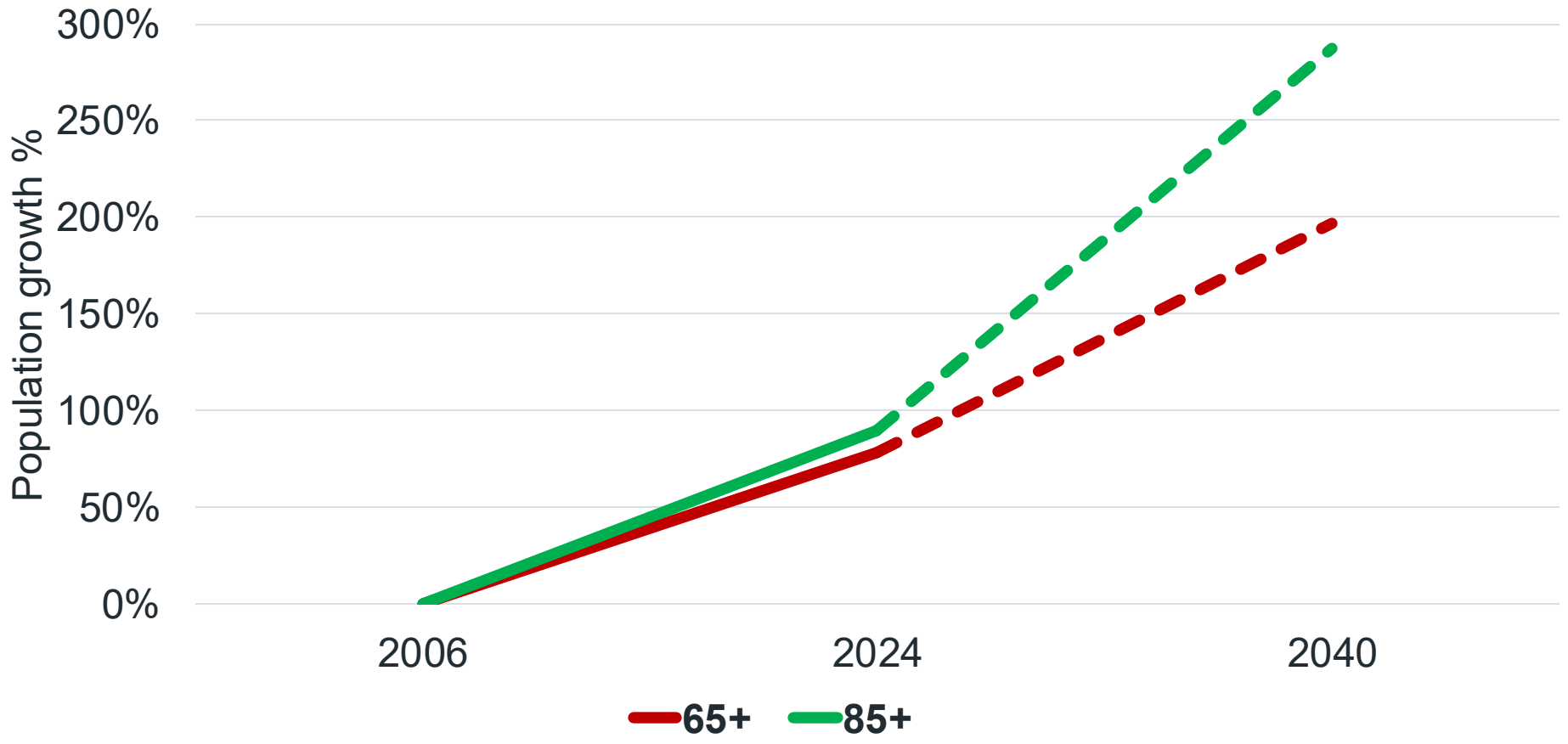
Dr Brendan Walsh
Economic and Social Research Institute

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Demographics

AN INSTITIÚID UM THAIGHDE EACNAMAÍOCHTA AGUS SÓISIALTA
ESRI ECONOMIC & SOCIAL RESEARCH INSTITUTE

# Older Population has Doubled since 2006, and will Double Again by 2040



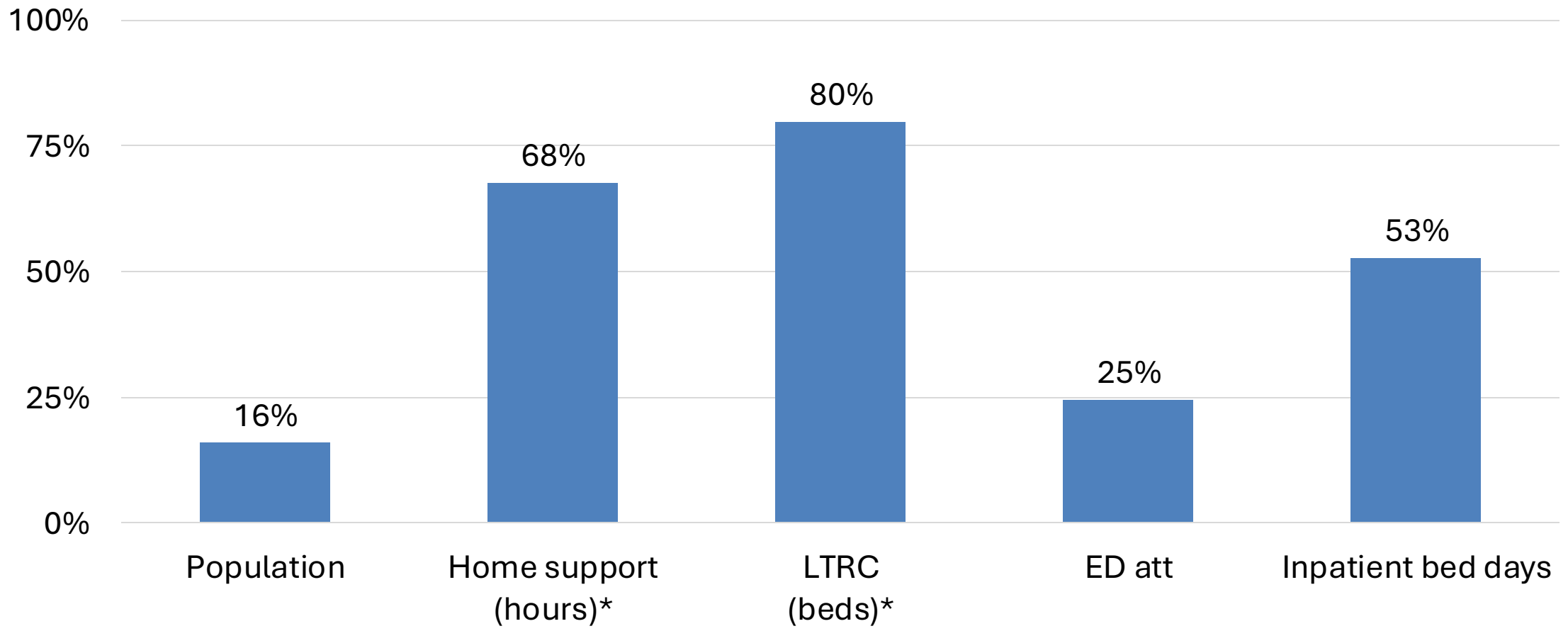

Source: CSO, Bergin & Egan 2024 https://doi.org/10.26504/rs190

# Projecting the Needs of Older Adult Populations

- **<u>Hippocrates model</u>**: ESRI published 6 reports projecting national (regional) demand and capacity requirements for health and social care:
  - *"Projections of national (regional) demand and bed capacity requirements for **public acute hospitals** in Ireland, 2023–2040."*
  - *"Projections of national (regional) demand and workforce requirements for **general practice** in Ireland, 2023–2040."*
  - *"Projections of national (regional) demand and bed capacity requirements for **older people's care** in Ireland, 2022–2040."*
- ESRI undertaking HSE workforce projections for non-acute services to 2040 using the Hippocrates Model.

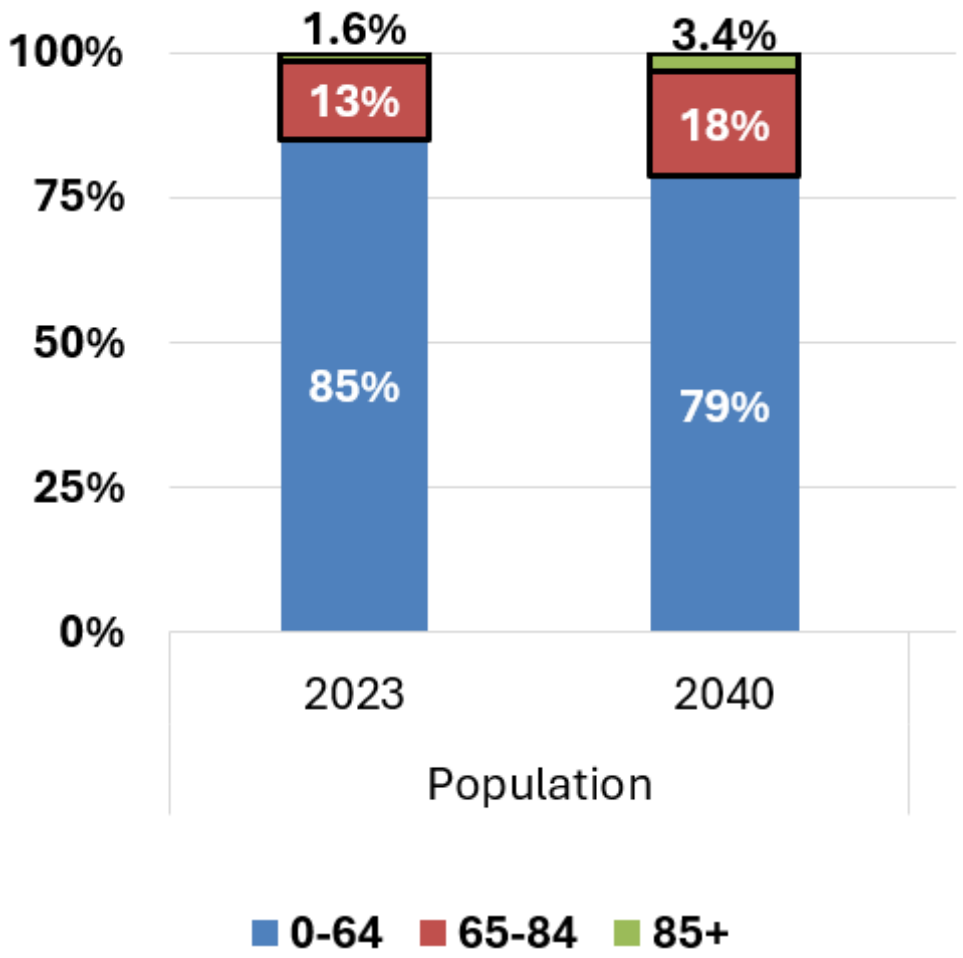
Source: https://www.esri.ie/HippocratesModel

