National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

Clinical Strategy and Programmes Division

Integrated Care Pathway for Older Persons - Metrics

Jennifer Hardiman
Integrated Care Programme for Older Persons
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Table of Contents

Introduction

The measurement of impact resulting from new service models are complex and challenging. In evaluating the impact, base line data, comparison group, user and professional perspective and analysis of cost and service utilisation are typical measures used. A number of useful resources are available (Minkman 2012, Health Foundation 2014, Raleigh et al 2014, Akpan et al 2018, Rutter 20018) and the European Patients Forum (Chassonay et al 2014) but choosing one all-encompassing measure brings its own challenges. When introducing integrated older person pathways, the attribution of impact is challenging in complex systems with many variables that cannot be controlled. These include levels of patient complexity, social circumstances, existing care processes and service resource. Data on this may not be readily available making it difficult to accurately measure the existing service versus any change introduced. Consequently, data associated with new integrated care pathways is proximate and will not capture all the complex variables needed to demonstrate attribution of impact (Walpert and Rutter 2018). This is especially true in the area of older persons where organisational and patient outcomes are not currently aligned.

Organisational measures of outputs will not capture metrics that service users and carers value. In the context of measuring the implementation and impact of integrated care this is a significant challenge. Insights into data collection in the context of implementing older person pathways (ICP OP 2018) is that data is collected in service delivery silos and collecting process of care delivery metrics alone are not an indication of systemic impact (performance).

A fundamental starting point requires the need to articulate key policy (strategic) aims. This is now set out in broad terms in Slaintecare. In the case of older persons this includes enabling people to stay at home, providing care in or near home and when needed older people can access specialist care in hospital. This strategic aim underpins the proposed metrics. They are drawn from the evidence and act as strategic proxies for outcomes that improve the chances of older people staying at home and accessing health and social care in the most appropriate setting with the right expertise (right place, right time, right person). There is now an opportunity to build on and refine the existing national data collection and measurement process as it applies to older persons. This paper sets out the detail of this approach and offers, for the first time in the Irish context a suite of measures that captures the entire integrated care journey.

Background

In the context of strategic and policy developments there are a number of factors that have informed the proposed metrics. This includes New Ways of Working, Slaintecare, the EU Joint Action on Frailty and the reform of the National Clinical Programmes. The need for age attuned services was first outlined in the NCP OP, Specialist Geriatric Services Model of care (HSE 2012). The deployment and testing of integrated care pathways, new roles and service models (ICP OP 2017, 2018) has resulted in a groundswell of interest in developing age attuned services (ICP OP 2018) with new teams and services emerging along the care continuum. Further strategic developments such as the Community Health Network Learning Sites seek to deploy models of care closer to home. Other initiatives (Acute Floor) seek to address patient flow and timey access to specialist care within the appropriate pathways.

The ICP OP 10 Step Framework (ICP OP 2018) provided a conceptual framework upon which local implementation of integrated care for older persons was based. ICP OP is primarily tasked with the implementation of bespoke care pathways, the different elements of which are developed dependent on financial resource and capacity. However, the programme also has a focus on supporting a preventative, positive ageing agenda and the metrics have been chosen to reflect both components. In this context, process measures were developed that captured activity associated with pathway elements. However, these required revision in the context of insights from implementation over the past two years. These were;

- Measures need to include a combination of indicators that incorporates current activity as well as patient outcome measures.
- Structural and process metrics need to capture the full patient journey.
- Local services need to have integrated data feedback on the progression of end to end pathways as well as discrete parts of the patient journey.
- A streamlined measurement process is required that captures the whole older persons care pathway in its entirety whilst maintaining relevance and meaning to ICPOP sites.
- There is a need to enable robust analysis to inform future decision making and service transformation at national and local level in the context of new ways of working (strategic commissioning).

Consequently, a National (Clinical/Managerial/User rep) ICPOP measurement task and finish group was set up in April 2019 to:

- Agree a revised measurement process
- Identify the structural, process and outcomes measures to map to the 3 elements of the older persons pathway

— Primary

— Community & Ambulatory

— Acute Floor and Acute Inpatient

This report sets out a measurement process for ICPOP, establishing a set of measures that incorporate, structural, process and outcomes (organisational and patient). These revised measures will seek to demonstrate more effectively the impact of integrated older person care pathways, the realisation of the fundamental aims of the programme, which in turn will seek to influence national strategic transformation planning.

The purpose of proposed metrics

The complexity of evaluating integrated care and understanding what to evaluate in an Integrated Care Programme is a key issue, (Goodwin 2014, Nolte 2015). This depends on the timeframe, the needs of patients, the opportunity for improvement and the ability to measure the impact, notwithstanding challenges in attribution. In order to measure these outcomes there is a need to ensure individuals within the target population need to be accurately identified and the target population must be 'enrolled' for a meaningful duration of time. As always, attribution of impact is problematic as the interventions deployed must be clearly identifiable in order to establish that they have modified outcomes. Whilst there are some metrics pertaining to older people, there are no metrics available that represent the entirety of the patients care journey.

However, a number of strategic opportunities now present themselves that allows a joined up approach to measurement. Heretofore, metrics relating to access, quality and experience of the care journey were stand alone and represented an aspect of the care pathway. The advent of a changed HSE structure allows clinical design, operational delivery and strategic planning allows for a more 'joined up' approach to service redesign and implementation based on population needs, evidence based models, feasibility, impact and value for money. In tandem with this, the potential offered by the development of Community Health Networks and Regional Integrated Care Organisations prepares the ground for a more comprehensive, integrated, person centred journey to be implemented. The proposed metrics allow new ways of working to be measured in terms of older person services across the care continuum.

How should the metrics be used?

Traditionally a heavy emphasis has been placed around performance metrics as a means of driving improvement. However, without the appropriate service (re)design (structures, pathways, resources) and care process (assertive case management, single point of contact) there is not going to be a change in performance. The suite of metrics proposed are high level proxies for the delivery of better outcomes based on the evidence available. If better outcomes are to be delivered, these elements need to be attended to. Much of the data from this matrix is already available or will be built into a dashboard, https://older-persons.healthatlasireland.ie/uat/login/.

