AN INTEGRATED APPROACH BETWEEN CORK KERRY COMMUNITY HEALTHCARE AND CUH TO IMPROVE PATIENT TRANSFER PROCESS

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Introduction

The Enhanced Community Care (ECC) programme of reform in Ireland represents a population-based approach to the expansion of primary and community care and, importantly, its integration with the acute hospital sector, providing health services closer to people's homes and reducing pressure on acute hospitals. The original referral pathway between CKCH and CUH dietetics e.g. paper transfers via post or email, was not efficient or user friendly and could result in lack of relevant information on occasion. The Covid-19 pandemic created an urgency in terms of providing services in the community so we looked at reviewing our approach.

Aims

- Improve the quality of referrals by ensuring all relevant information included.
- Reduce duplication of information by having the document on a system available to both acute and community dietetic services.
- Improve hospital transfer rates out to community dietetics.
- See appropriate patients in a more timely fashion in community and reduce pressure in the acute setting.

Methods

- The Dietitian teams in Community and CUH met to define the goal of the project to ensure our patients are at the centre of our health system and receive the appropriate care in the right setting.
- The two Dietitian teams worked together with colleagues in IT on an initiative to create a dietetic discharge process via the iCM portal (an existing IT system used by both acute and community services).
- We looked at reducing the time taken by acute colleagues to complete referrals. The new system included details such as patient name, address, GP, next of kin and medical record number as the iCM system extracts this information.
- Standard Operating Procedures (SOPs) were created and staff in both sites were trained in the use of the new transfer system.

Results

- Improved quality of patient care - a more comprehensive discharge report was created and a higher level of relevant clinical information (e.g. from doctors, SLT's) is now shared with community dietitians as iCM extracts this information.

- The increased transfer rate out to community has reduced the need for some acute outpatient clinics in CUH and supports the overall aim of Slaintecare by providing health services closer to people's homes.

- Resource optimisation -there was a 50% reduction in the time taken by acute dietitians to complete the transfer form.

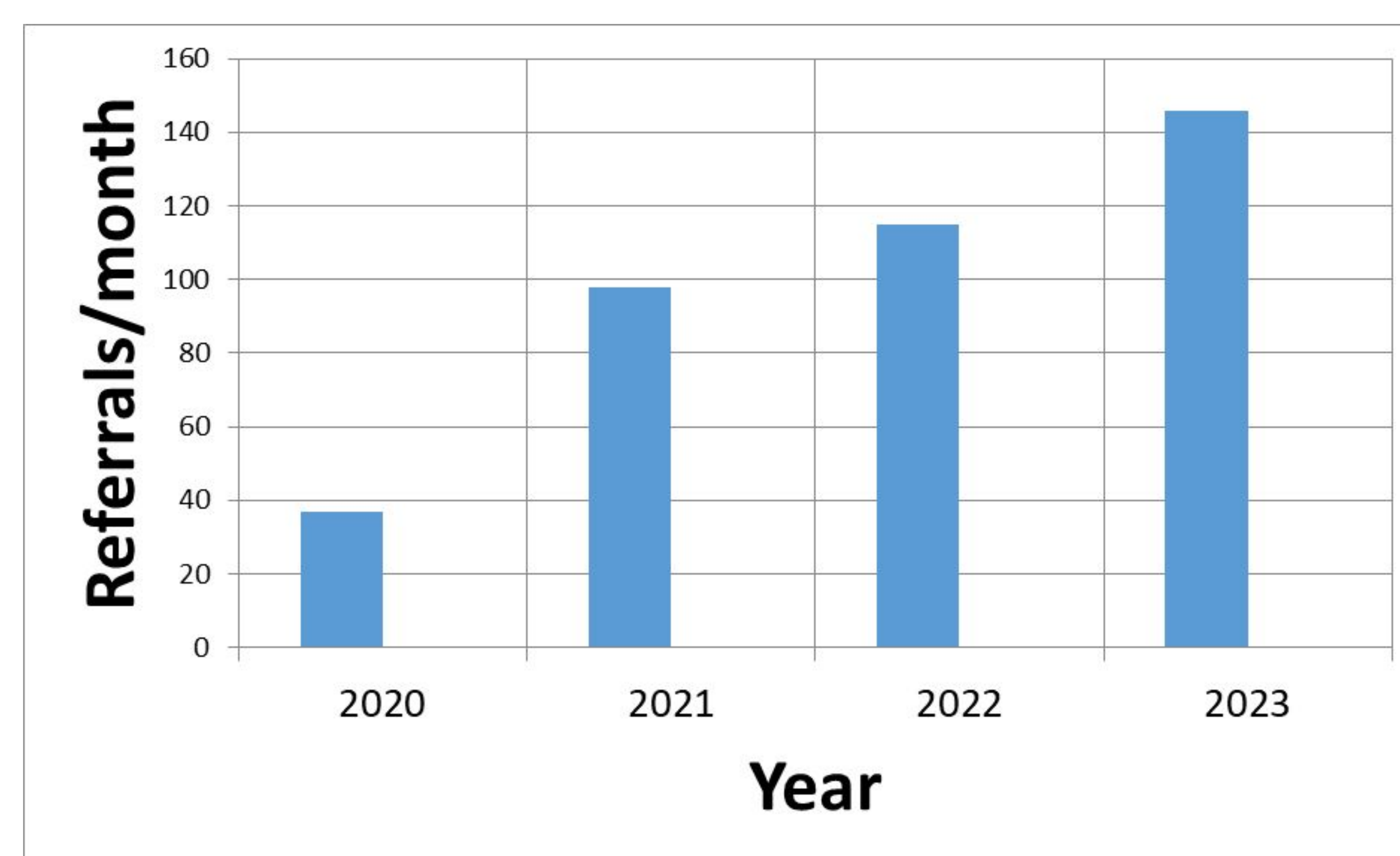
- Sustainability – 1,723 referrals went through the portal in 2023 thus avoiding significant paper wastage and costs associated with postage.

- GDPR – by digitising the process, we have reduced the risk of personal data leakage. The information is also more traceable and accessible.

Results

The numbers of referrals coming out to Community continues to increase:

- In 2020, 37 transfers per month were processed. This went up to 98 transfers per month in 2021 and increased again in 2022 to 115 transfers per month and 146 per month in 2023 (see table below). This represents a 4 fold increase in referrals from acute to community over this time period.



Conclusion

Overall, this project demonstrates strong evidence for the value of close community/acute integration which has led to more seamless transition of patient care across services. It has reduced dietitian time required to transfer patients out from acute to community services. This time saving has allowed for increased resources for acutely unwell in-patients.

Most importantly, it has provided patients with the "**Right care, in the Right place, at the Right time by the Right team**".

Acknowledgments: Mary Murnane, Yvonne O'Brien, Freda Horan - Community Dietitian Managers, Fiona Byrne, Dietitian Manager CUH, Annmarie Dineen & John Froggatt, CUH IT

References: National Service Plan 2023, Sláintecare Implementation Strategy & Action Plan 2021 – 2023.

Breathe Easy, Beat Strong: A unified approach to Cardiopulmonary Disorders

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BACKGROUND

Patients with COPD and/or Heart Failure wait for extended periods of time before they see a specialist and obtain diagnostic testing. This affects their clinical outcome resulting in increased disease severity, risk of exacerbations and hospital admissions.