# Projected % Increase in Requirements: 2023-2040



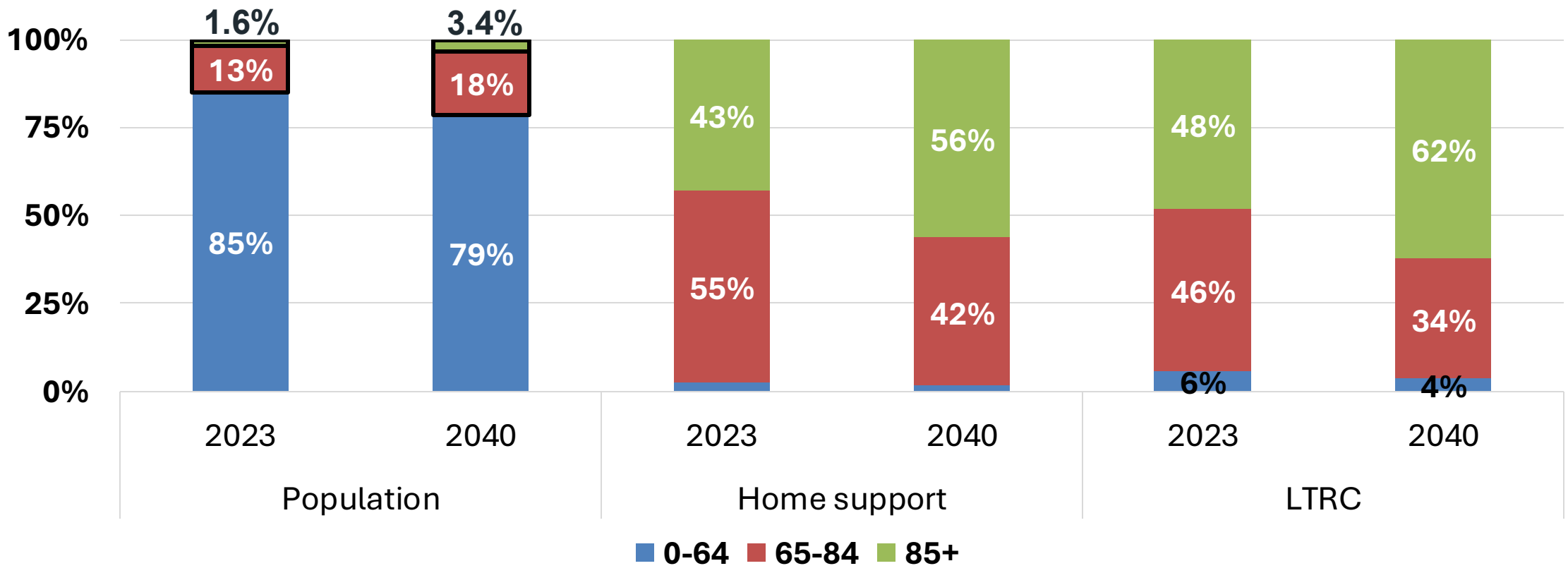

Source: https://www.esri.ie/HippocratesModel. Presented projections based on central assumptions. * relates to a 2022 baseline

# Age Composition of Population: 2023-2040



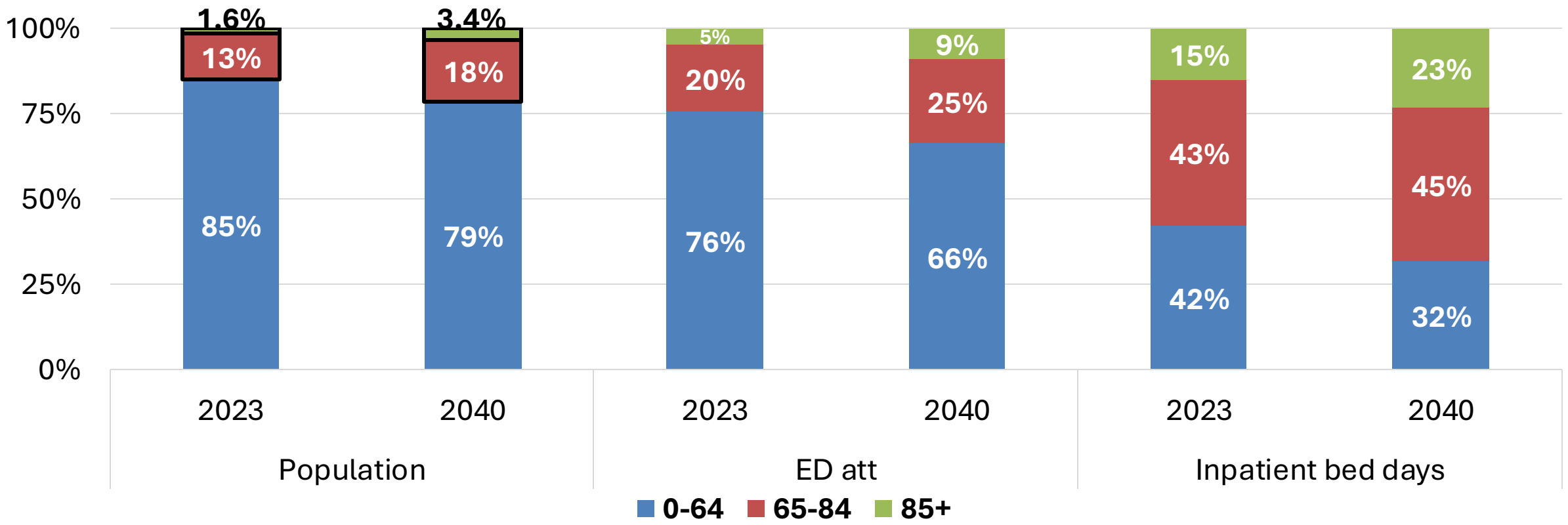

Source: https://www.esri.ie/HippocratesModel

# Age Composition of LTC: 2023-2040




Source: https://www.esri.ie/HippocratesModel

# Age Composition of Hospital Care: 2023-2040




Source: https://www.esri.ie/HippocratesModel

# Person-centred Care

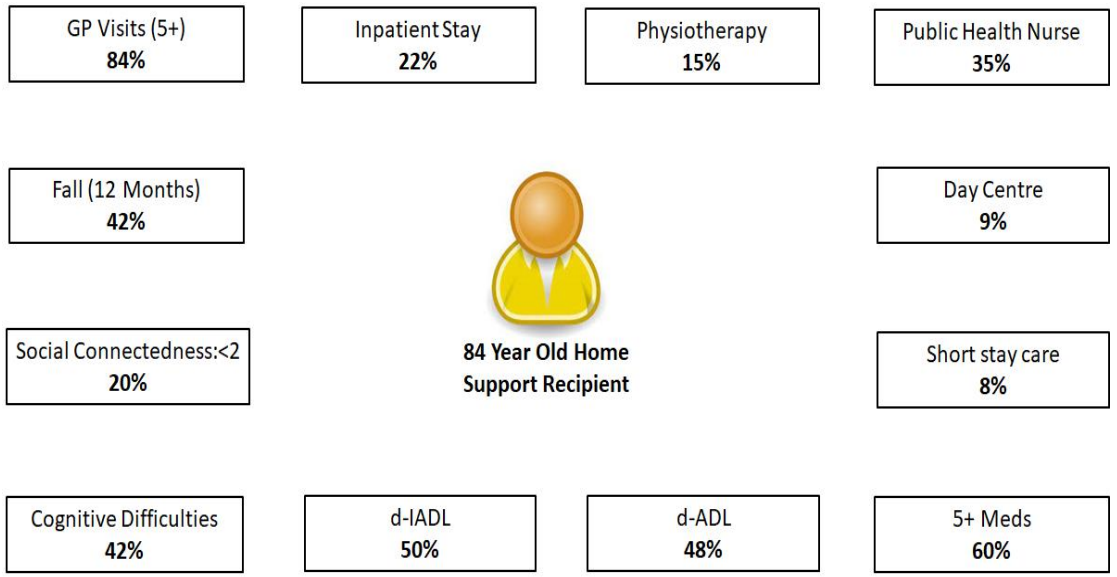
AN INSTITIÚID UM THAIGHDE EACNAMAÍOCHTA AGUS SÓISIALTA
ESRI ECONOMIC & SOCIAL RESEARCH INSTITUTE

# ‘Typical’ Home Support User

| | | | |
|---|---|---|---|
| GP Visits (5+) **84%** | Inpatient Stay **22%** | Physiotherapy **15%** | Public Health Nurse **35%** |
| Fall (12 Months) **42%** |  **84 Year Old Home Support Recipient** | | Day Centre **9%** |
| Social Connectedness:<2 **20%** | | | Short stay care **8%** |
| Cognitive Difficulties **42%** | d-IADL **50%** | d-ADL **48%** | 5+ Meds **60%** |

Source: The Irish Longitudinal Study of Ageing (TILDA)

# Integration: Technical Approach




- **Integrate**: Services should wrap around person
- **Assess**: Systematic assessment
  - *InterRAI*
- **Embed information collection and sharing**
- **Fund**: Money following the person
  - *Step 1: Population-based resource allocation*
  - *Step 2: Pooled Budgets?*