To request access to this dashboard please contact Jennifer.hardiman@hse.ie

It is a key function of local older person governance groups to look at the data as a source of service innovation and improvement, to inform estimates submissions or to articulate the need for change to existing service design. Other supplementary sources of data and guidance are available on Health Atlas https://www.healthatlasireland.ie or on demand and capacity planning https://www.ntpf.ie/home/PDF/TG%20Web.pdf.

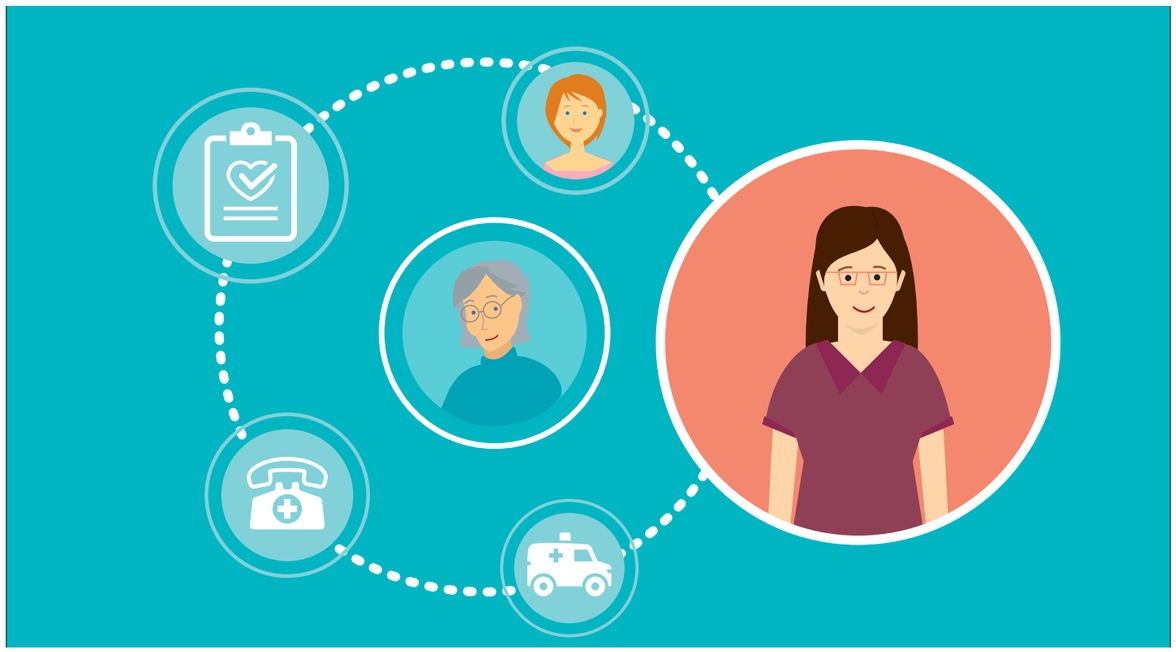
Measurement Matrix

The national ICPOP Task & Finish group was set up in April 2019 to agree a revised measurement process that articulates, structural, process and outcome measures (Organisational and patient outcomes) Figure 1 describes each of the measures across the entirety of the older person's pathway. Therefore, where an integrated care site has implemented, an element of the pathway, this can be measured against indicators that are relevant to that pathway. E.g. a site with a front door frailty team in place and an ambulatory care hub as well will report on those sections of the matrix only with a view to implementing all elements of the pathway in time as a result of the spread and scale of integrated care (ICP OP).

Each of the elements of the pathway and the metrics are described in detail in Appendix 1-3, outlining the calculation method, data source and frequency of reporting and the breakdown of the data structure is described in Appendix 4, 4a and 4b..

Data Collection

Data is currently collected manually by the ICP OP teams, collated locally by the team administrator and submitted to the national team via an excel spread sheet with drop down box options. The national team is currently working to develop a system whereby data is submitted directly by team members using the mobile tablet devices that they have been allocated. This information will then be validated and made available along with the existing HIPE data on the older person's dashboard to give a broad view across the acute and community older person's care pathway.



Indicator	Primary Care Reporting	Integrated care reporting		
	Primary Care (Enablers)	**Ambulatory/Community Care**	**Acute Floor**	**Acute Inpatient**
Structural	'Register' of at risk older persons in place	Older persons with complex care needs can access a HUB which acts as a single point of contact for specialist MDT assessement There is an inreach function to the acute setting	A bespoke age atuned pathway is in place for older persons with complex care needs on the acute floor There is an inreach function to inpatients	Number of cohorted specialaist bed days meets the demands of older persons with complex care needs There is an outreach function to primary & community care
Process	Number of older persons recorded on the 'register' by Community Health Network	The number of all patients • Referred • Accepted on to caseload • Discharged from caseload • Remaining on the MDT caseload at close of business on the final day of the reporting period	• The total number of attendances on the acute floor aged >75 years during the reporting period • The total number of acute floor attendances aged >75 years who have received a screening assessment during the reporting period • The number aged >75 who screen positive for frailty following assessment	AVLOS (Medical) • All Patients YTD 75+ • Age 75+ Excluding Those >30 Days YTD • Patients 75+ % Of Total Bed Occupancy YTD • Patients 75+ Median LOS Over 30 Days
	Receipt of MDT transfer of care plan within 24hours of discharge from acute hospital	The number of patients on the MDT caseload during the reporting Period with: • High • Moderate } Complex Care Needs • Low	Total number of CGAs commenced by the MDT acute floor team during the reporting period	Percentage change from the same month in the preceding year Indicate if increased or decreased
		Source of referral: • GP/Primacy care team • Self/relation/carer • Acute floor • Acute Inpatient • OPD • Other	Total number of older persons >75 years re-attending within 7 days on the acute floor	Number of discharges from cohorted ward Number of patients in a cohorted ward discharged with an MDT transfer of care plan
		Number of patients seen with a discharge destination of a. Home b. Tertiary care c. Long Term Care	Source of each referral within the reporting period Either • GP/PHN • Self/Home • Nursing Home • Ambulatory care hub • OPD/ Day Case	Number of cohorted beds Bed day demand
		Total number of patients on caseload with a completed CGA	Percentage of: • PET < 6Hr 75+ • PET < 9Hr 75+ • PET < 24Hr 75+	Percentage change from the same month in the preceding year Indicate if increased or decreased
		• Number of patient questionnaires completed at entry, discharge and 3 months post eg EQ5D (PROMS)	Admission rate (%) for older persons >75 years during the reporting period	
		• Number of Patient Narrative stories reviewed each quarter (PREMS)		
Outcomes	Older persons with complex care needs proactively identified and managed in Community Health Network	• Number of older persons who have received the right level of care, at the right time in the most appropriate location closer to home will increase • Patient experience will improve	• PET times will meet national targets (HSE NSP 2019) • Patient experience will improve	• AVLOS targets will be age attuned in line with national standards (HSE NSP 2019) • Patient experience will improve
Benefits	Early identification of at risk cohort of patients in CHN	Alternative point of access in place that avoids acute hospital attendance	Older persons attending the acute floor are triaged using a frailty screening tool PET times will improve	Older Persons with complex care needs have a care plan and the primary and ambulatory care teams are aware of the discharge and plan
Strategic Objective	Improving Population Health	Delivering Care Closer to Home	Developing Specialist Hospital Care	Developing Specialist Hospital Care