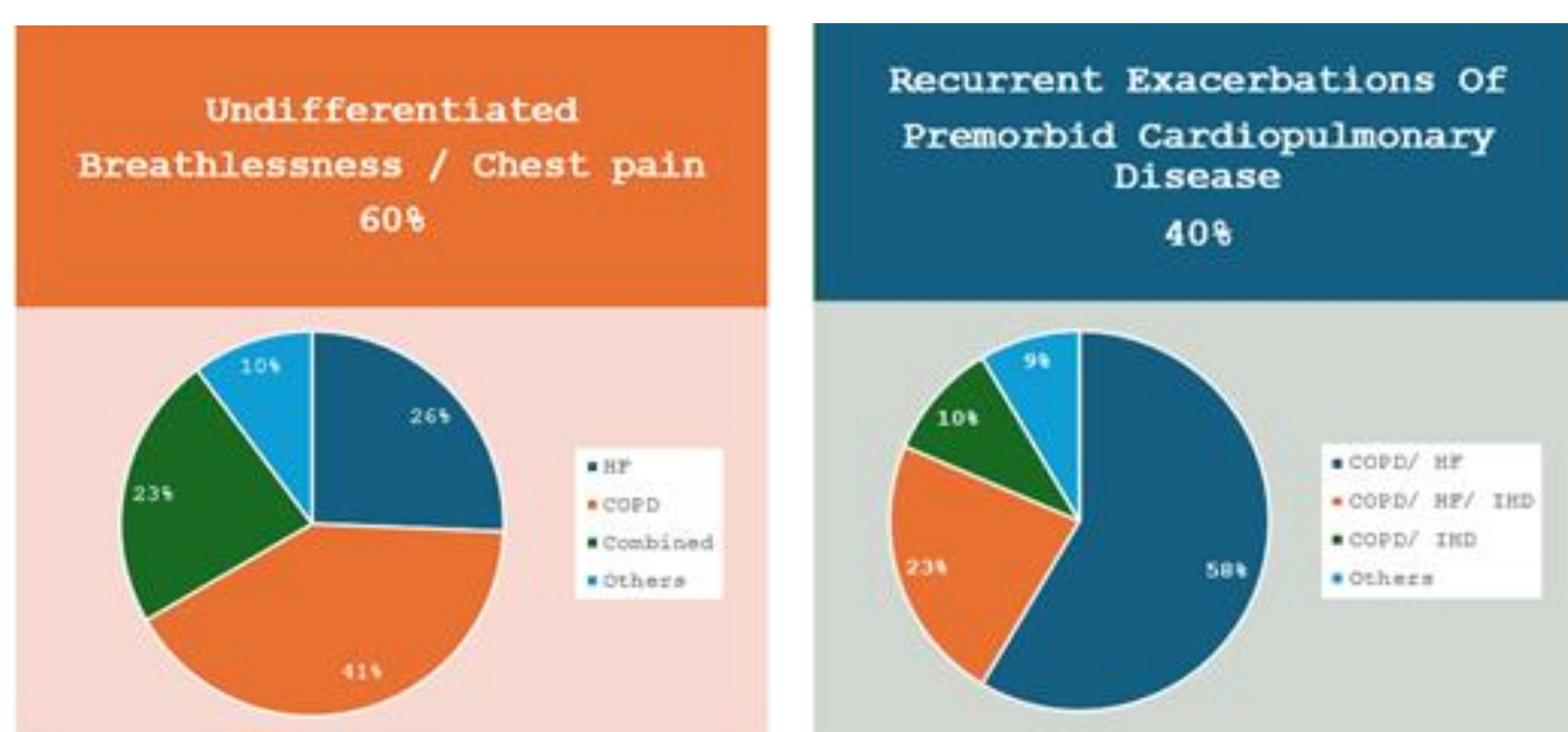
Physicians treating comorbid cardiorespiratory disorders face several diagnostic and therapeutic challenges. These include shared risk factors, similar demographics, symptoms, pathophysiology, complex interpretation of diagnostics and frequent pharmacological interactions. Addressing these issues requires interdisciplinary collaboration for effective diagnosis and therapeutic interventions. Establishing effective teamwork and care pathways is therefore crucial for improving patient outcomes. Our solution involved implementing an integrated care model for the assessment and management of comorbid Cardiovascular disease and COPD in a community based setting.

In line with Sláintecare's aim, the Dublin North West integrated care team pioneered a combined model of care for evaluation and treatment of patients with concomitant cardiopulmonary diseases.

METHODOLGY

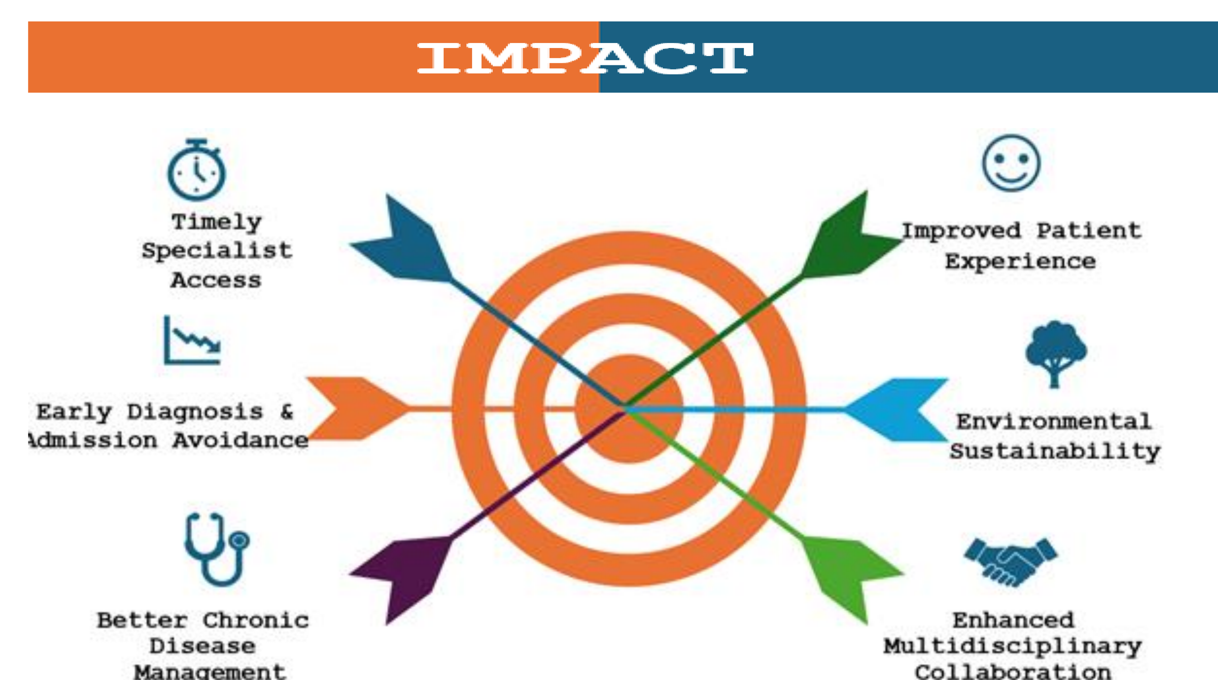
- A retrospective review was conducted on 52 patients (over 10 clinics) who attended the joint Cardiorespiratory Clinic between April 2023 and May 2024.
- Reason for referral was documented with the final diagnosis and outcome documented (see Figure 1.)
- Waiting times for both services were compared before and after establishment of the joint clinic.
- Financial cost savings were analysed and operational costs, patient visit costs and overall cost savings were calculated.
- Carbon footprint was assessed as potential greenhouse gas emissions associated with reductions in time travel to and from the clinic.