# ‘Individual’ Home Support User

Mother | Spouse | Friend | Neighbour

Mass goer | Carer

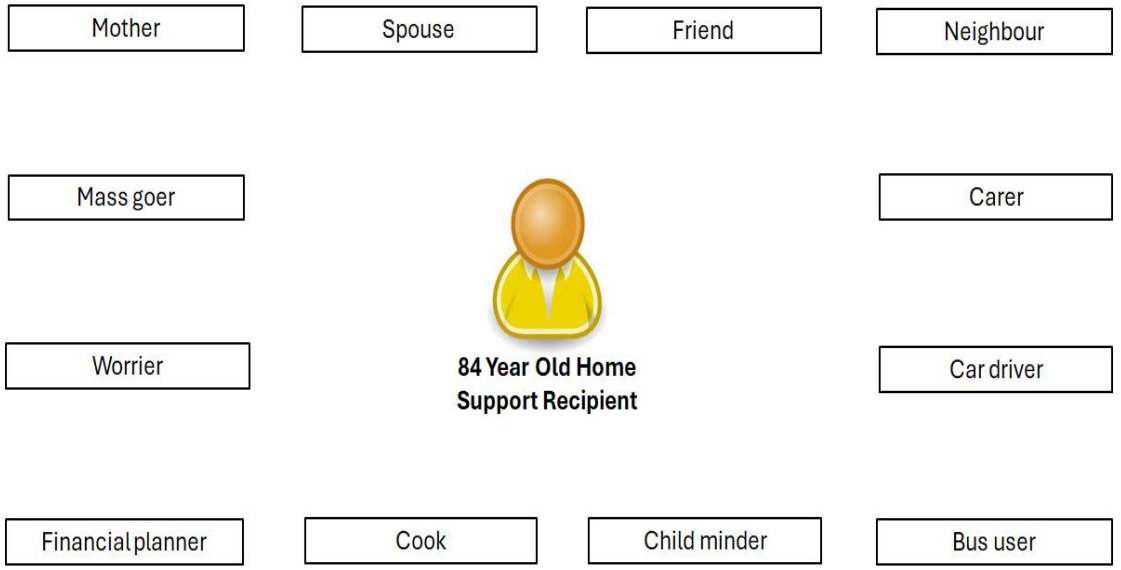
**84 Year Old Home Support Recipient**

Worrier | Car driver

Financial planner | Cook | Child minder | Bus user

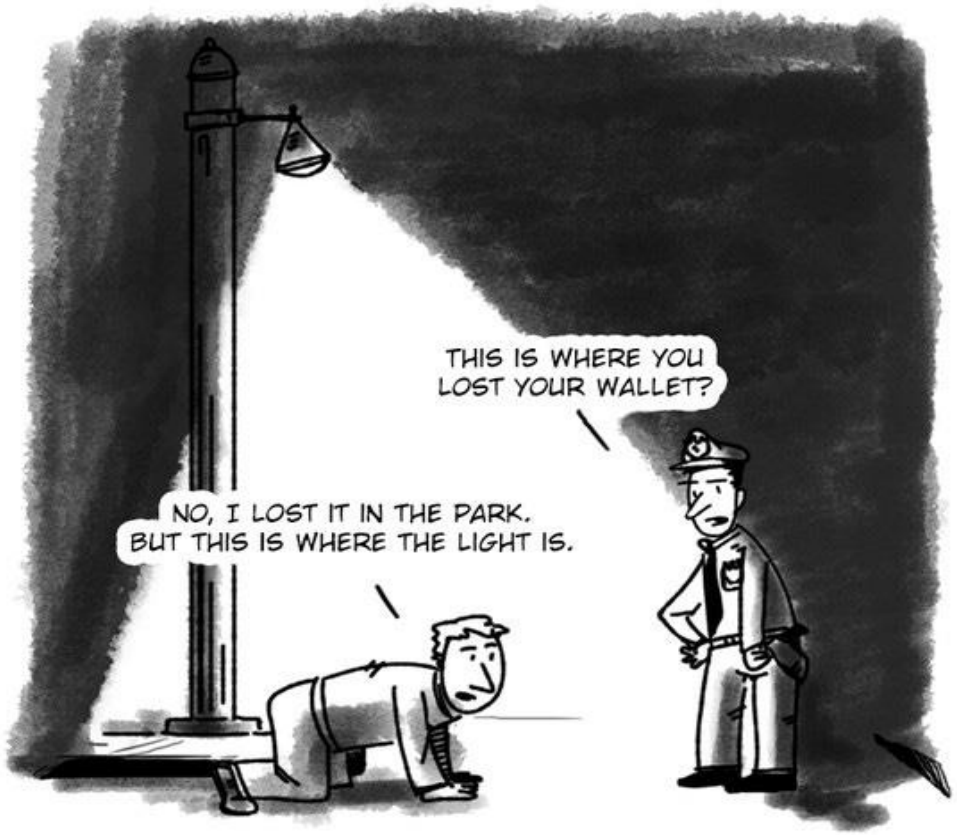
Source: The Irish Longitudinal Study of Ageing (TILDA)

# Integration: Person-centred Approach




- **Choice**: Tailor care to meet peoples' needs and ambitions
- **Flexibility**: 30min HS visits at 9am Monday – Friday is not sufficient
- **Ageing well at home**: Home adaptions, tech
- **Community**: Engagement, social capital
- **Family carers**: Complement, support

# Planning Needs to be Informed




- Information ‘light’ needs to be brightened
- Standardised assessment tool(s)
- Health information systems capturing needs across all health and social care services
- Centralised data collection
- Measuring effectiveness
  - *Outcomes*
  - *Aims, benchmarks*

# Takeaways

- Meeting the needs of older people will increasingly be integral to meeting overall population care needs
- **Population ageing** is the main determinant of increasing demand for health and social care accounting for:
  - ⬆ >80% in home support, LTRC and ⬆ >70% inpatient beds requirements by 2040
- Healthy ageing and new models of care **can moderate**, **but not offset**, this population ageing effect
- Adaption needed: **Health system designed for older people**
  - *Integrated care **and support***
  - *Age-friendly planning*
  - *4Ms*

# Thank You

**Brendan.Walsh@esri.ie**


ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Improving Population Health for Older Adults