APPENDIX 1: AMBULATORY/COMMUNITY CARE

Item No.	Area	Type	Measurement Matrix (010519) Reference	Metric Title (Short)	Metric Description / Comment	Metric Type	Calculation Method (If Required)	Source of Date	Frequency of Reporting
A01	Amb/ CC	Structural	Older persons with complex care needs can access a HUB which acts as a single point of contact for specialist MDT assessment There is an in reach function to the acute setting	MDT HUB	Has a HUB been established? Does this HUB coordinate MDT Assessments for all patients with Complex Care needs referred to it? Complex care defined as: "Signs of frailty, with 2 or more co-morbidities, more than 1 event in the last 3-6 months, requires additional input that exceeds the core primary care team e.g. GP, PHN/RGN, SW, PT, and OT. And/or high intensity users of services (both primary/ secondary care). (Lewis et al 2019)	Text Yes/No	N/A	Local ICPOP data source	Annual - any in year variations to be reported
A02	Amb/ CC	Structural		In reach Function	Does the HUB have a documented SOP relating to an Acute Setting in reach function? Is responsibility assigned and are appropriate resources available for this SOP?	Text Yes/No	N/A	Local ICPOP data source	Annual - any in year variations to be reported
A03	Amb/ CC	Process	The number of all patients • Referred • Accepted on to caseload • Discharged from caseload • Remaining on the MDT caseload at close of business on the final day of the reporting period.	Number of Referrals	The total number of new referrals to the MDT from all sources during the reporting period	Number	Gross count of referrals made to the ICPOP team	Local ICPOP data source	Monthly
A04	Amb/ CC	Process		Accepted Referrals	The number of referrals accepted by the MDT during the reporting period. (Acceptance Criteria as documented in the SOP)	Number	Count of referrals minus any rejected referrals	Local ICPOP data source	Monthly
A05	Amb/ CC	Process		Discharges from Caseload	The number of patients discharged from and no longer under the care of the MDT during the reporting period.	Number	Count of all discharges from the caseload of the integrated care team for this reporting period.	Local ICPOP data source	Monthly
A06	Amb/ CC	Process		Caseload Closing Balance	The number of patients on the MDT Caseload at the end of the reporting period. Note: This number will be equal to: Previous Closing Balance plus Accepted Referrals during reporting period minus Discharges from Caseload during reporting period.	Number	Count of referrals still active on caseload (not yet discharged from integrated care) received from prior reporting periods plus all new referrals received within the reporting period	Local ICPOP data source	Monthly
A07	Amb/ CC	Process	The number of patients on the MDT caseload during the reporting Period with: • High } Complex • Moderate } Care • Low } Needs	Caseload Count - High	The number of patients on the Caseload Closing Balance assessed as having "HIGH" Complex Care Needs. Please state what frailty score you are using as a team and what score constitutes High level needs	Number	"High" complex care needs assessed using agreed frailty score or alternative assessment method as stated in the documented SOP	Local ICPOP data source	Monthly
A08	Amb/ CC	Process		Caseload Count - Moderate	The number of patients on the Caseload Closing Balance assessed as having "MODERATE" Complex Care Needs. Please state what frailty score you are using as a team and what score constitutes Moderate level needs	Number	"Moderate" complex care needs assessed using agreed frailty score or alternative assessment method as stated in the documented SOP	Local ICPOP data source	Monthly
A09	Amb/ CC	Process			The number of patients on the Caseload Closing Balance assessed as having "LOW" Complex Care Needs Please state what frailty score you are using as a team and what score constitutes Low level needs Note: HIGH + MODERATE + LOW must equal the Closing Balance	Number	"Low" complex care needs assessed using agreed frailty score or alternative assessment method as stated in the documented SOP	Local ICPOP data source	Monthly
A10	Amb/ CC	Process	Source of referral; • GP/Primacy care team • Self/relation/carer • Acute Floor • Acute Inpatient • OPD- Geriatrician	Referrals - GP/ PCT	Number of Referrals received during the Reporting Period from GPs and/or Primary Care Team	Number	Count of new referrals by referral source for this reporting period	Local ICPOP data source	Monthly
A11	Amb/ CC	Process		Referrals - Self/ Carer	Number of Referrals received during the Reporting Period from Self, Relation and/or Carer	Number			
A12	Amb/ CC	Process		Referrals - ED	Number of Referrals received during the Reporting Period from Acute Hospital floor incl MAU	Number			
A13	Amb/ CC	Process		Referrals - IP	Number of Referrals received during the Reporting Period from Acute Hospital IP Note: Sum of all Referrals by Source equals the Total Referrals (Ref Metric A03)	Number			
					Number of Referrals received during the Reporting Period from OPD Geriatrician	Number			
A14	Amb/ CC	Process	Number of patients discharged within the Reporting Period with a discharge destination of a. Home b. Tertiary care c. Long Term Care	Discharges - Home	Number of patients discharged to HOME during the reporting period	Number	Count of all discharges from the caseload back to the patient's usual place of residence for this reporting period.	Local ICPOP data source	Monthly
A15	Amb/ CC	Process		Discharges - Tertiary Care	Number of patients discharged to TERTIARY CARE during the reporting period	Number	Count of all discharges from the caseload to another hospital or specialist unit for this reporting period	Local ICPOP data source	Monthly
A16	Amb/ CC	Process		Discharges - Long Term care	Number of patients discharged to LONG TERM CARE during the reporting period Note: The sum of all discharges to the three destinations equals the total discharges within the Reporting Period (excluding "Deaths")	Number	Count of all discharges from the caseload to a new LTC placement for this reporting period.	Local ICPOP data source	Monthly