Figure. 1 Reason For Referral

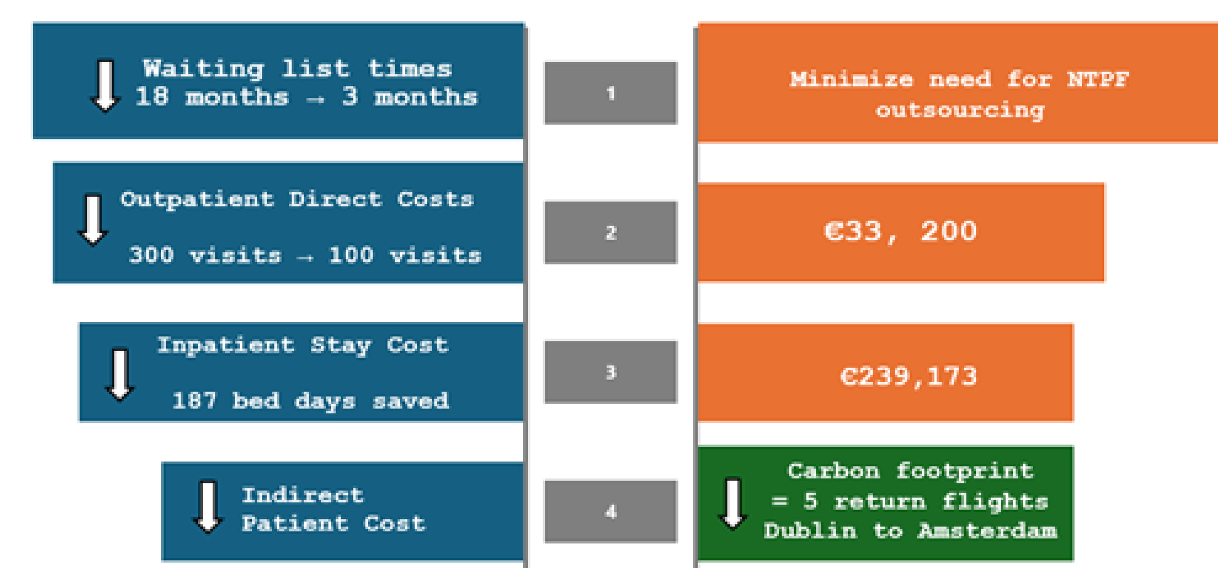


RESULTS

- Reduction in Out-Patient Department (OPD) wait times from 18 months to 3 months.
- OPD appointments reduced by 200, resulting in savings of €33,200.
- Reductions in Emergency Department presentations and Hospital admissions (187 Bed days) resulting in savings of approximately €239,173.
- Patient travel time reduced with a resultant carbon footprint reduction of 906.085 Kg CO2e/Km (equivalent to 5 return flights from Dublin to Amsterdam).

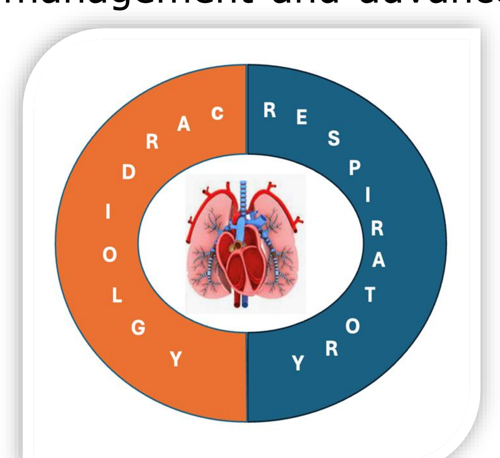


COST EFFECTIVENESS ANALYSIS



FUTURE STEPS

- Development of a combined cardiopulmonary rehabilitation program for patients with coexisting heart failure and COPD.
- Establishment of an Oxygen Assessment Clinic for both ambulatory and long-term oxygen therapy.
- Integration with the Palliative Care Team for symptom management and advanced care planning.
- Local-level pilot expansion.
- Blueprint design for the Clinic.
- Development of a patient experience questionnaire.



CONCLUSION

Physicians treating comorbid cardiorespiratory disorders face several diagnostic and therapeutic challenges. Addressing these issues requires interdisciplinary collaboration for effective diagnosis and therapeutic interventions. Establishing effective teamwork and joint care pathways is therefore crucial for improving patient outcomes. Our solution involved implementing an integrated care model for managing those with co-morbid CVD and COPD in a community based setting. Our clinic has proven to be service user friendly, financially effective and has advantages of environmental sustainability. Such clinics can also be rolled out at a national level.

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2. Howard et al, The implementation of Restoring Health – a chronic disease model of care to decrease acute health care utilization systematic review of UK and international evidence. Chronic Respiratory Disease 2008; 5: 133–141.
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ACKNOWLEDGEMENT

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Skinnovate phase 2: Alternatives to traditional OPD clinics in managing routine skin referrals

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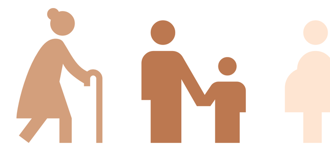
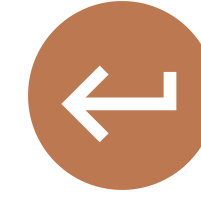
The problem

47000 adults are waiting for an outpatient Dermatology consultation in Ireland. In 2021, using lean methodology, the Mater Dermatology department streamlined internal processes and achieved a 40% reduction in its waiting list. However, due to factors such as population growth and increasing skin cancer prevalance, the rate of referrals has accelerated rapidly (30% increase in the previous 3 years alone). Projection analysis indicated that without radical intervention, the waiting list would return to its original levels within 3-5 years.



Increasing Population Growth

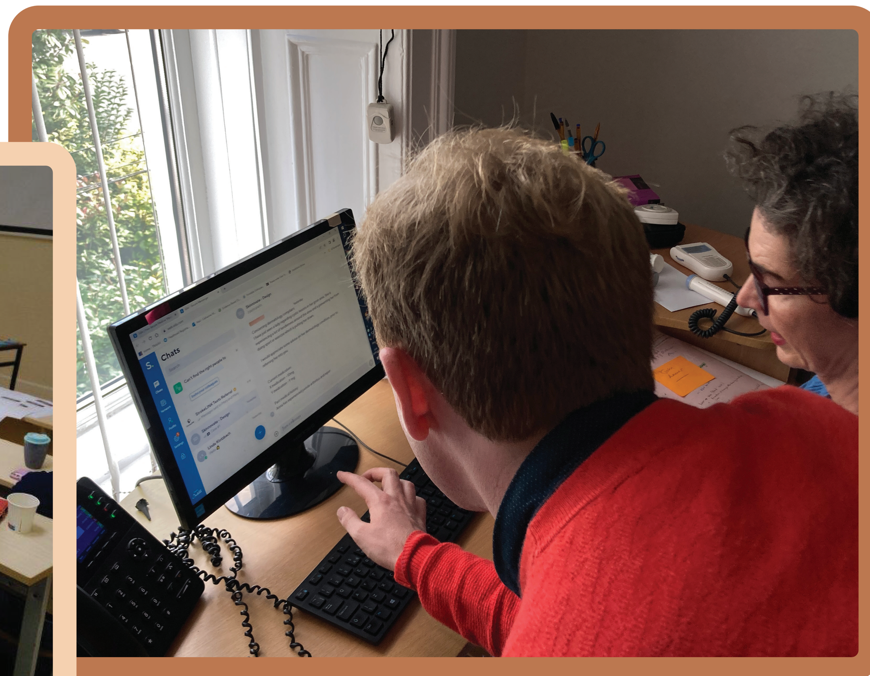
Increasing Skin Cancer Prevelence



return visits
take up slots that could be used to deal with new urgent cases

25%

25 % of routine referrals
are by sent in by 3% (27) of GPs

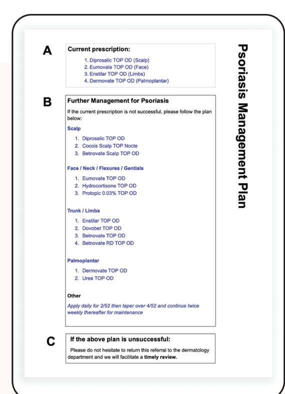


Methodology

Currently if a GP has uncertainties with regard to management of skin conditions, the only option is to refer to an outpatient clinic. Our team used a Human Centred Design led approach, working with local GPs to co-design a suite of solutions that will provide them with novel options for accessing support, reducing reliance on OPD clinics.