## The Ageing Well in Later Life Profile

Dr Mary Browne

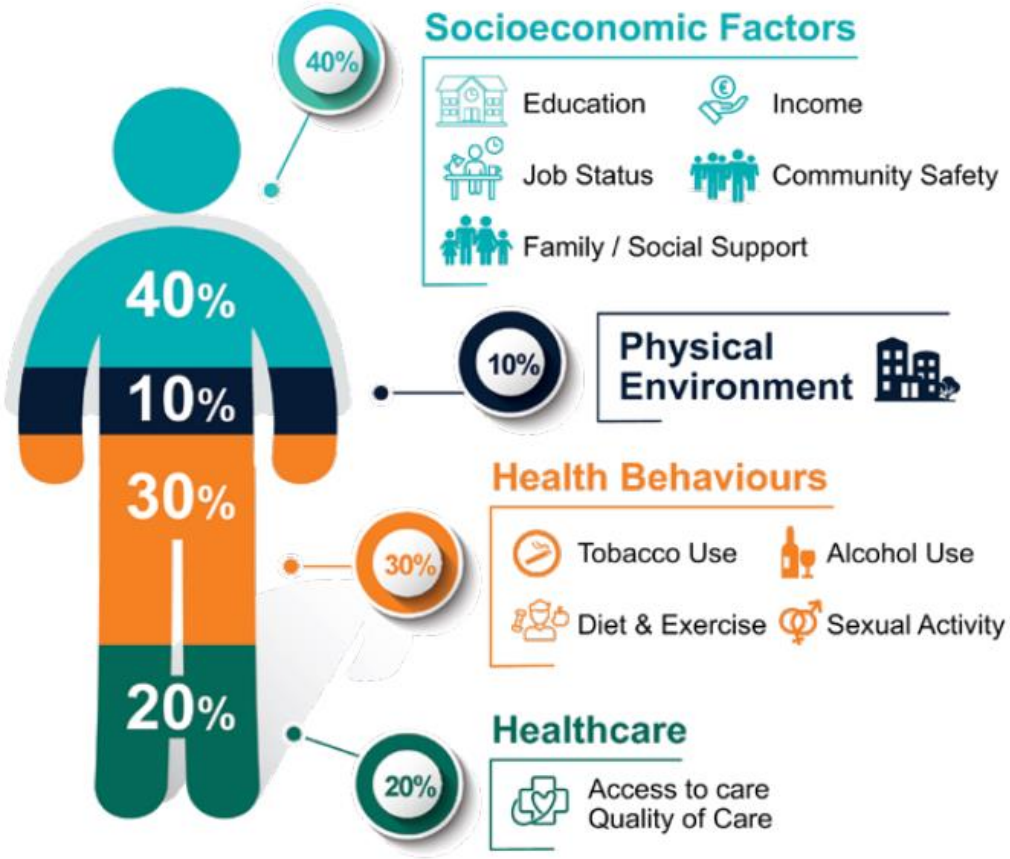
Consultant in Public Health

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Overview

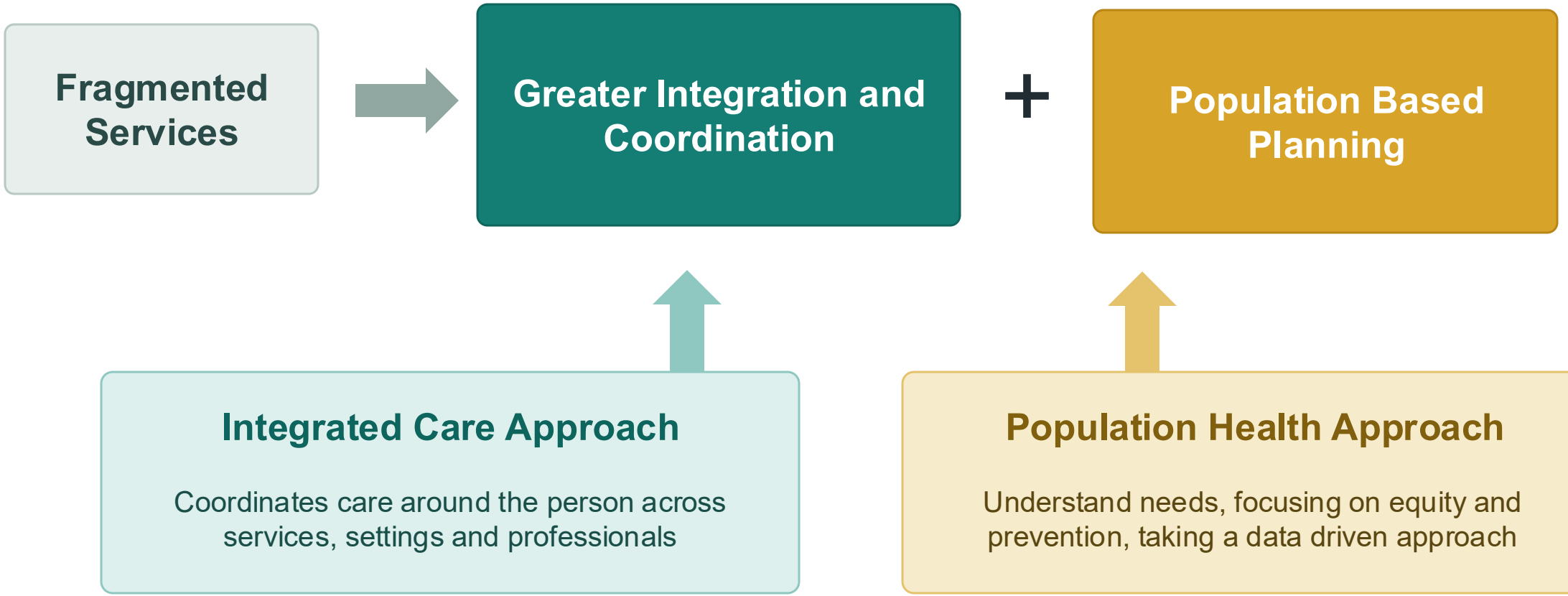
- Synergies between population health and integrated care
- Health Profiles and their role in planning services for older adults
- Ageing Well in Later Life Profile
- Where to next?

# Improving Population Health




*Source: Institute for Clinical Systems Improvement, 2015*

# Improving Health and Healthcare Outcomes




**Two complementary approaches to strengthen healthcare systems**

# Health Profiles

- First step in Population Based Planning
- Gives you a picture of the health and wellbeing of a defined population
- Bringing together different measures of health that look at it from different perspectives

**value** – Combining the profile's evidence with the knowledge of the local communities, people who use health services and those delivering services.

## Population Based Planning Cycle

# Older Adult Health and Wellbeing Profile

## Purpose

1. Support the planning of services to meet the needs of older adults
2. Underpin decision making with evidence and data
3. Monitor trends in health outcomes
4. Identify opportunities for improvement and research

# Co-Design Approach

## 1. People at the Centre

- What matters most to Older Adults?
- What information do decision makers need?

## 2. Understanding Data Landscape

- Broad engagement with data publishers
- Data quality and feasibility assessments

## 3. Evidenced based

- Completed Literature review

# What is different about this Profile

- The **people the profile serves were involved throughout the project** - through workshops, engagement activities and project governance.
- The profile was **designed around the needs of the people who will use it.**
- The profile is **grounded in a real planning environment** making it more actionable and transferable.

***'What's different about this profile is not simply the information it contains, but how easy it is to see and understand the information'***

# Ageing Well in Later Life


Ageing_Well_in_Later_Life__Older_Adult_Health_and_Wellbeing_Profile.pdf

Decision Support Hub: Population Based Planning

# Ageing Well in Later Life

# Contents

# Use of Community Services

This chapter focuses on Community Healthcare Services which are the broad range of services that are provided outside of the acute hospital system and includes Primary Care, Social Care, Mental Health and Health and Wellbeing Services.

These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people's homes.

Community Healthcare services focus on keeping you well so that you can continue to live at home or close to home through our health promotion, diagnosis, treatment and rehabilitation programmes.

# Use of Community Service Indicators

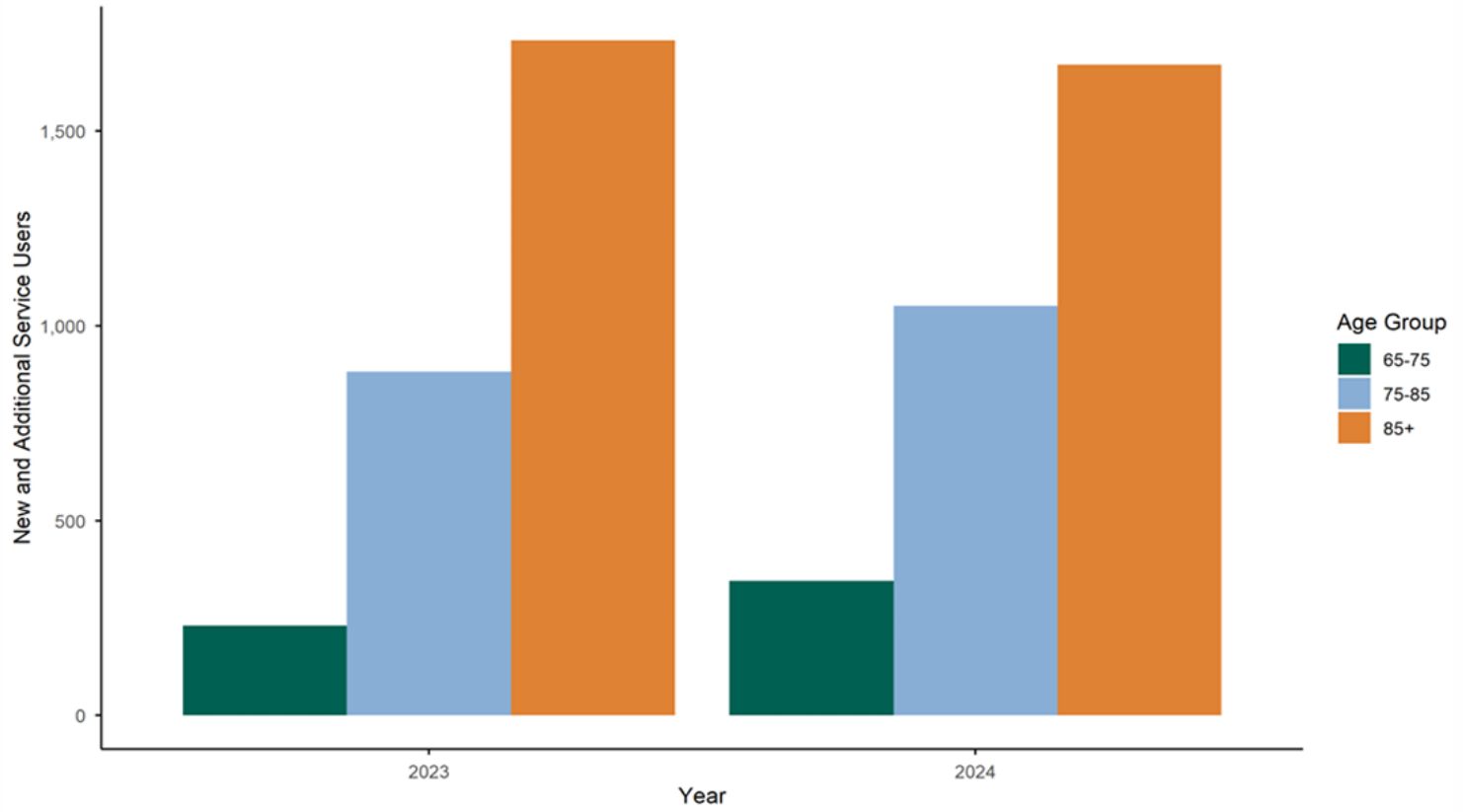
1. Percentage of people 65 years and over with a GP visit card or medical card
2. Number of GP visit cards in older adults
3. Number of medical cards in older adults
4. Mean number of GP visits in older adults aged 65 years and over in the last year
5. Total number of Home Support hours provided by HSE Home Support service
6. Number of new and additional Home Support hours provided to those aged 65 and over
7. Total number of HSE Home Support service users
8. Number of new and additional Home Support service users aged 65 and over
9. Total number of new and accepted ICPOP referrals by referral source
10. ICPOP Population by Clinical Frailty Scale Score
11. Number of referrals (including re-referred) accepted by Psychiatry of Later Life Community Mental Health Teams
12. Number of older people newly supported by ALONE services by year
13. Number of older people in receipt of ongoing support by ALONE services by year
14. Percentage of older adults aged 65 years and over who attend Day Centre Services
15. Percentage of older adults aged 65 years and over who are in receipt of Meals-on-Wheels
16. Percentage of older adults aged 65 years and over who report unmet need for a community care service

# Number of New and Additional* HSE Home Support Service Users Aged 65 And Over

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

Key Messages:

- In 2023 and 2024 the majority of new older adult Home Support service users are aged over 85 years (60% in 2023 and 53% in 2024)