Item No.	Area	Type	Measurement Matrix (010519) Reference	Metric Title (Short)	Metric Description / Comment	Metric Type	Calculation Method (If Required)	Source of Date	Frequency of Reporting
A17	Amb/ CC	Process	Total number of patients on caseload with a completed CGA	Completed CGA	Total number of patients on caseload with a completed CGA (Comprehensive Geriatric Assessment) Note: The maximum value this can have is "Caseload Closing Balance"	Number	Count of CGAs that have been completed with input from all of the relevant members of the MDT. Only count completed CGAs for patient not the number of MDT member inputs that go into the CGA. E.g. 1 patient = 1 CGA	Local ICPOP data source	Monthly
A18	Amb/ CC	Process	Number of patient questionnaires (e.g. EQ5DL) completed at entry, discharge and 3 months post discharge from the ICPOP team	Patient Questionnaires	Number of patient questionnaires completed for this reporting period at: 1. First assessment 2. Discharge from ICPOP team and 3. 3 months post discharge from ICPOP team • Annual report collating information from 1,2&3 above completed Questionnaire design as agreed in ICPOP team SOP. E.g. EQ5DL (EuroQol)	Number	Count of all completed questionnaires by1,2,& 3 for reporting periods: Q1. Jan-Mar Q2. Apr-Jun Q3. Jul-Sep Q4. Oct-Dec Annual report for preceding 12 month period	Local ICPOP data source	Quarterly plus collated report Annually
A19	Amb/ CC	Process	Number of Patient Narrative stories reviewed within the reporting period	Patient Narratives	Number of Patient Narratives reviewed each reporting period	Number	The "Your voice matters" database to accessed at least each quarter and the count of patient narratives submitted and reviewed within the reporting period relating to ICPOP is recorded Q1. Jan-Mar Q2. Apr-Jun Q3. Jul-Sep Q4. Oct-Dec	"Your Voice Matters" database	Quarterly
A20	Amb/ CC	Outcome	Number of older persons who have received the right level of care, at the right time in the most appropriate location closer to home will increase	Right care right place	Number of patients seen in an ambulatory or domiciliary setting compared to the preceding year	Number	National ICPOP programme use only	Annual figures from ICPOP measurement	Annual (ICPOP team use only)
A21	Amb/ CC	Outcome	Patient experience will improve	PREMS	Outcome of annual report from Metric A18	Report	National ICPOP programme use only	Local ICPOP annual report	Annual

APPENDIX 2: ACUTE FLOOR

Item No.	Area	Type	Measurement Matrix (010519) Reference	Metric Title (Short)	Metric Description / Comment	Metric Type	Calculation Method (If Required)	Source of Date	Frequency of Reporting
AF01	Acute Floor	Structural	A bespoke age attuned pathway is in place for older persons with complex care needs on the acute floor. There is an in reach function to inpatients	Bespoke Pathway	Is there is defined, documented and resources bespoke pathway for older persons with complex care needs. Complex care defined as: *"Signs of frailty, with 2 or more co-morbidities, more than 1 event in the last 3-6 months, require additional input that exceeds the core primary care team e.g. GP, PHN/RGN, SW, PT, and OT. And/or high intensity users of services (both primary/secondary care).* (Lewis et al 2019)	Text Yes/No	N/A	Local ICPOP data source	Annual. Any in year variations to be reported
AF02	Acute Floor	Structural		In reach Function	Is there a documented SOP relating to an Inpatient Setting In reach function? Is responsibility assigned and are appropriate resources available for this SOP	Text Yes/No	N/A	Local ICPOP data source	Annual. Any in year variations to be reported
AF03	Acute Floor	Process	• The total number of attendances on the acute floor aged >75 years during the reporting period. • The total number of acute floor attendances aged >75 years who have received a screening assessment during the reporting period • The number aged >75 who screen positive for frailty following assessment	Total Attendances	Total number of patients, 75 years and older, presenting at the ED during the reporting period	Number	Already calculated on dashboard	Older Persons dashboard	Monthly
AF04	Acute Floor	Process		Total Screened	Number of patients, 75 years and older, presenting at the ED and who received a "frailty assessment" during the reporting period.	Number	Count of patients who have had an acute floor front door frailty screen as stated in SOP e.g. VIP screening tool	Local MDT team data	Monthly
AF05	Acute Floor	Process		Total Screened Positive	Number of patients, 75 years and older, presenting at the ED and who were assessed positively for frailty during the reporting period.	Number	Count of patients screened positive using front door frailty screening tool as stated in SOP	Local MDT team data	Monthly
AF06	Acute Floor	Process	Total number of CGAs commenced by the MDT acute floor team during the reporting period	CGA's Completed	Number of CGAs (Comprehensive Geriatric Assessment) commenced by the Multi-Disciplinary Team during the reporting period.	Number	1 Patient = 1 CGA commenced. Do not count the number of MDT members who have provided input into the CGA		Monthly
AF07	Acute Floor	Process	Total number of older persons >75 years re-attending within 7 days on the acute floor	Re-attendances	Total number of older persons >75 years re-attending within 7 days on the acute floor	Number	Count of the number of patients seen by the MDT on the acute floor who have gone on to re-attend within 7 days	Local Patient administration system. e.g.PAS/iPIMS	Monthly
AF08	Acute Floor	Process	Source of each referral within the reporting period. Either: • GP/PHN • Self / Home • Nursing Home • OPD/Day case • Ambulatory care hub	Referrals - GP/ PHN	Number of Referrals (of patients 75 years and older) received during the Reporting Period from GPs and/or Primary Health Nurse	Number		Local Patient administration system. e.g.PAS/iPIMS	Monthly