Results

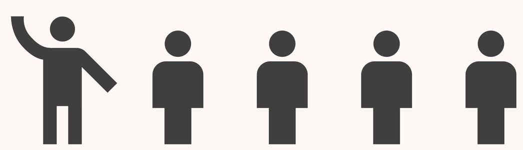
We have collaboratively designed and are currently testing a range of options as follows:



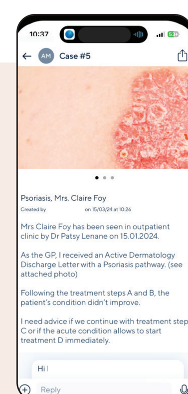
Active Discharge Letter

Patients are seen once at the Dermatology clinic and then discharged back to the GP with guidance for further dermatology management of routine conditions (such as Psoriasis, Acne, Eczema), reducing the number of follow up appointments in the hospital. The GP has the option to rapidly access an outpatient appointment if required.

Pilot results



Since its introduction, only **5 patients** have returned to clinic for further acute follow up, within 12 month of their initial clinic visit! (n=59)



Siilo for routine Dermatology queries

We have developed a GP to acute Dermatologist channel using Siilo, an encrypted messaging app. This enables GPs to share photos and access specialist advice from a dermatologist - without having to wait for an outpatient consultation.

Pilot status
Testing currently with 3 local GPs. 1 GP is working closely with the homeless.

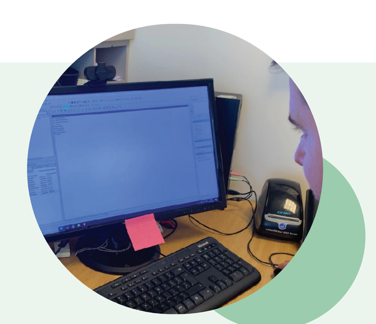
Through this pilot we expect a reduction in the GPs need to refer to acute dermatology. In the piloting with GPs working in homeless services we are simultaneously developing inclusive services for our local area needs.

Derma diary

DermaDiary is a GDPR compliant app to be prescribed to help patients keep track of skin flares and what triggers an outbreak. Aimed at routine conditions - this information is valuable for both patient, their GP and Consultant.

Pilot status
The app is in the process of being approved by Google Play Store / Apple App Store. Once live we aim to user-test the app with patients to feed back into its design.

We aim for patients to be empowered in monitoring their skin condition & help them, their GP and Consultant to understand their skin flares.



GP with extended role in Dermatology

Since July 2023, A GP training in dermatology has been present in the outpatients clinic 1 day per week seeing routine patients from the Mater waiting list & carrying out surgery with support from Mater Dermatologists. Ultimately this GP will take referrals directly from other GPs in the community while linked back with the hospital.

Pilot results
A qualified General Practitioner has taken part in the post. In his first year he has seen 171 patients. This experience will enable the GP to return to community with enhanced dermatology knowledge – which he can share with other GPs and Community healthcare workers.

Conclusion

There is a clear need to provide GPs with alternatives to the traditional OPD clinic for specialist support. Co-designing these alternatives ensures that they are acceptable for stakeholders across the system.

- **40% reduction**
  in Mater Dermatology wait-list since 2020 (see Skinnovate phase 1 poster)
- **Sustained improvement**
  3 years later despite a 30% increase in referrals
- **Solutions that bridge the hospital walls**
  The Mater team continues to work with a network of local GPs to co-design innovative alternatives to outpatient clinics facilitated by Mater Transformation with expertise in design & lean.
- **Continued piloting & iteration**
  These pilot results have significant opportunity for embedding and scaling both within the Mater Dermatology service and in the wider healthcare system

AN INTREGRATED SOLUTION TO INCREASING ACCESS TO NATIONAL SPECIALIST REHABILITATION BEDS

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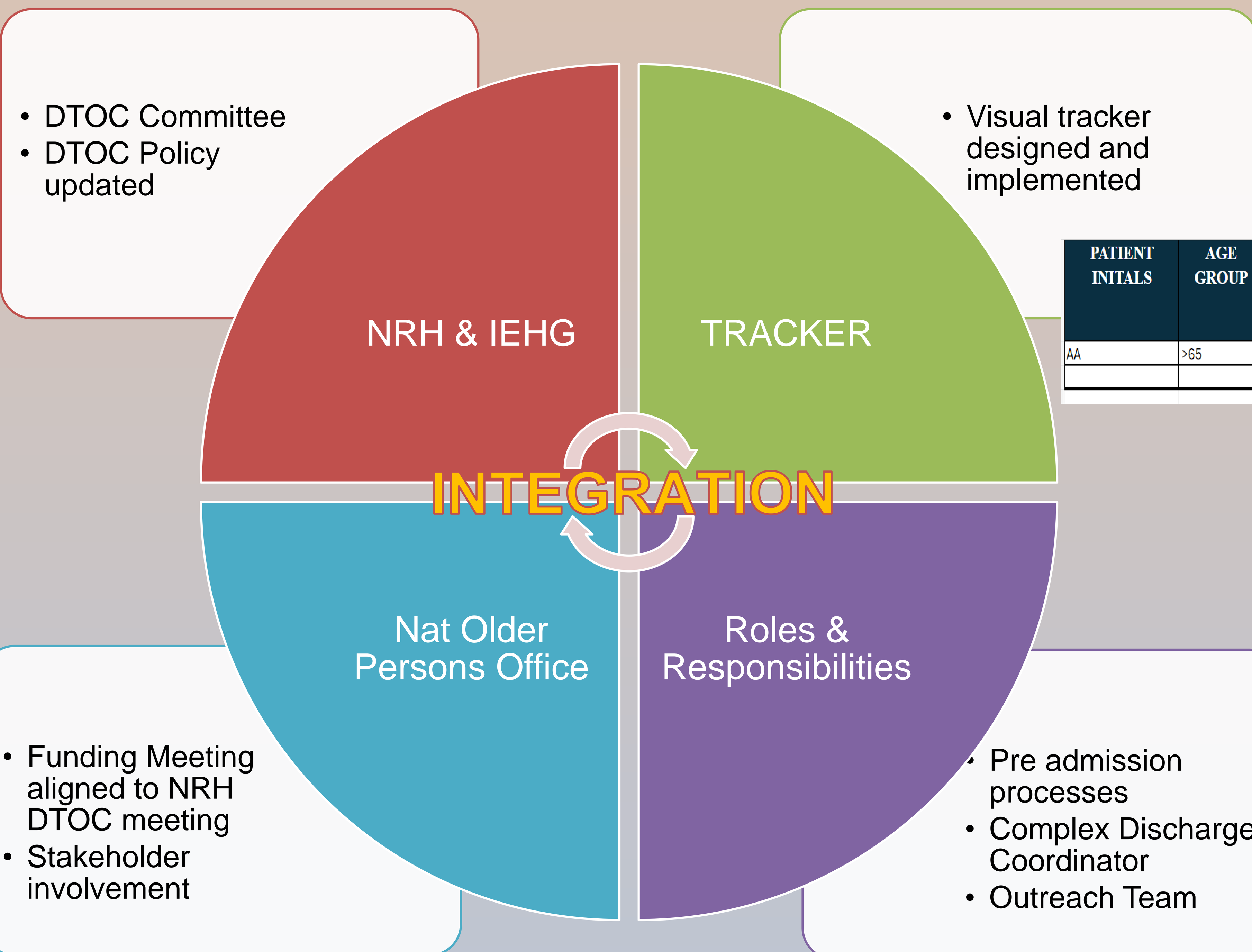
Context:

- The National Rehabilitation Hospital (NRH) delivers specialist rehabilitation services and education dedicated to returning patients to the highest level of independence possible and aims to maximize the quality of their lives. The National Delayed Transfers of Care List (DTOC) demonstrates the demand for both patients requiring access to the NRH and patients who have competed their rehabilitation within the NRH, but their discharge is delayed to their residential placements.
- One of the challenges facing the NRH is the ability to transfer/discharge patients safely once their rehabilitation period has finished. When a patient's discharge is delayed, they experience unnecessary prolonged stays in hospital (Independent Expert Review of Delayed Discharges, 2018). When a patients discharge from the NRH is delayed this then has a direct impact on patients within other sites accessing specialised rehabilitation.
- On 16th January 2024, there were 14 patients within the NRH that were listed on the National DTOC report. This equated to 2267 Bed days Lost (BDLs) by patients who no longer required rehabilitation care. Within the same period 27 patients discharges were listed on the National DTOC report awaiting access to the NRH. This equated to 1408 BDL nationally.
- One resourced bed has the capacity to facilitate rehabilitation treatment for (4-5) patients in one year assuming an anticipated length of stay of 70-90 days. There is a careful balance to be struck between maintaining the standards of service and patient centred focus, while also meeting the needs of the HSE and the wider health system by ensuring continuous patient access.