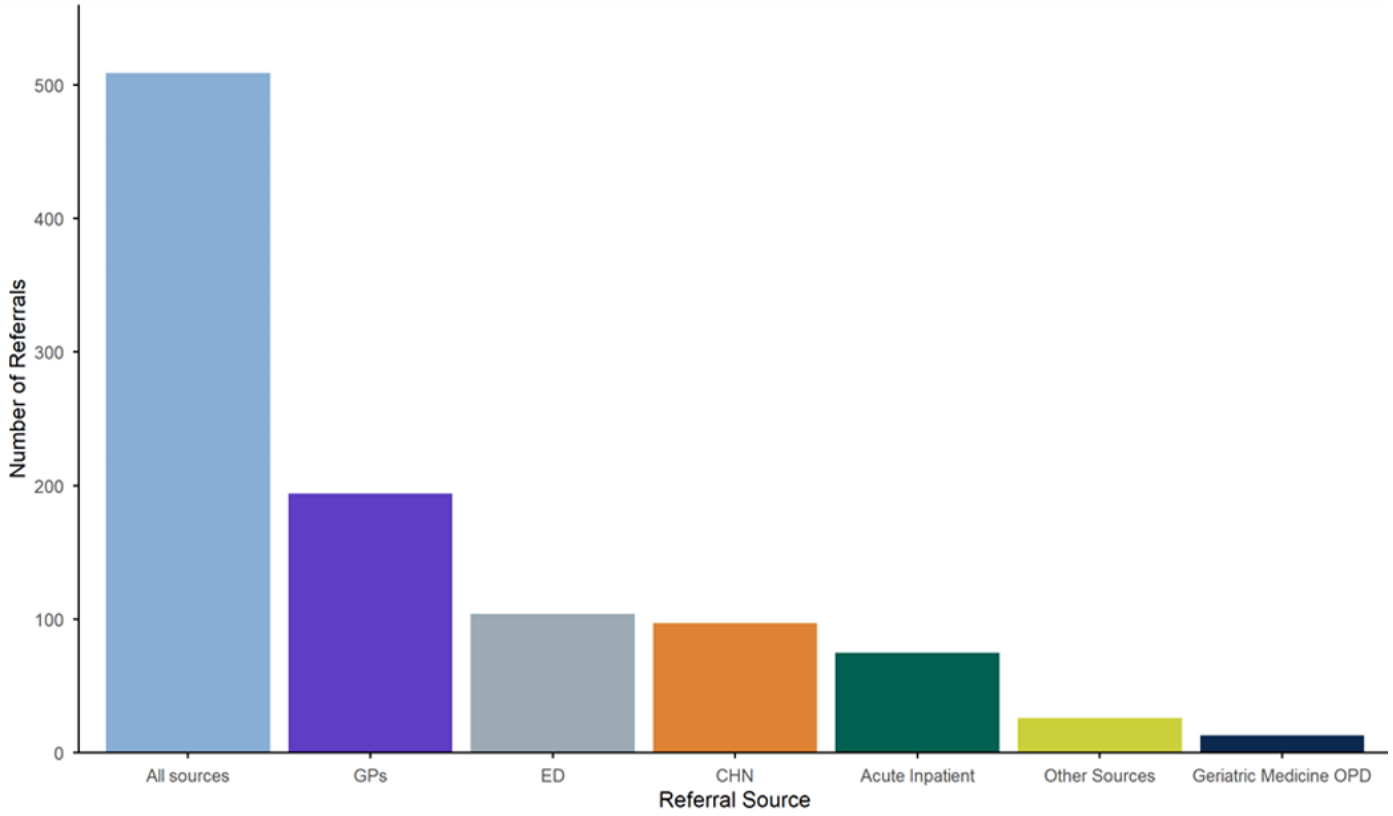

**Note:** *New and additional home support hours refers to new service users who have commenced home support service or existing service users who have been allocated additional hours of service
While HSE Home Support Services are primarily for people aged 65 or over , sometimes exceptions are made for people younger than 65 who may need support e.g. for people with early onset dementia or a disability.

**Source:** HSE National Home Support Office (IHA Level) and HSE National Business Information Unit

# Total Number of New and Accepted ICPOP Referrals by Referral Source

Key Messages:

- There were 509 new referrals seen by the ICPOP team in 2024
- GP's were the most frequent referrer with 194 new referrals in 2024
- Referrals were also sent from Emergency Departments (ED), Community Health Networks (CHN), Acute Inpatients, Geriatric Medicine out-patients (OPD) and other sources

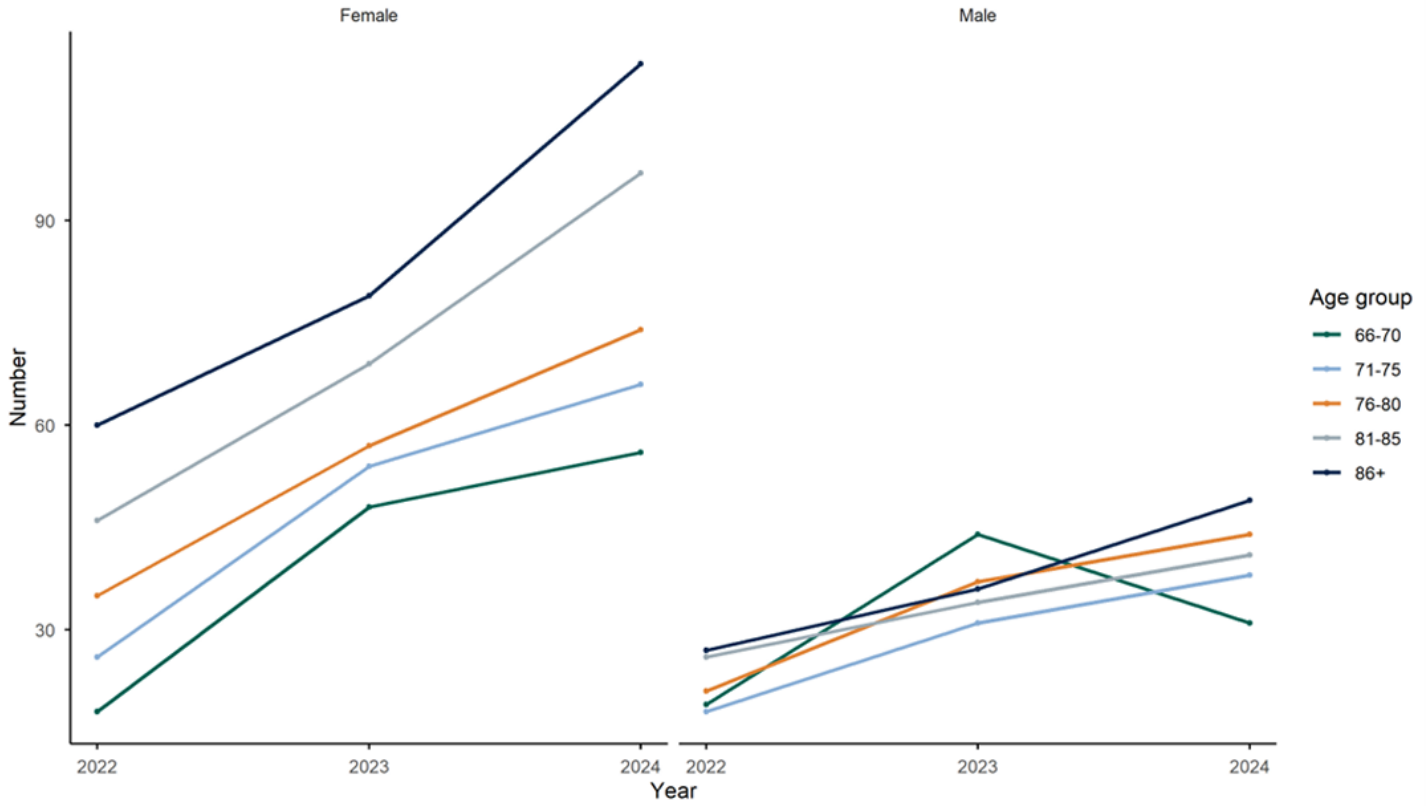



**Source**: HSE Integrated Care Programme for Older People (IHA Level)

# Number of Older People Newly Supported by ALONE Services by Year

Key Messages:

- There was an increase in the numbers newly supported in this time period from 296 people in 2022 to 609 people in 2024
- There are substantially higher numbers of female than male older adults newly supported by Alone Services in this IHA
- The number supported increased with age with the highest numbers in the over 86 year category




**Source:** ALONE (IHA Level)

# Where to Next

- Blueprint: Scaling to IHAs, Regional and National Profiles
- Inform Regional Population Based Planning
- Inform Older Person Councils and Community Groups in their planning and advocacy roles
- Integrated National and Regional Healthcare Needs Assessment for Older Adults - HSE Dublin and Midlands

# Embedding the 4Ms across Care Transitions


Dr Maria Costello
Consultant Geriatrician ICPOP Galway West City and County
Senior Lecturer in Geriatric Medicine, University of Galway
maria.costello@hse.ie

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# What are the 4Ms?


ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

Consensus panel
Healthcare leaders and experts in Geriatric Medicine

17 of the strongest evidence based models for older adult care identified

90 elements identified

Distilled down into the most important – the 4 Ms

## Impact of 4Ms on Older Adult Care

- Improved clinical outcomes
- Improved healthcare experience
- Decreased harm
- Decrease in unnecessary medications
- Improved carer experience

J Aging Health. 2021 Feb 8;898264321991658. doi: 10.1177/0898264321991658.
Online ahead of print.

**Evidence for the 4Ms: Interactions and Outcomes across the Care Continuum**

Kedar Mate [1], Terry Fulmer [2], Leslie Pelton [1], Amy Berman [2], Alice Bonner [1], Wendy Huang [3], Jinghan Zhang [3]

Affiliations + expand

PMID: 33555233 DOI: 10.1177/0898264321991658
Free article

**Abstract**

**Objectives:** An expert panel reviewed and summarized the literature related to the evidence for the 4Ms-what matters, medication, mentation, and mobility-in supporting care for older adults. **Methods:** In 2017, geriatric experts and health system executives collaborated with the Institute for Healthcare Improvement (IHI) to develop the 4Ms framework. Through a strategic search of the IHI database and recent literature, evidence was compiled in support of the framework's positive clinical outcomes. **Results:** Asking what matters from the outset of care planning improved both psychological and physiological health statuses. Using screening protocols such as the Beers' criteria inhibited overprescribing. Mentation strategies aided in prevention and treatment. Fall risk and physical function assessment with early goals and safe environments allowed for safe mobility. **Discussion:** Through a framework that reduces cognitive load of providers and improves the reliability of evidence-based care for older adults, all clinicians and healthcare workers can engage in age-friendly care.