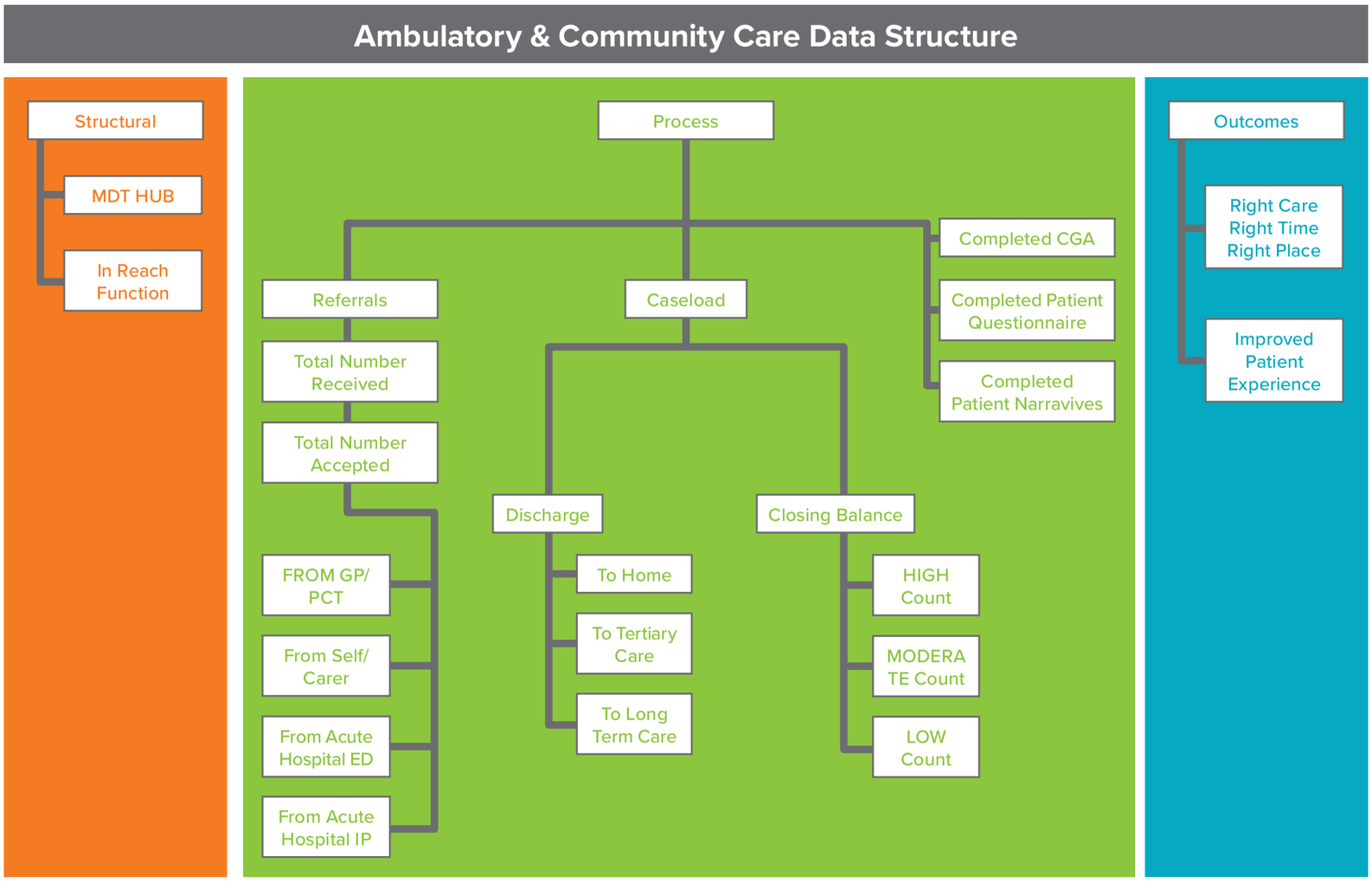
Item No.	Area	Type	Measurement Matrix (010519) Reference	Metric Title (Short)	Metric Description / Comment	Metric Type	Calculation Method (If Required)	Source of Date	Frequency of Reporting
AF09	Acute Floor	Process	Source of each referral within the reporting period. Either: • GP/PHN • Self / Home • Nursing Home • OPD/Day case • Ambulatory care hub	Referrals - Self/ Home	Number of Self / Home Referrals (of patients 75 years and older) received during the Reporting Period	Number		Local Patient administration system. e.g.PAS/iPIMS	Monthly
AF10	Acute Floor	Process		Referrals - Nursing Home	Number of Referrals (of patients 75 years and older) received during the Reporting Period from Nursing Homes	Number		Local Patient administration system. e.g.PAS/iPIMS	Monthly
AF11	Acute Floor	Process		Referrals - OPD/ Day Case	Number of Referrals (of patients 75 years and older) received during the Reporting Period from Outpatients and/or Day Case	Number		Local Patient administration system. e.g.PAS/iPIMS	Monthly
AF12	Acute Floor	Process		Referrals - Ambulatory Care Hub	Number of Referrals (of patients 75 years and older) received during the Reporting Period from Ambulatory Care Hub.	Number		Local Patient administration system. e.g.PAS/iPIMS	Monthly
AF13	Acute Floor	Process	Percentage of: • PET < 6Hr 75+ • PET < 9Hr 75+ • PET < 24Hr 75+ Percentage change from the same month in the preceding year. Indicate if increased or decreased	6 Hour PET Percentage	Percentage of all patients, 75 years and older, with a recorded PET of 6 Hours or less during the reporting period.	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF14	Acute Floor	Process		9 Hour PET Percentage	Percentage of all patients, 75 years and older, with a recorded PET of 9 Hours or less during the reporting period.	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF15	Acute Floor	Process		24 Hour PET Percentage	Percentage of all patients, 75 years and older, with a recorded PET of 24 Hours or less during the reporting period.	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF16	Acute Floor	Process		6 Hour PET Percentage Change	6 Hour PET Percentage Change (increase or decrease)	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF17	Acute Floor	Process		9 Hour PET Percentage Change	9 Hour PET Percentage Change (increase or decrease)	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF18	Acute Floor	Process		24 Hour PET Percentage Change	24 Hour PET Percentage Change (increase or decrease)	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF19	Acute Floor	Process	Admission rate (%) for older persons >75 years during the reporting period	Admission Rate	Admission rate (%) for older persons >75 years during the reporting period	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AF20	Acute Floor	Outcomes	• PET times will move towards meeting national targets • Patient experience will improve	PET Times	National standard for Acute Floor attendances: 95% of patients are admitted or discharged within six hours of attending an ED	As above	PET time figures will inform this outcomes as above	Older Persons dashboard	Annual
AF21	Acute Floor	Outcomes		PREMS	National Experience survey data will improve compared to preceding year	Report	National Report	National Report	Annual