Methods :



PATIENT INITALS	AGE GROUP	CHO AREA	SPEC	ADMITTED	PDD (UPDATED EVERY TUESDAY)	DATE (UPDATED EVERY TUESDAY)	LOS	DTOC LOS	DTOC TYPE (e.g. A3/B5/D2)	REASON FOR DELAY	DISCHARGE DESTINATION	CHO UPDATE	NRH Update 08/01/2023	9/1/2024	Assigned Person	Timeframe
AA	>65	X	Spinal	1/1/2024	1/3/2024		35	20	A3	Funding	XX Lodge	xx	xx	xx	CC	

Challenges:

- Lack of specialist residential placements for patients with complex needs.
- Funding challenges for specialist residential placements. Limited Public funded specialised beds available country wide.
- Lack of interim step-down facilities catering for patients with complex needs, e.g. Neurogenic bowel care, NG tubes, Tracheostomy care, Behavioural support.
- Costs and lengthy timeframes for home adaptations or resolution of housing/homelessness issues.
- Shortage of suitable qualified personnel in community settings to meet complex patient needs.
- National supply of rehabilitation services/beds.

Recommendations:

- Ensure an integrated approach to patient centred care, to ensure pre and post admission process are optimised.
- Establish a central funding model to meet the needs of complex patients within their residential settings.
- Development of a National NRH outreach team (Pilot ongoing).
- Expansion of Discharge Liaison posts nationwide for earlier identification of discharge requirements. (Pilot ongoing).
- Monitor and review of new processes to ensure continuous service improvement.

Results:

Since 16th January 2024 26 patients categorised as Delayed Transfers of Care have been discharged from the NRH. Their Length of Stay (LOS) ranged from 65 – 845 days

Improvement in Bed Days Lost (BDLs)

Extract from National DTOC List

DTOC No/BDL Total	16/01/2024	13/08/2024	BDL Variance
	2267	486	-1781
Type A: Destination Home	984	0	-984
Type B: Destination Long Term Nursing Care	913	0	-913
Type C: Rehab	0	0	-
Type D: Complex needs	78	320	+242
Type E: Housing/Homeless	292	124	-168
Type F: Legal Complexity/ADMA	0	0	-
Type G: Non-compliant	0	42	+42
Type H: COVID-19	0	0	-

*Complex needs remains a challenge

As of 15th August 2024, there are 5 patients classified as DTOC in NRH.

Extract from NRH DTOC List

NRH DTOC 16/01/2024		
DTOC Type	No. pts	DTOC LOS (Days)
A. Home	5	984
B. Long Term Nursing Care	4	913
C. Rehab	-	-
D. Complex needs	1	78
E. Housing/Homeless	4	292
F. Legal Complexity/ADMA	-	-
G. Non-compliant	-	-
H. Covid-19	-	-
Totals:	14	2267

NRH DTOC 15/08/2024		
DTOC Type	No. pts	DTOC LOS (Days)
A. Home	-	-
B. Long Term Nursing Care	-	-
C. Rehab	-	-
D. Complex needs	3	320
E. Housing/Homeless	1	124
F. Legal Complexity/ADMA	-	-
G. Non-compliant	1	42
H. Covid-19	-	-
Total:	5	486

All of these patients are being actively managed in a defined process

Acknowledgements:

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Carlow Kilkenny ICPOP Rapid Improvement (RIE) 2023

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CONTEXT:

Continuous service improvement is crucial in the evaluation and development of services.[1] In response to an evolving landscape of healthcare; the ICPOP multi-disciplinary team used a Lean methodology[2] and a rapid improvement event (RIE) to gain an in-depth understanding of the needs of older persons. This collaborative effort brought together colleagues from both acute and primary care setting, recognising the importance of a united approach to enhanced service developments.

ABOUT CARLOW KILKENNY ICPOP:

The Carlow Kilkenny Integrated Care Programme for Older Persons (ICPOP) was established in 2021. The service
aims to contribute to creating a comprehensive and responsive integrated care service tailored to the specific needs of older persons in Carlow Kilkenny.

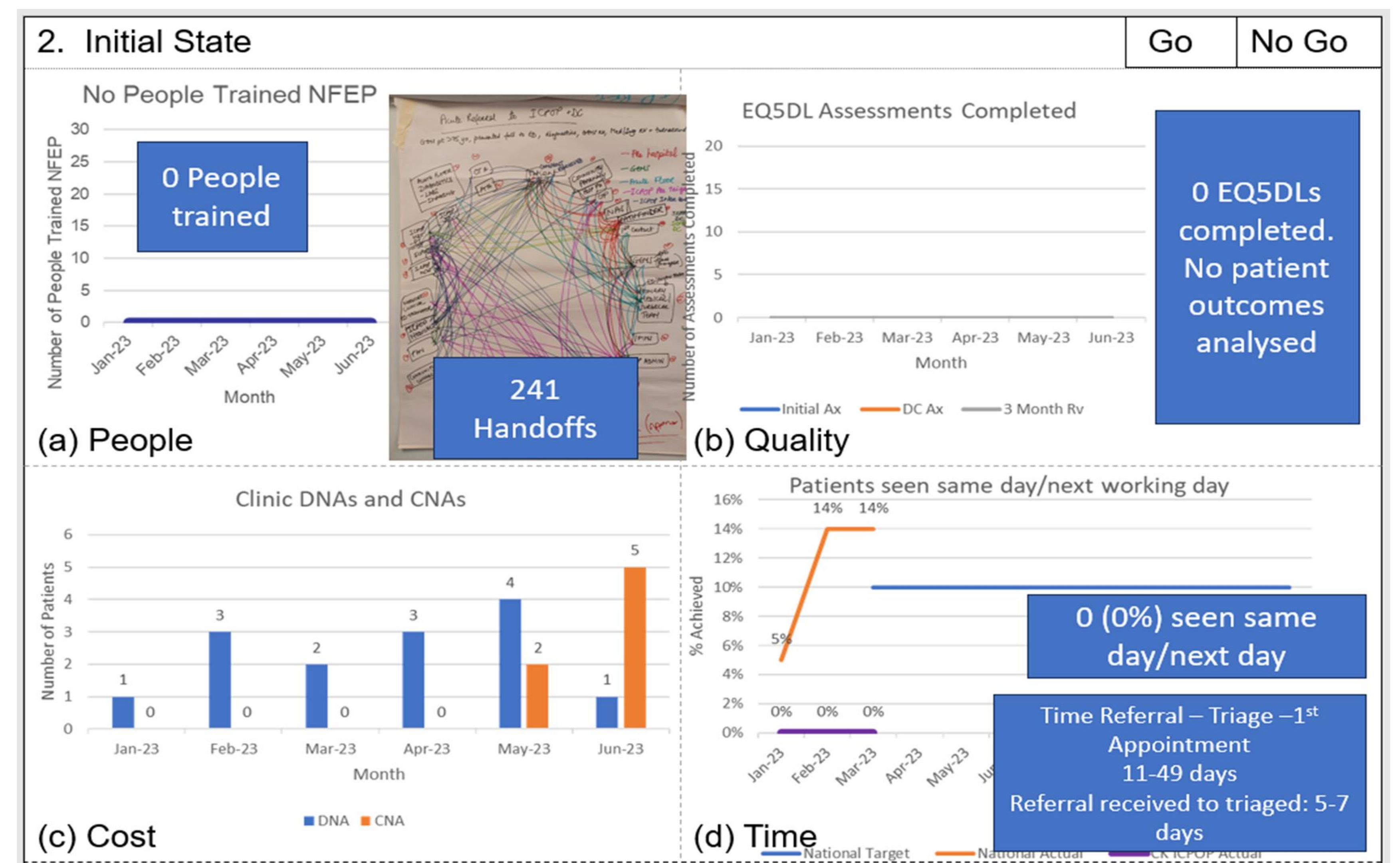
AIM:

Enhance the overall quality, efficiency and effectiveness of integrated care delivery by the HSE across Carlow & Kilkenny Older Person Services (South East Community Healthcare).