**Keywords:** goal-directed care; quality; safety.

# Our Approach in ICPOP West

## Setting is important!

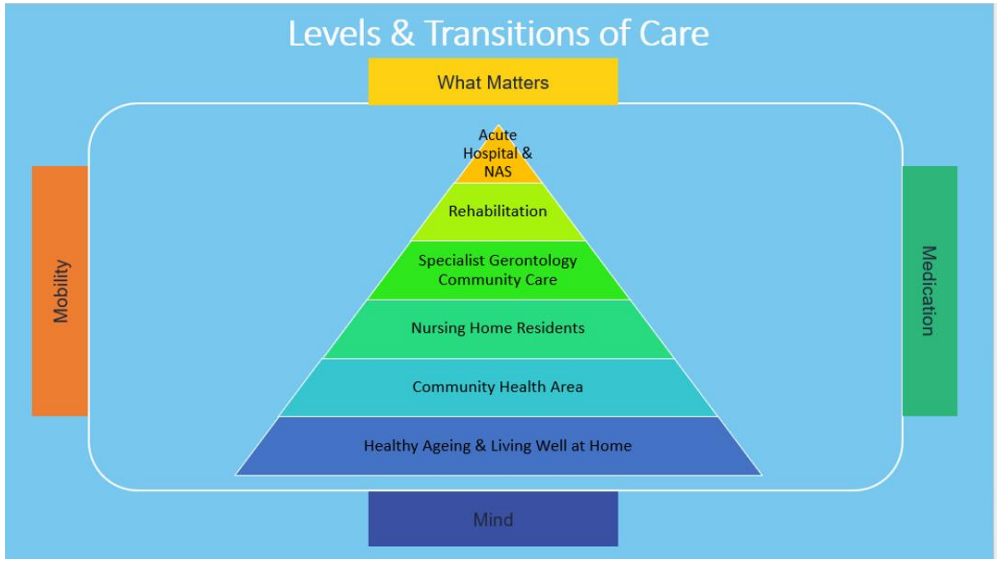
**Internal Team process**

**External Team Partners**

Primary Care

Acute and Community Specialist Geriatric Teams

**Our Community**



# 4Ms Approach


What Matters

Mobility

Medication




Mind

Reference

# Internal Team Process

## Signed up for IHI Age Friendly Health System Accreditation

### Level 1 (Participant) recognition

- Demonstrates that your team has a clear plan for assessing, documenting, and acting on all 4Ms.

### Level 2 (Committed to Care Excellence)

- Recognition demonstrates implementation of the 4Ms and submission of at least three months of data showing older adults received care that included all 4Ms

# Internal Team Process

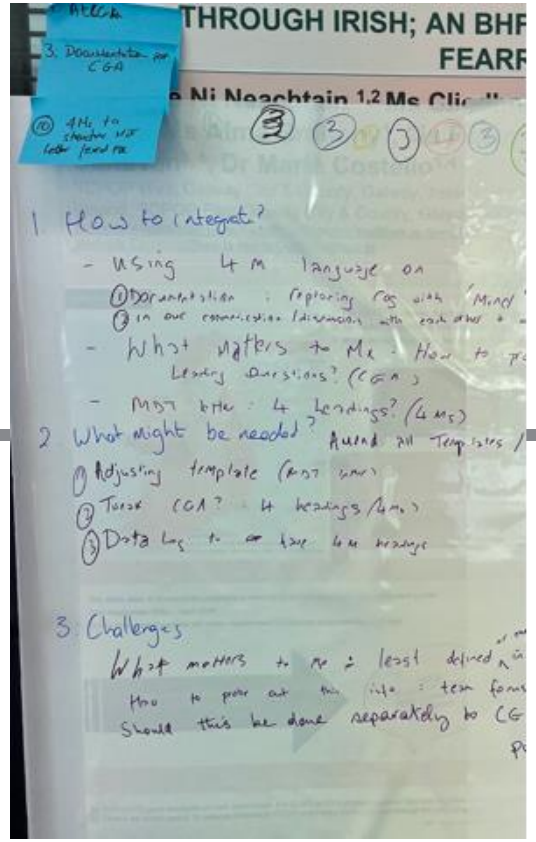
## Process Mapping

What are we already doing

Ideas to integrate the 4 Ms

What might be needed / changes required

Potential Challenges




## Actions

Education into 'What Matters Most'(Opportunity 6)

What Matters Most is asked during the CGA and documented in Clinical Letter (Opportunity 3)

What Matters Most is brought up first during the MDT Meeting (Opportunity 4)

# ICPOP West Partners- Primary Care

- Asked to be involved with the development of a Primary Care initiative to collaboratively develop a 4Ms prompt tool for the Clinical Team Meetings relating to older persons care
- Supported Education on 4M's for those working in Primary Care

| What Matters | Medication | Mind and Mental Wellbeing | Mobility |
|---|---|---|---|
| Do you know what is important to this person right now?<br><br>***Do you know their goals and priorities in life?***<br>Do they have concerns about their life and health?<br><br>***What are their most important goals if their health was to worsen?***<br>Has an advanced care plan been discussed?<br><br>***Do you know their will and preferences when it comes to their health and social care?***<br>What would they like to achieve in the next six months and through their interaction with this healthcare team?<br><br>***Is there someone they would like to include in this conversation to support them in their aims?*** | Is there an up-to-date medication list?<br>***Have the medications been ratified lately in context of their age and comorbidities?***<br>Is this person taking multiple (>5 polypharmacy, increased risk of falls, >10 increased risk of adverse drug reactions and hospitalisations) medications or supplements?<br>***Have they been screened for high-risk medications?*** Has there been any changes in their health and or personal circumstances since the review?<br>***Does this person demonstrate they understand what they are taking and why?***<br>How do they manage their medications? Is this working? Timing? Assistance needed? Blister packs etc?<br>***Has this person been assessed from Bone Health Perspective? Are they on an appropriate medication/ regime?*** | Does this person have any concerns about their concentration, memory or thinking? Or past med Hx?<br><br>***Has this person/carer reported the person feeling depressed or anxious?***<br>Can this person communicate their wants and needs? And make their needs understood?<br><br>***Is there any evidence of delirium? Acute confusion?*** Are they sleeping well?<br><br>***Have they adequate care and support where they live?*** Does this person have regular social contact? Has this person reported feeling lonely.<br><br>***Is there a risk of elder abuse/safeguarding concerns?*** Are they living in a safe, secure and supported home environment?<br><br>***Has this person had a vision and hearing test in last two years?*** | Has this person reported /demonstrated any change in their mobility/function resulting in reduction of their quality of life and/or reducing their independence?<br><br>***Have they reported any Falls including unexplained, injurious, frequent falls (>2) in the last year and/or are unable to get up off the floor without assistance?***<br>What daily activities/exercise is this person doing? Does this person move optimally/to their maximum every day to maintain or improve function?<br><br>***Does this person need review of their home, community access and social environment to promote independence and activity?***<br>Is there evidence of Frailty?<br><br>***Is skin integrity intact? Are there any pressure area concerns.*** Has this person had any unintentional weight loss, poor nutritional intake, weight gain? Are they hydrating well?<br><br>***Can the person drink and eat safely?*** Does this person have any incontinence issues? |

# How this now looks….

## Clinical Team Meeting Report

*Name of Client*: *D.O.B* *GMS Yes*

*Address:* *Contact Phone No:*

*Next of Kin*: *Contact Phone No*

*Key Worker:* *GP Name & Address* *Tel No*

*Further Relevant Information/ reason for referral*

| *Date* | *Issues discussed under 4 M framework*<br>1. *What Matters for the person*<br>2. *Medication*<br>3. *Mentation*<br>4. *Mobility* | *Action*<br>1. *What Matters for the person*<br>2. *Medication*<br>3. *Mentation*<br>4. *Mobility* | *Date to be achieved by* | *Person responsible for 1.2.3 and 4 4M action* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

# ICPOP West Partners – Specialist Older Adult Teams

**Using the 4Ms to Strengthen Care for Older Adults in your service**
**Date August 20th**
**Venue ILAS building University of Galway**

| Time | Session |
|---|---|
| 9.30-9.40am | Opening Remarks, welcome and introduction: Building an Age-Friendly Health System |
| 9.40-10.00am | External Showcase: Implementing the 4Ms in Practice |
| 10.00-10.15am | How to Become an Age-Friendly Service: Lessons from the Accreditation Journey |
| 10.15-10.35am | What Matters to You? Bringing Person-Centred Care into Everyday Practice/Introduce Scenarios |
| 10.35-11.05am | Scenarios to be discussed in groups |
| 11.05-11.35am | Discussion on scenarios – feedback |
| 11.35-12.05am | Refreshment Break |
| 12.05-12.20pm | The 4Ms in Practice: Embedding Age-Friendly Care in Primary Care Team Meetings |
| 12.20-12.35pm | From Framework to Practice: Engaging Teams in Age-Friendly Care |
| 12.35-13.05pm | Interactive Breakout Groups: Identifying Opportunities in Your Service |
| 13.05-13.40pm | Reporting Back: Key Learning and Priority Actions |
| 1.40-1.50pm | Next Steps and Survey completion. |
| 13.50-2.00pm | Workshop Summary and Closing Remarks |


ICPOP HSE West N West x 4
Pathfinder
OPRAH
Frailty Front Door
Home First
Acute Hospital Geriatrics
UHG/PUH
ANP and CNS for Geriatric Medicine/Dementia

# Pre Workshop

## Survey results

- 54/80 respondents
- Good baseline understanding of how the 4Ms can improve care for older adults (77.4%)
- Confidence in applying the framework in day-to-day practice was lower (53.7%)

**Suggests a gap between knowledge and implementation**

| Reported Barriers to 4M implementation | Frequency (n) |
|---|---|
| Lack of awareness/understanding | 29 |
| Lack of training | 26 |
| Time constraints | 22 |
| Uncertainty about roles and responsibilities | 20 |
| Staffing/resource limitations | 19 |
| Difficulty integrating into workflows | 19 |
| Lack of organisational support | 15 |

# Post Workshop Survey Results

- 52/80 respondents
- 100% rated the workshop Good or Excellent
- 100% found the workshop relevant to their role.