APPENDIX 3: ACUTE INPATIENT CARE

Item No.	Area	Type	Measurement Matrix (010519) Reference	Metric Title (Short)	Metric Description / Comment	Metric Type	Calculation Method (If Required)	Source of Date	Frequency of Reporting
AI01	Acute Inpatient	Structural	Number of cohorted specialist bed-days meets the demands of older persons with complex care needs.	Cohorted Bed Capacity	Is there sufficient cohorted bed capacity to meet the inpatient bed-day demand for patients 75 years and older with complex care needs. "Signs of frailty, with 2 or more co-morbidities, more than 1 event in the last 3-6 months, requires additional input that exceeds the core primary care team e.g. GP, PHN/RGN, SW, PT, and OT. And/or high intensity users of services (both primary/ secondary care). (Lewis et al 2019)	Yes/No	To calculate bed days required per annum, identify the mean number of daily attendances together with the daily conversion rate and multiply this by the AVLOS for people aged >75 (mild to severe frailty) and excluding >30 days LOS. (For further information please refer to the SDU Technical Guidance on Demand and capacity Planning SDU 2013)	Older Persons dashboard	Annual
AI02	Acute Inpatient	Structural	There is an outreach function to primary & community care	Outreach Function	Is there a documented SOP relating to an Inpatient Setting Outreach function? Is responsibility assigned and are appropriate resources available for this SOP	Yes/No	N/A	Local ICPOP data source	Annual. Any in year variations to be reported
AI03	Acute Inpatient	Structural	Bed day demand	Bed day demand	Mean number of daily attendances	Number	Already calculated on dashboard	Older Persons dashboard	Monthly
AI04	A cute Inpatient	Structural	Number of cohorted beds	Cohorted Beds	Number of cohorted beds actually in place for older persons at the time of reporting	Number	Cohorted bed count	Local Patient administration system.	Monthly
AI05	Acute Inpatient	Process	AVLOS (Medical) • All Patients YTD 75+ • Age 75+ Excluding Those >30 Days YTD • Patients 75+ % Of Total Bed Occupancy YTD Percentage change from the same month in the preceding year. Indicate if increased or decreased	75+ AVLOS YTD	YTD Medical AVLOS for all patients 75 years and older.	Number	Already calculated on dashboard	Older Persons dashboard	Monthly
AI06	Acute Inpatient	Process		75+ AVLOS Excluding Delayed Discharges	YTD Medical AVLOS for all patients 75 years and older excluding those with a Length of Stay >30 Days (Delayed Discharges)	Number	Already calculated on dashboard	Older Persons dashboard	Monthly
AI07	Acute Inpatient	Process		% of Bed Days Used by patients 75 years and older YTD	% of Bed Days used by patients 75 years and older with a LOS greater than 30 Days	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AI08	Acute Inpatient	Process		YTD LOS for Delayed Discharges	YTD Median LOS for patients 75 years and older with a LOS greater than 30 days.	Number	Already calculated on dashboard	Older Persons dashboard	Monthly
AI09	Acute Inpatient	Process		% Change in 75+ AVLOS YTD	% Change in the YTD Medical AVLOS for all patients 75 years and older compared to the same period last year.	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly

