Overview of Clinical Case Manager Role in Dublin North Promoting Integrated Care

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Clinical Case Manager for Older Person
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Older People

The number of older people worldwide is dramatically increasing (WHO, 2015).

For the first time in history most people can expect to live into their 60's (Global Strategy and Action Plan 2016-2020)

By 2050 1 in 5 people will be 60years and older (Global Strategy and Action Plan 2016-2020).

Older People in Ireland

By the year 2021 there will be 17.3% increase in the number of people aged 65years and over (ICPOP, 2017).

As people age their health needs tend to become more chronic and complex (WHO, 2015)

CSO 2016 – Increase in >85's - up 150% on last census

Impact on Hospitals

People aged 65 and over use 53% of inpatients beds (ICPOP, 2017)

Patients over 75years spend 3 times longer in ED (ICPOP, 2017).

35% of 70 year olds admitted to hospital show some form of functional loss on discharge and this increases to 65% for 90year olds (NCPOP, 2012).

Integration in Practice

This is a short video depicting how an individual can become increasingly frail in the community.

It explains her care journey.

It depicts how an Integrated Care approach could have been provided to co-ordinated care and future care needs.

The Role of the Clinical Case Manager

To be responsive to community services to avoid unnecessary admissions to acute care.

Communicate and link the community and acute services

Act as a point of contact for the patients and their families.

Co-ordinate care between PCT and acute care

To develop a longer term care plan which anticipates future care needs.

Referral Criteria

Over the age of 65 years

Complex medical/social issues

Under the Medical Care of a Geriatrician.

Resides in CHO 9.

Services Accessed

CIT, Phn's, GP's, Primary Care Services for Physio and OT input, Day Centres, Alzheimers Association of Ireland, Day Hospitals, Home Care Package Co-ordinators and Manager of Older Persons Services, AMAU, Respite services, SAGE, Age Action, FOLD, nursing homes, Nursing home support office.

Key: Using services appropriately to avoid admissions to the acute services.

Primary care of the individual in the Community remains with the GP

St Mary's Hospital supporting Clinical Case Managers

Geriatricians

Day Hospital

Community Response beds (Elms) Nursing and MDT

Transitional care beds (Rosal) Nursing

Respite beds.

Safeguarding Team (Based in St Mary's Hospital)

Phoenix Park Community Nursing Unit

Case Study (Mrs O)

91 yr old lady - fall at home resulting in compression fracture T12 - treated conservatively.

Admitted to MMUH - transferred to Cappagh Hospital for rehabilitation

Assessed by Geriatrician and CNM 2 as frail.

As part of discharge plan – refer to CCM.

Number of risk factors: Lives alone, history of falls, 91years old, multiple co-morbidities.

Case study (Mrs O)

Support services in place on discharge. Home Care Package and Follow up appointment is Mater Day Hospital.

On Home visit

Mrs O appeared frailer, decreased mobility, reported poor appetite, lower limb cellulitis. Observations Stable.

Input from PHN and GP.

On oral antibiotics. Cellulitis not resolving.

Case discussed with Prof Power.

Case Study (Mrs O)

Aim to avoid ED due to frailty however inpatient management required

Linked with Medicine for the elderly team in St Mary's Hospital.

Mrs O accepted for community response bed on Elms ward.

Mrs O admitted and received IV therapy and MDT input. Progressed well during inpatient stay.

Discharged home 1 month later.

Outcome of Case Manager Input

Management Mrs O was proactive rather than reactive

Avoidance of ED

Mrs O received Comprehensive Geriatric Assessment in a Specialised Geriatric Ward with full MDT input.

Case Study Mrs O

Due to complex nature of care needs will continue to be monitored and subsequent admissions may be required

Supports the older person to stay at home longer

Alternative=Acute episode – ED or Residential care

Thank you for your attention

Contact details

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