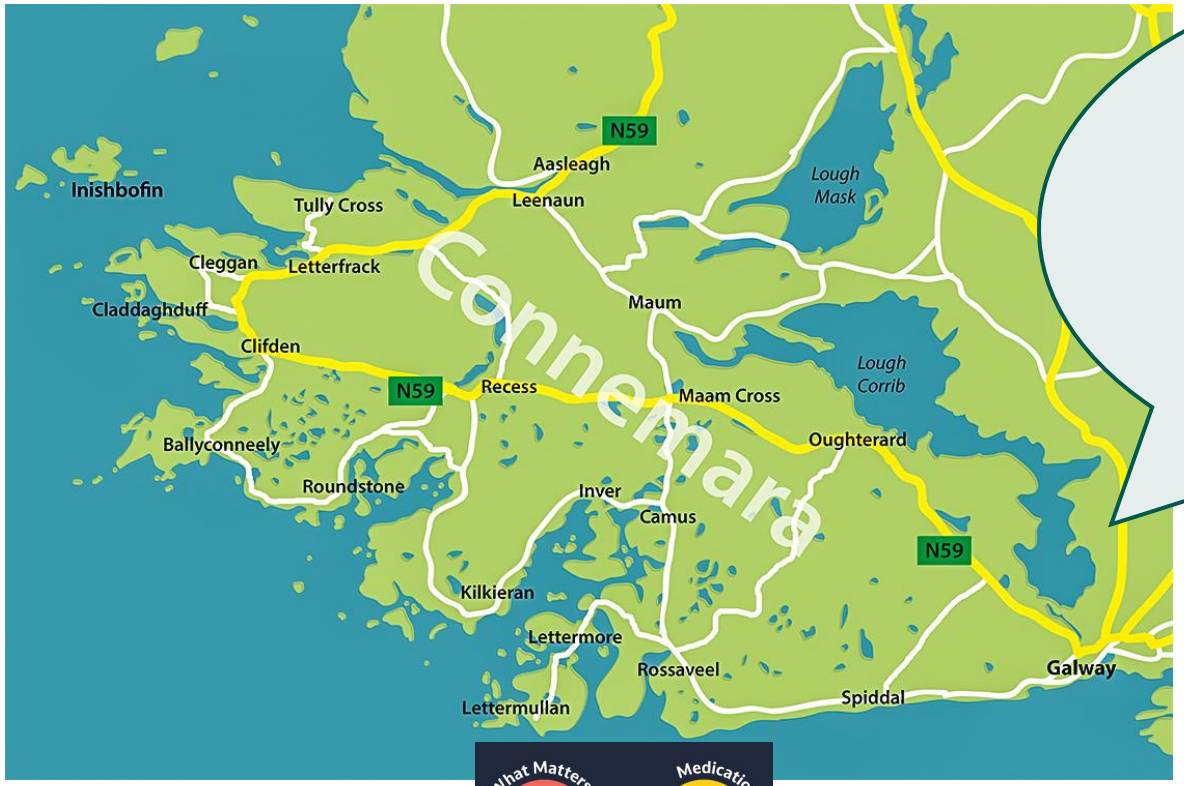
- The most frequently cited learning points
  - Understanding and implementing "What Matters" conversations
  - Using the 4Ms as a practical framework for person-centred care
  - Importance of consistent documentation of the 4Ms
  - Value of multidisciplinary collaboration
  - Recognition that many teams are already practising elements of the 4Ms but not formally identifying them as such

- The most commonly requested implementation supports were:
  - Practical implementation tools
  - Examples of best practice
  - Leadership/management support
  - Further workshops
  - Audit and quality-improvement resources
  - Peer networking opportunities

Confidence applying the 4Ms Framework
- Pre-workshop positive responses: 53.7%
- Post-workshop positive responses: 96.1%

# Our Community Case Study- Why this Really Matters

80 year old Rural Dwelling Man




"I am on my own in the house with him and at 83 I am overwhelmed , low mood and exhausted and have lost 5 kilos. And have vertigo, . I cannot continue".

"I am concerned for him and myself"

I have 3 family, all living away with families and jobs, so very limited help. And as you know, there are no services on the island.

| Stage | What Matters | Mentation | Medication | Mobility |
|---|---|---|---|---|
| Community Concern | Wishes to remain at home with wife | Progressive cognitive decline, behavioural symptoms | Existing dementia treatment | Functional decline emerging |

Referred to ICPOP West Team

| | | | | |
|---|---|---|---|---|
| Initial CGA ICPOP West | Carer concerns identified | Cognitive and behavioural assessment | Medication review | Falls risk identified |
| 4M Interventions | Future care planning | Formal Diagnosis of Alzheimer's Dementia with non-cognitive symptoms<br>ICPOP OT | Cognitive enhancers<br>Quetiapine initiated<br>Bone health addressed | Safety and function reviewed ICPOP PT |

2 Months later Emergency Presentation to UHG with urosepsis

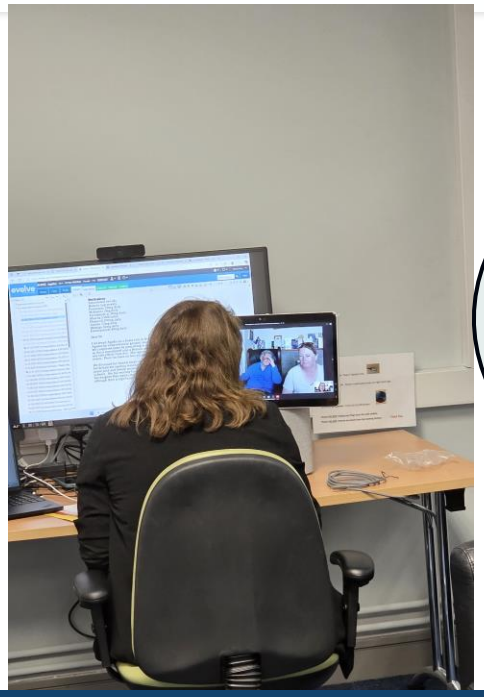
| | | | | |
|---|---|---|---|---|
| Hospital Admission | Goal to return home | Delirium recognised and treated | Rivastigmine and Melatonin optimisation | Admitted to SGW. MDT input to avoid deconditioning |

Follow up review with ICPOP West

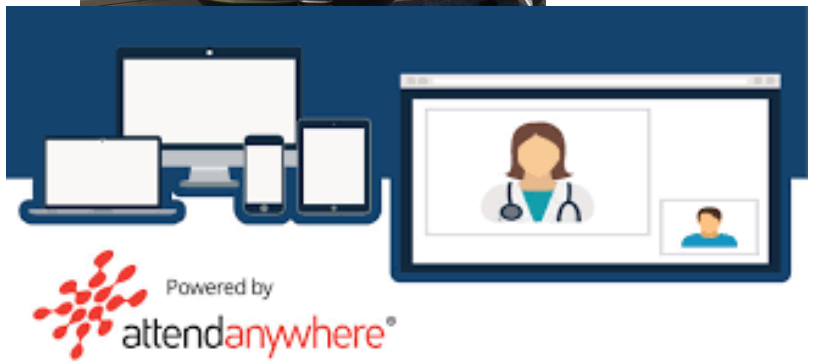
| | | | | |
|---|---|---|---|---|
| 4 weeks later | Home with live-in care, Back up discussion on LTC | Ongoing monitoring and education | Regular medication reviews | Maintaining independence and safety |

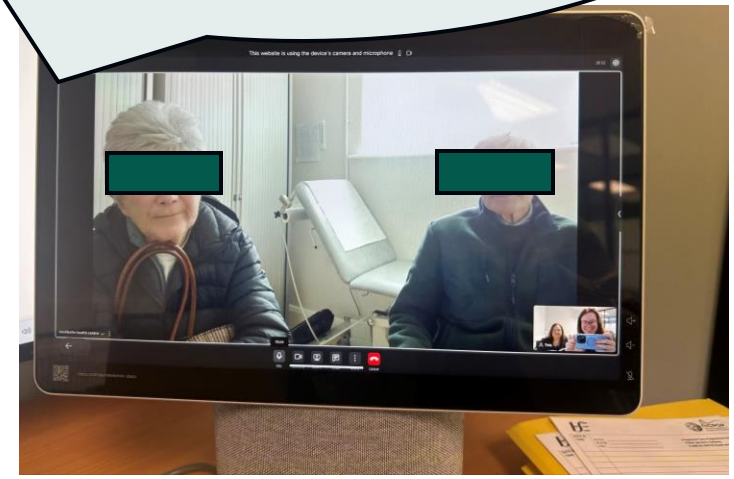
# Connecting to community





"It was much, much easier, if we weren't doing that (remote consultation) we'd have been on the boat at 8.15, this morning, or even yesterday, and staying somewhere, into the hospital, out again and then back on the boat, we wouldn't have him settled back home again till after 8pm tonight – it really takes it out of him, and all of us!"

# Age Strong, Live Long

## From the Community Even to the Integrated Care Model


Marie Alexander

Operational Lead ICPOP Mayo,

HSE Integrated Care Programme for Older


ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Age Strong, Live Long:

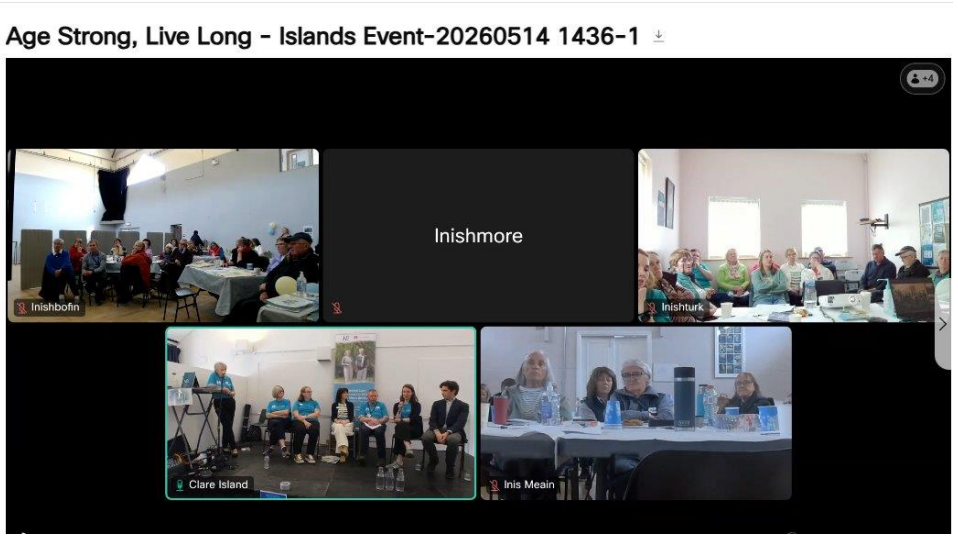
## From Community Event to Integrated Care Model



- Started in Mayo, October 2025
- Healthy Ageing, Prevention and Community Empowerment
- Aligned with Slaintecare and the 4Ms Framework

# What we learned:

## Engagement Creates Behaviour Changes




Some outcome measures:

- 95% Attendees reported learning something new,
- 82% more Confident managing their health
- 70% planned lifestyle changes.