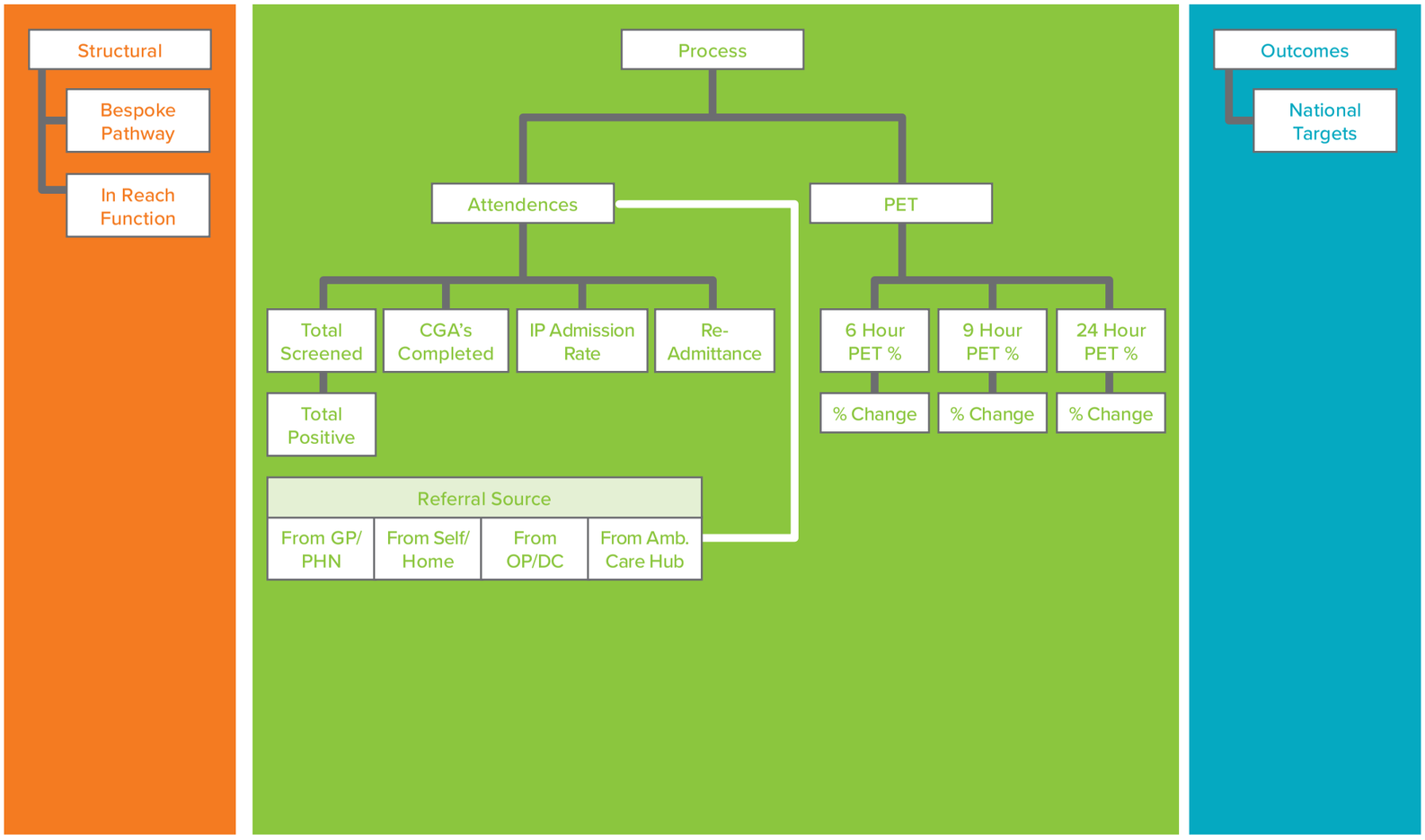
Item No.	Area	Type	Measurement Matrix (010519) Reference	Metric Title (Short)	Metric Description / Comment	Metric Type	Calculation Method (If Required)	Source of Date	Frequency of Reporting
AI10	Acute Inpatient	Process	AVLOS (Medical) • All Patients YTD 75+ • Age 75+ Excluding Those >30 Days YTD • Patients 75+ % Of Total Bed Occupancy YTD Percentage change from the same month in the preceding year. Indicate if increased or decreased	% Change 75+ AVLOS Excluding Delayed Discharges	% Change in the YTD Medical AVLOS for all patients 75 years and older excluding those with a Length of Stay >30 Days (Delayed Discharges) compared to the same period last year.	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AI11	Acute Inpatient	Process		Change in % of Bed Days Used by patients 75 years and older YTD	Change in the % of Bed Days used by patients 75 years and older with a LOS greater than 30 Days compared to the same period last year	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AI12	Acute Inpatient	Process		% Change in YTD LOS for Delayed Discharges	% Change in the YTD Median LOS for patients 75 years and older with a LOS greater than 30 days compared to the same period last year	Percentage	Already calculated on dashboard	Older Persons dashboard	Monthly
AI13	Acute Inpatient	Process	Number of discharges from cohorted ward	Discharges from Cohorted Ward	Number of patients 75 years and older discharged from the cohorted ward during the reporting period.	Number		PAS system	Monthly
AI14	Acute Inpatient	Process		Discharged with MDT transfer of care plan	Number of patients 75 years and older discharged with an MDT Transfer of Care Plan from the cohorted ward during the reporting period.	Number	Cohorted ward staff plans and implements discharge and follow-up with all parties, including in complex situations. Ensures onward referral is communicated effectively. (NCPOP Jan 2016)	Cohorted ward data	Monthly
AI15	Acute Inpatient	Outcomes	AVLOS will meet national standards Patient experience will improve		AVLOS targets will be age attuned in line with national standards (HSE NSP 2019)	Number	National calculation	Age attuned HIPE data	Monthly
AI16	Acute Inpatient	Outcomes		PREMS	National Experience survey data will improve compared to preceding year	Report	National Report	National Report	Annual.