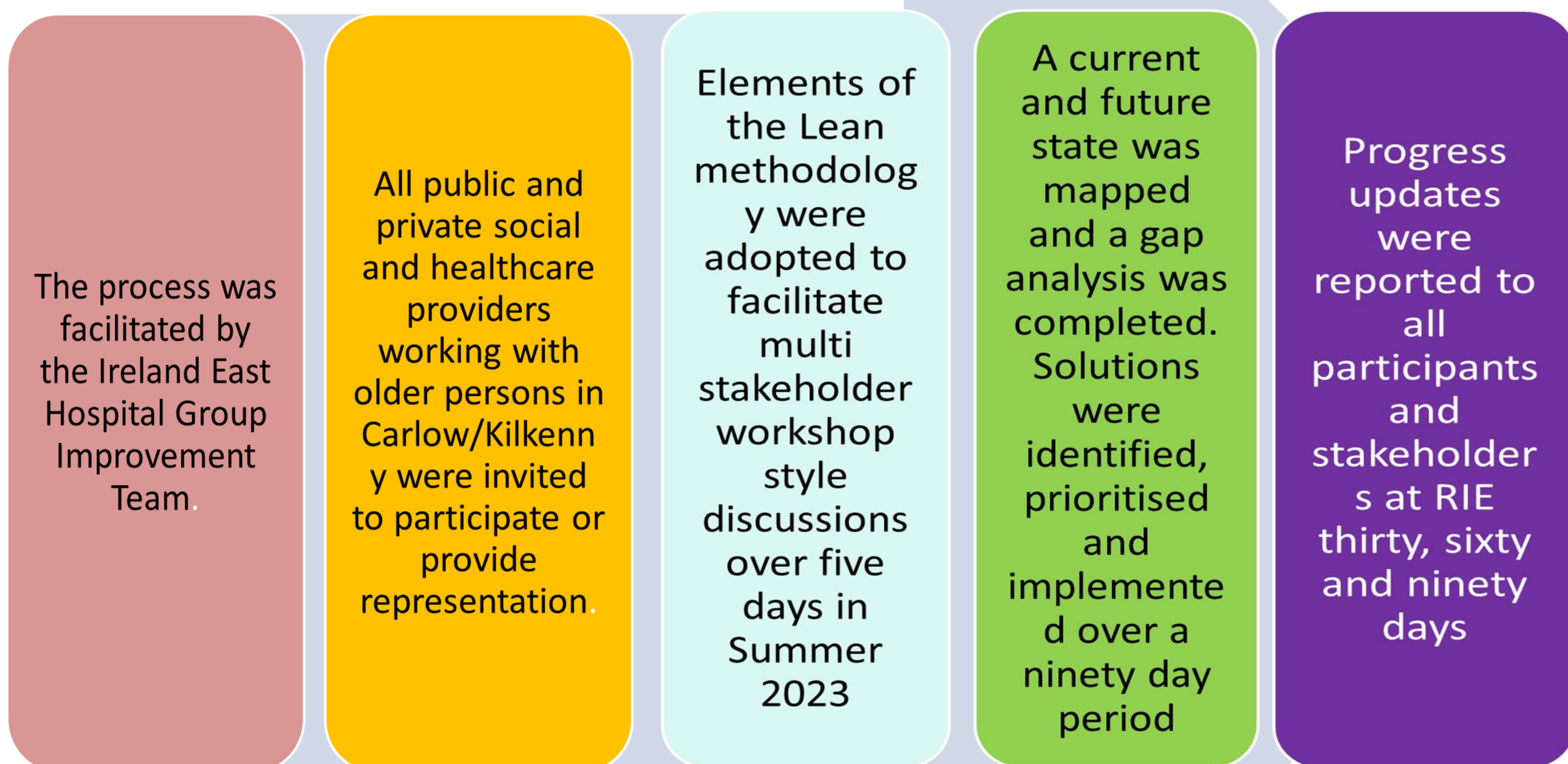
OBJECTIVES:

- Evaluate current service which was established in 2021
- Foster, enhance and promote inter-professional collaboration
- Identify opportunities for improvement
- Devise an action plan to implement sustainable changes and to provide a seamless service

CURRENT STATE:



METHODOLOGY:



Priority areas for development and changes in practice

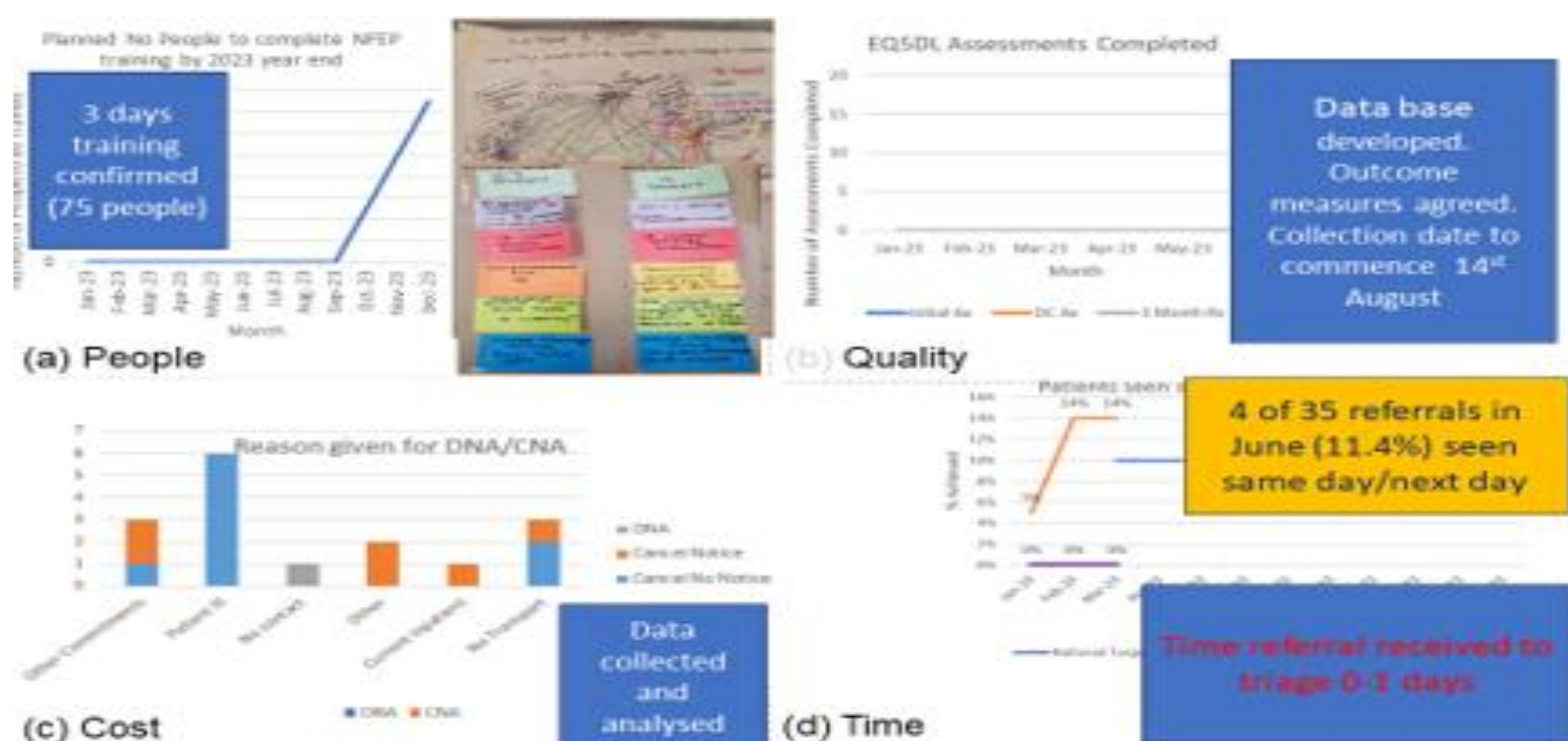
Defined inclusion criteria, triaging and prioritization system. This facilitated more timely access for patients most in need. ICPOP team were are able to see patients identified at high risk of hospital admission in a more timely fashion, without any changes in resources.