- Breaffy Castlebar- 250+ Attendees
- Round table discussion with questions generated by attendees asked to panel of Experts.

- Islanders across 5 islands participated in the event.
- Panel of Experts hosted on Clare Island, delivered live to Inishturk, Inis Meáin, Inishbofin & Inis Mór

# Why This Matters:

## Health Outcomes and Economic Benefits

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

Healthy Ageing is Good for People and Good for Health Services

### Pillar 1: Prevention


### Pillar 2: Independence



### Pillar 3: Reducing Service Demand



# Bringing the 4Ms to life


Key Priorities:

- Awareness of the 4Ms
- Access to Preventative Services
- Community Connectedness
- Equity of Access
- Health Literacy & Empowerment

**Expected Reach:**

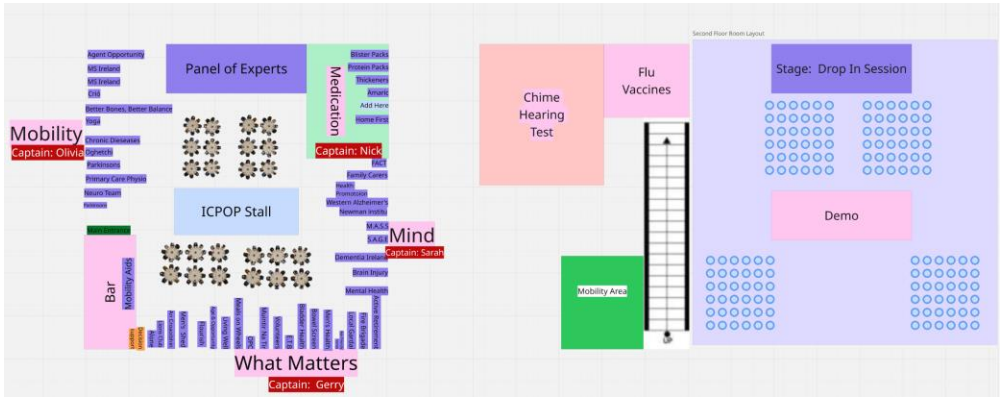
- 400+ attendees
- Mayo & Galway/Roscommon
- Webinar & recording
- Community follow-up

# Age Strong, Live Long 2026

## Scaling What Works

Key Priorities

- Awareness of the 4Ms
- Access to Preventative Services.
- Community Connectedness
- Equity of Access
- Health Literacy & Empowerment

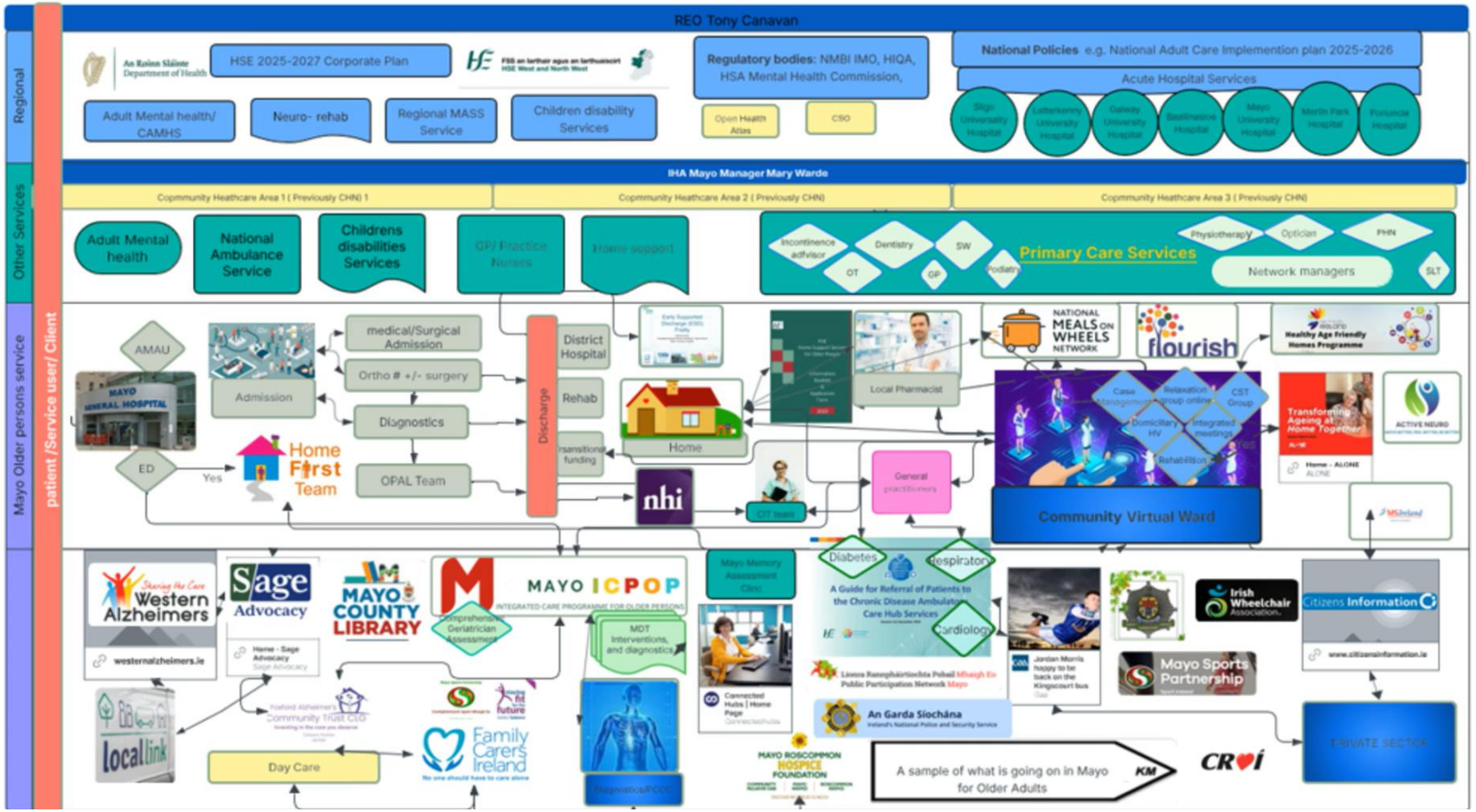




What Matters - Medication - Mind - Mobility

Expected Reach:

- 400+ attendees
- Mayo & Galway/Roscommon
- Webinar & recording
- Community follow-up

# Healthy Ageing happens in Communities, not just clinics



Discussion Panel

# Setting Integrated Care in the Context of Community


## Prof. Áine Carroll

Chair, International Foundation for Integrated Care (IFIC)
Professor of Healthcare Integration and Improvement, UCD School of Medicine Consultant in Rehabilitation Medicine, National Rehabilitation University Hospital


IFIC International Foundation for Integrated Care

UCD DUBLIN

NRH National Rehabilitation University Hospital

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# IFIC sees a continuum of definitions of integrated care

Where care systems sit on this continuum shapes what “integration” means in practice — and for whom.

| NARROW | BROAD — COMMUNITY |
| --- | --- |
| Linkage and co-ordination of services and providers within the formal health system — seeking to overcome fragmentation of care (EU Expert Group on Health Systems Performance Assessment, 2017). | Addresses fragmentation beyond the boundaries of the formal health and care system — wellbeing and quality of life, and people’s capacity to live healthy, meaningful, connected lives in their own community. |

*“Systems need to adopt a definition that meets the needs of their community, and recognise the wider context in which they sit. The guiding principles remain constant — person- and community-centred, co-ordinated, and with continuity.”*

# The IFIC 9 Pillars of Integrated Care (2026)

A meta-framework and the knowledge spine IFIC uses to organise integrated care knowledge


integratedcarefoundation.org/ific-9-pillars-of-integrated-care

## Pillars in focus for today

**2** **Health in Context**

Care shaped by the reality of people's lives, homes, and local communities — not only the clinical setting.

**3** **People as Partners**

Older people, families and carers as co-producers of their care, not passive recipients of it.

**4 / 5** **Teamwork & Coordination**

The engine of integration: coordinated, continuous care across home supports, primary care, geriatric medicine and the voluntary sector.

# Setting today's discussion in context


- Integrated care for older people is defined by what matters to them in their own homes and communities — not only by clinical pathways.
- The guiding principles hold across the continuum: person- and community-centred, co-ordinated, and continuous.
- Today's panel reflects that continuum in practice — home supports, population health, geriatric medicine, general practice, and the community & voluntary sector.

***How do we build care around what matters to older people — in their own communities?***

# Panel Discussion

**Chair – Prof. Áine Carroll,** Professor of Integrated Care and Improvement, UCD

- **Patricia Whelehan**
- **Sonya Cotter**, Integrated Healthcare Area Manager, Cork North
- **Prof. Emer Ahern**, NCAGL for Older Persons
- **Dr Brendan Walsh**
- **Dr Paul Carroll**, GP Lead, Churchtown Primary Care Centre
- **Seán Moynihan**, CEO, ALONE

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event

# Closing Remarks

Sandra Broderick
REO, HSE Mid West

ÉIRE2026.EU
IRELAND2026.EU
Imeacht Gaolmhar | Associated Event