Appendix 4



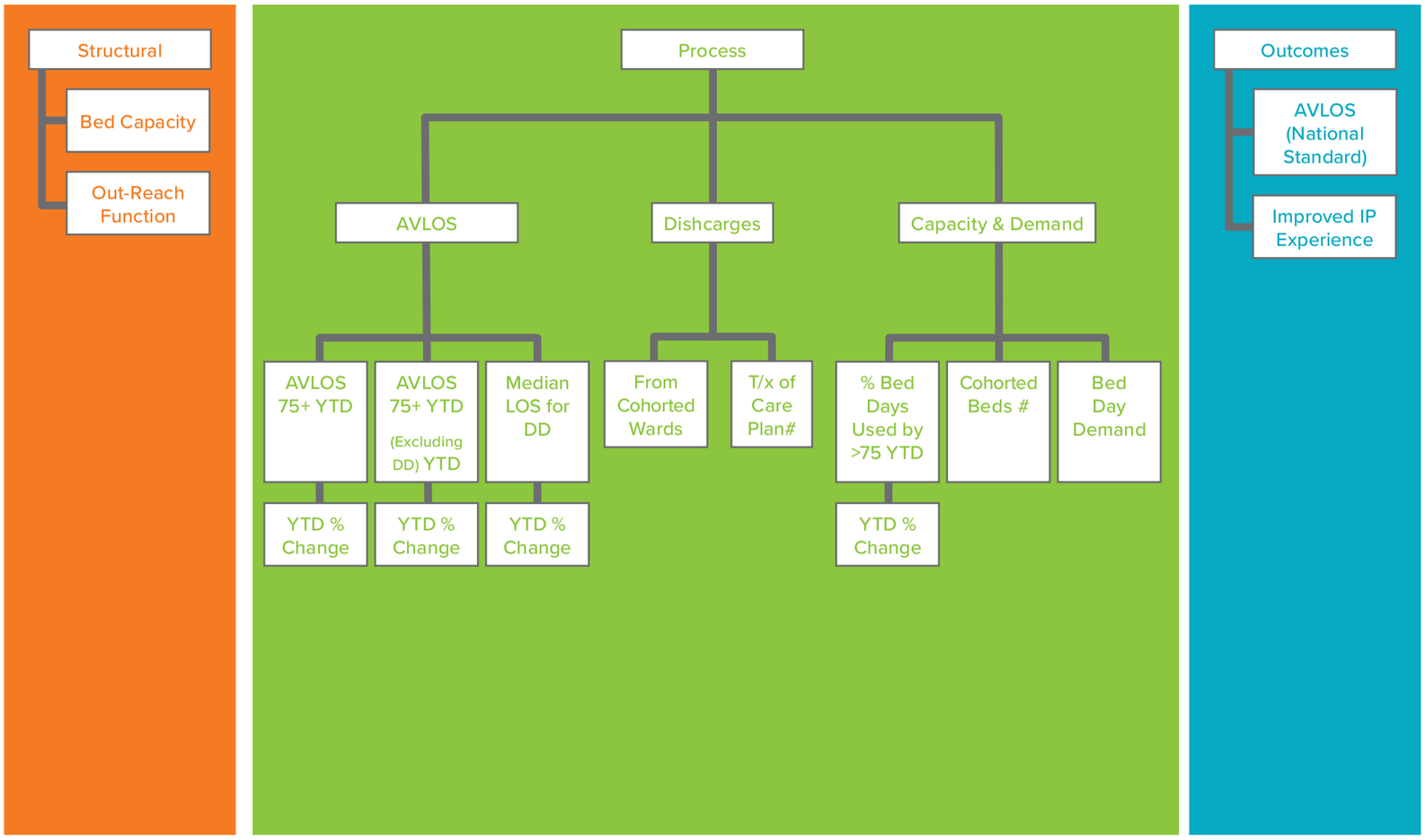
Appendix 4a

Acute Floor Data Structure



Appendix 4b

Inpatient Data Structure



Glossary of Terms

AMU	Acute Medical Unit
AVLOS	Average Length of Stay
CHN	Community Health Network
CGA	Comprehensive Geriatric Assessment
DC	Day Case
ED	Emergency Department
GP	General Practitioner
HSE	Health Service Executive
ICP OP Persons	Integrated Care Programme- Older
IP	Inpatient
KPI	Key Performance Indicators
LOS	Length of Stay
MDT	Multidisciplinary Team
NCPOP People	National Clinical Programme for Older
NSP	National Service Plan
OPD	Outpatient Department
OT	Occupational Therapist
PAS	Patient Administration System
PET	Patient Experience Time
PCT	Primary Care Team
PHN	Public Health Nurse
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcome Measures
PT	Physiotherapist
RGN	Registered General Nurse
SDU	Special Deliver Unit
SOP	Standard Operating Procedure
SW	Social Worker
VIP	Variable Indicative of Placement risk
YTD	Year to Date

National ICPOP Measurement Task & Finish Group membership

Barbara	Murphy	General Manager Older Persons Services	CHO 5 Waterford SECH
Danielle	Reddy	Senior Occupational Therapist	CHO 5 Kilkenny St Luke's
Gillian	Hogan	Senior Occupational Therapist	CHO 4 Cork CUH/MUH
Dr Nichola	Boyle	Consultant Geriatrician	CHO 6 Vincents
Margaret	Costello	Project Lead	CHO 3 Limerick
Oliver	O'Halloran	cANP	CHO 3 Limerick
Leahnora	Clohessy	Senior Occupational Therapist	CHO 3 St Joseph's Ennis
Austin	Warters	General Manager Older Persons Services	CHO 9 Mater
Adrienne	Sweetman	Senior Occupational Therapist	CHO 9 Mater
Dr Gráinne	O'Malley	Consultant Geriatrician	CHO 1 Sligo
Dr Frances	Dockery	Consultant Geriatrician	CHO 9 N Dublin Beaumont
Patrice	Reilly	Social Worker	CHO 9 Nth Dublin Beaumont
Clare	Lewis	Deputy Chief Nursing Officer Community	Department of Health
Berneen	Laycock	Project Officer	Department of Health
Gerry	Kelleher	Business Intelligence Unit	RCSI
Eileen	Moriarty	General manager- Older Persons Services	HSE
John	McLoughlin	Data Consultant	ICP OP
PJ	Harnett	National Programme Manager ICP for Older Persons	ICP OP
Des	Mulligan	Service Improvement Manager ICP for Older Persons	ICP OP
Dee	Conroy	Programme Manager, ICP for Older Persons	ICP OP
Jennifer	Hardiman	Service Improvement Manager, ICP for Older Persons	ICP OP
Belinda	Buckley	Administrator, ICP for Older Persons	ICP OP

Integrated Care Pathway for Older Persons - Metrics

Jennifer Hardiman
Integrated Care Programme for Older Persons
June 2019
e: Jennifer.hardiman@hse.ie