Development, evaluation and re-evaluation of defined metrics to measure impact of service interaction on older persons' quality of life and function.

The development and provision of education modules on older person's service and frailty education for health and social care providers.

Development of a service directory for older persons and establish clear integration pathways across acute and community services.

RESULTS:



Conclusion:

This Integrated Care Older Persons RIE has proven to be a transformative journey, successfully achieving all objectives through collaborative efforts. The impact is evident with a sustained increased referral rate of 26% over a 5 month period. This demonstrates the success of our streamlined processes which ultimately improved outcomes for Older Persons and services.

References
1 James E. Hill, Anne-Marie Stephani, Paul Sapple, and Andrew J.Clegg *"The effectiveness* of continuous quality
2. Gupta S., Sharma M., Sunder M.V. (2016). Lean services: A systematic review. International Journal of Productivity and Performance Management, 65(8), 1025–1056

Enhancing Access and Service User Experience

A Service Improvement Project for Physiotherapy Waiting Lists across CHNs in the South East

Anna Marie Lanigan, Head of Service Primary Care **Kate Weeks, CHN Manager/Service Improvement Lead**

Background

In January 2023 there were **5337** patients classified as Priority 2 referrals waiting over 52 weeks for Physiotherapy Treatment across Waterford and Wexford Community Healthcare Networks (CHNs) within CHO5. **63%** of patients had been waiting between 2 to 5 years . Demand across the Community Healthcare Networks (CHNs) was outstripping the capacity, impacting KPIs, leaving staff feeling overwhelmed and impacting on the reputation of the services. It was agreed a central targeted approach would be needed to ensure that all those on the waiting lists who still required a service would receive an appointment as soon as possible.

METHODOLOGY

Challenges	Actions Taken/Lessons Learned
Quantify Waiting lists were kept in multiple formats across the Community Healthcare Networks (CHNs).	Collating waiting lists for all the CHNs and reporting on them by CHN, length of time waiting, age and demographics enabled us to focus on reducing the number of people waiting and the length of time waiting in each CHN. All progress was measured against this baseline data.
Validate Patients Due to the length of time people had been waiting, it was unclear which of these patients still required treatment.	Validation alone enabled us to reduce the waiting lists, however during our validation calls it was clear that for those still requiring treatment it was upsetting not be offered an appointment at that point of contact. In the future we will endeavour to offer a treatment appointment at Validation in order to further enhance the patient experience.
Validate with GPs GPs were informed if there had been no contact with their patients during validation and when they had been discharged from the Waiting Lists. This was done via letters to GPs per patient by post. The GPs found this practice time consuming and wasteful.	We agreed with GPs going forward that all validation would be done electronically, once per week or month for example and we would email a list of patients for the GP to validate – this practice was also put in place when a patient was discharged from the Waiting List.
Did Not Attend (DNA) Rates DNA rates across the CHNs was having an impact on clinical time.	By utilising a central team to manage the appointments and reminder calls the DNA rate for the programme was maintained at 4%. Clinical time was not wasted reminding patients and rebooking appointments. All cancelled appointments were rebooked quickly by the team ensuring the best use of clinical time.
Appointments Demand was outstripping capacity across CHNs and additional resources were limited. Additional funding was required to support to make the greatest impact on the Waiting lists.	Funding was agreed for HSE Out of Hours clinics and interim support from Private Physiotherapy Practices to target the longest waiters. This enabled us to have the biggest impact on the longest waiters in the most affected CHN areas in the shortest time frame.
Visibility for the CHN's on Progress The teams with the CHN were unable to see any progress or light at the end of the tunnel as new referrals were being received every day .	CHN Managers,Therapists and Therapy Managers have access to comprehensive data per CHN, age profile and length or time waiting .This can inform prioritisation and decision making, thus enhancing the success and learning across the South East.

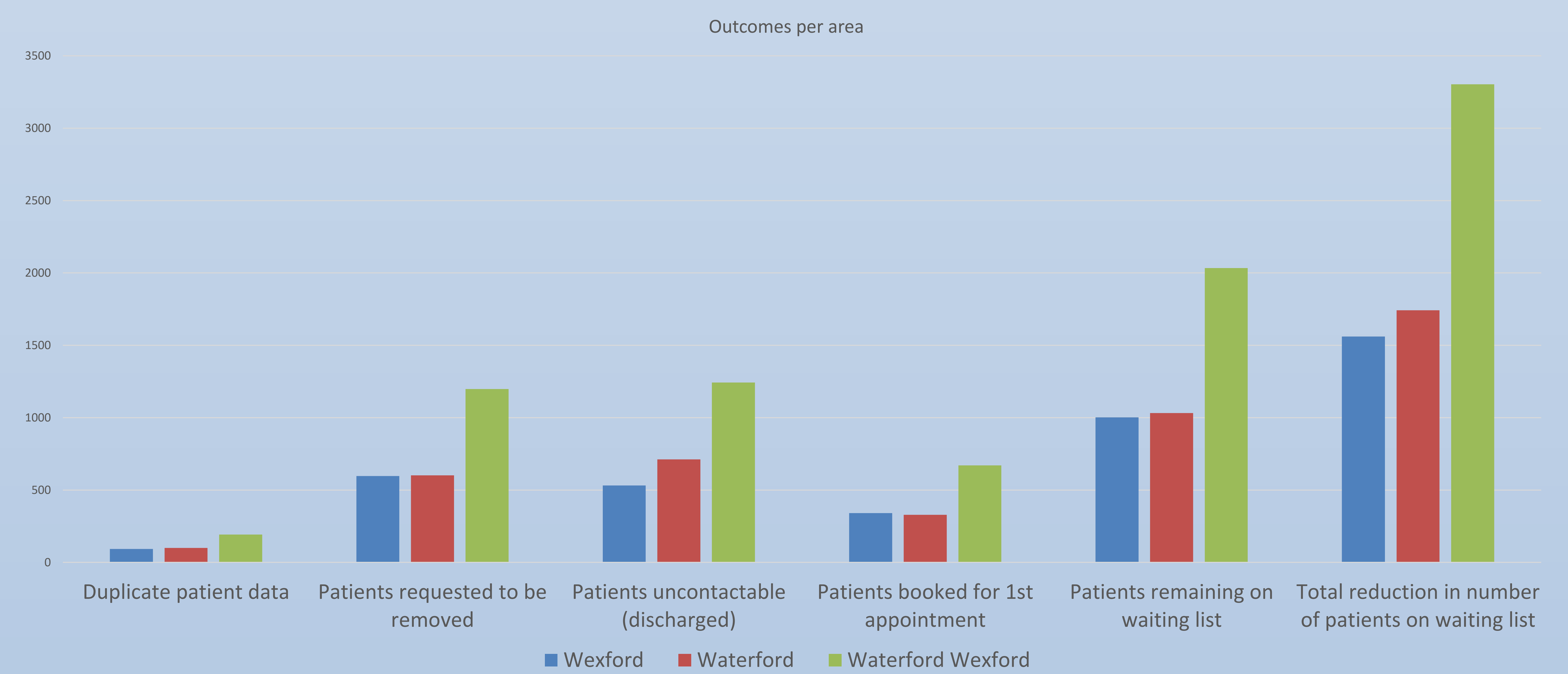
RESULTS

62% Reduction in Waiting lists >52

- **Total of 3303 people removed from the Waiting List between March 23- December 2023.**
- **670 people removed following referral to HSE Out of Hours Physiotherapy clinics and utilising interim private practice support.**
- **Therapists and CHNs have visibility of status and progress being made.**

REPORTS

	Network	Original waiting list numbers	Duplicate patient data	Patients requested to be removed	Patients uncontactable (discharged)	Patients booked for 1st appointment	Patients remaining on waiting list	Total reduction in number of patients on waiting list	Total Percentage Reduction of patients on waiting List
	8	347	5	96	61	0	185	162	47%
	9	1046	49	294	199	341	164	882	84%
	10	675	21	119	165	0	370	305	45%
	11	495	18	88	106	0	283	212	43%
Wexford	Total	2,563	93	597	531	341	1002	1,561	61%
	6	1,229	43	242	349	57	538	691	56%
	7	1,545	57	359	363	272	494	1,051	68%
Waterford	Total	2774	100	601	712	329	1032	1,742	63%
Waterford Wexford	Total	5337	193	1198	1243	670	2034	3303	62%



Patient Feedback

This is the first day in a long time that I have not had any pain, I appreciate it and want to thank you very much for the appointment.

"The Physio was very thoughtful and helpful. I am thrilled: I'll be running marathons after this"

"I am very happy, small steps. I think this will be a good start. I can walk, I can make dinner now and I can play with my kids when before I was crying in pain"

"I have had loads of treatment over the years and nothing has really worked but within 10 minutes with the Physio the pain was gone. He knew what he was talking about. I am absolutely thrilled with the treatment I got"

"The Physio I saw was so kind and nice; he was very professional; he was absolutely great"

"This is the first day I have had , in I don't know how long, that I do not have pain. I really appreciate it and thank you very much for the appointment"

"I thought the Physio was very good, he was so helpful, nice and easy to talk to . He's very nice an down to earth. I'm so impressed. Also, the place is lovely!"

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INTRODUCTION OF POINT-OF-CARE BLOOD TESTING FOR OLDER AMBULANCE PATIENTS WITH SUSPECTED LOW-GRADE INFECTION AND DEHYDRATION – A QUALITY IMPROVEMENT INITIATIVE

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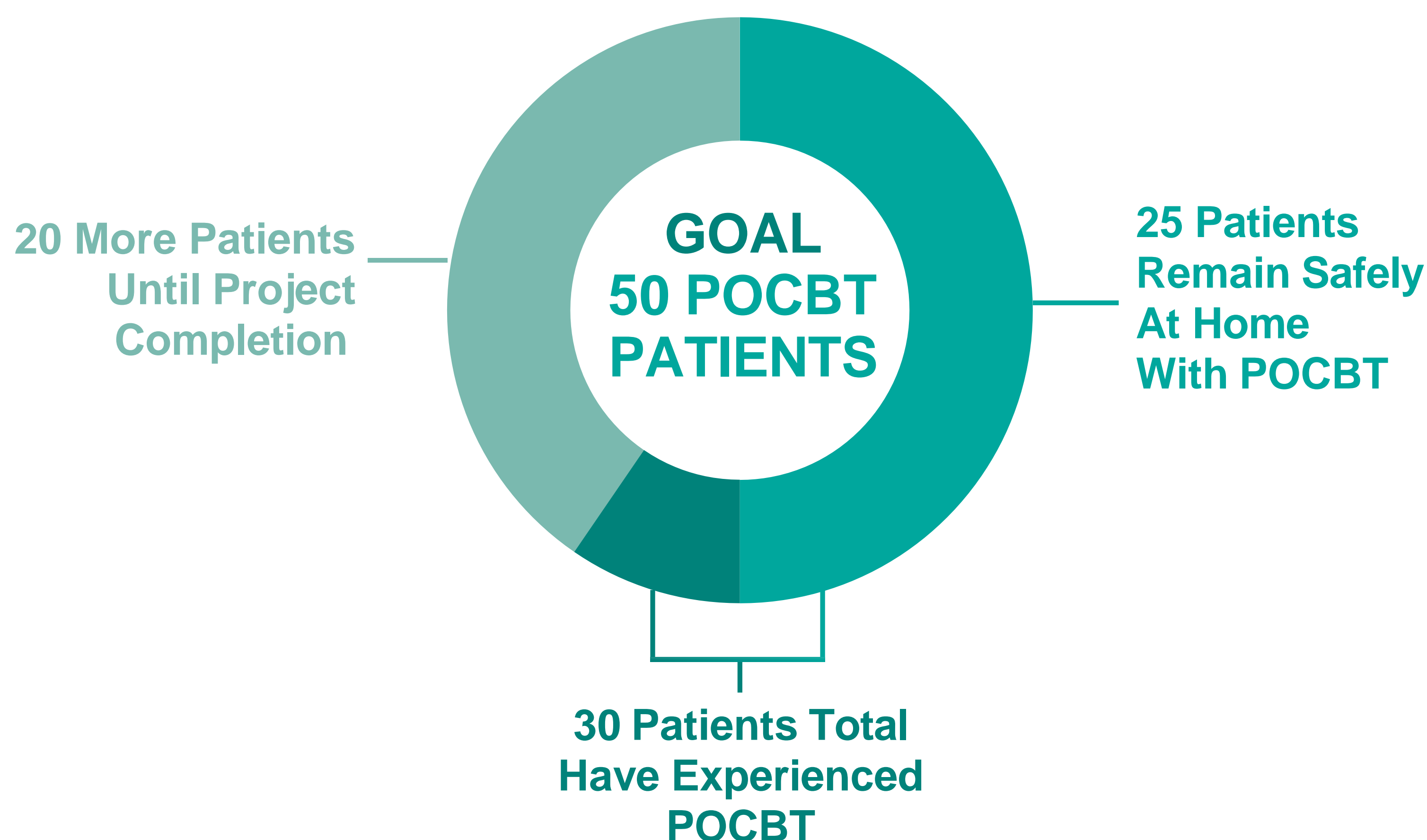
Team: Dr. Sean O'Rourke, Siobhan Masterson PhD

INTRO

- Globally, ambulance services need to find innovative but safe ways to treat vulnerable patients in the community, and avoid unnecessary conveyance to overcrowded Emergency Departments(ED).
- Letterkenny Pathfinder is an ED avoidance service, for the over 65s. It's a collaboration between the National Ambulance Service (NAS) and Letterkenny University Hospital (LUH) Physiotherapy and Occupational Therapy departments.
- The aim of this quality improvement study is to investigate if Point-of-care blood testing (POCBT) if feasible for Pathfinder patients.
- POC can facilitate the identification and safe management of 50 patients at home with low grade infections and dehydration.



METHODS

- This quality improvement project is supported by a multi-disciplinary team including hospital, NAS, General Practitioners (GP) and laboratory staff.
- Abbotts Istat analyser is used alongside CHEM8 and CG4 cartridges, with all relevant training completed.
- Clinical oversight is provided by the patients GP
- Data is derived from patient, GP and staff feedback surveys.
- Statistical data is recorded for time on scene with POC patients and if they differ from other Pathfinder calls.

30 Patients Experienced POCBT
25 Safely Remaining At Home

0%
ADVERSE REACTIONS

60%
COMPLETED TO DATE

100%
POSITIVE FEEDBACK

RESULTS TO DATE

- To date, 30 patients experienced POCBT with 25 safely remaining at home.
- Patient experience to date is promising and positive.
- GP collaboration is growing and enthusiastic.
- "This initiative has been groundbreaking, it has helped me to make safer clinical decisions for my older patients." - Dr. E. Mc Manus

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