

Expression of Interest

Piloting Falls and Bone Health Integrated Care Pathway for Older Persons (65 years and older)

BACKGROUND

HSE and the State Claims Agency are inviting persons working in the following settings: primary care, community care, hospitals /groupings or residential care (at least one in each HSE Administrative Area) to participate in piloting a falls and bone health integrated care pathway for persons aged 65 years and older. The integrated care pathway (ICP) needs to be able to respond to the needs of an older person with one or more co-morbidities who is living in their own home with/without a home care package or in a residential care setting who has fallen at least twice in the last 12 months with the final fall resulting in a hip fracture. The falls and bone health ICP will serve to test the Specialist Geriatric Services Model Pathway (*See Appendix 1 SGS Model Pathway modified*) supporting its ongoing development.

The aim of the programme is to pilot an integrated care pathway for falls preventions, management and bone health so as to:

- Prevent falls,
- Identify and reduce the risk factors for falling,
- Reduce the injuries from falls,
- Manage falls effectively and
- Improve health and wellbeing through a focus on bone health.

for persons 65 years and older in the Republic of Ireland through implementation of the Strategy to Prevent falls and Fractures in Ireland's Ageing Population, 2008, hereafter known as the National Strategy.

Following are some key requirements of potential pilot sites/early adopters:

1. Each pilot site will form a multidisciplinary team (MDT) from one or more of the following settings: primary care, community care, hospitals /groupings or residential care. This team will consist of **up to 10 persons** (preferable a group whom already work in a team but not essential) who best represent the various settings and multidisciplinary team members needed to deliver a falls and bone health service that meets the worst case scenario of an older person with one or more co-morbidities falling resulting in a hip fracture as outlined above.
2. Each pilot site should read and complete the **Falls Readiness Proposal** and the Online Audit Survey of how existing services are organised in their organisation.
3. The multidisciplinary team may be made up of any of the following – Consultant Geriatrician, GP, specialist nurse, Transformation Development officer, public health nurse, pharmacy, physiotherapist, occupational therapist, health care assistant, dietician, social worker, health promotion– this is not an exhaustive list. A lead/co lead for each pilot site will be nominated for each of the MDT Teams in each site.

4. All pilots will begin in Quarter 3 2013 and continue for a period of 12 months.
5. Site support will be given by the Joint National Co-ordinators in collaboration with the A Regional Implementation Team (RIT). The RIT will meet regularly to enable and track the pilots' progress and/or challenges. The MDT Lead (key contact person) for each pilot site will be nominated to the Regional Implementation Team and will serve as the primary communications' portal for each pilot site.
6. Lessons learned from the pilot sites will be used to inform the roll out nationally of falls and bone health integrated care pathways, a quality and patient safety initiative in 2014/2015.
7. The deadline for receipt of Expressions of Interest is **ASAP**
8. All Expressions of Interest should be signed by the Director/Authorised Persons of the various settings involved in the ICP where practically possible.

If you have any queries please feel free to contact Irene O' Byrne-Maguire/ Anne Marie Ryan, Joint National Project Co-ordinators at iobyrnemaguire@ntma.ie or annemarie.ryan@hse.ie or 087-6727705 (Irene) or 087-2493407 (Anne Marie)

Expression of Interest

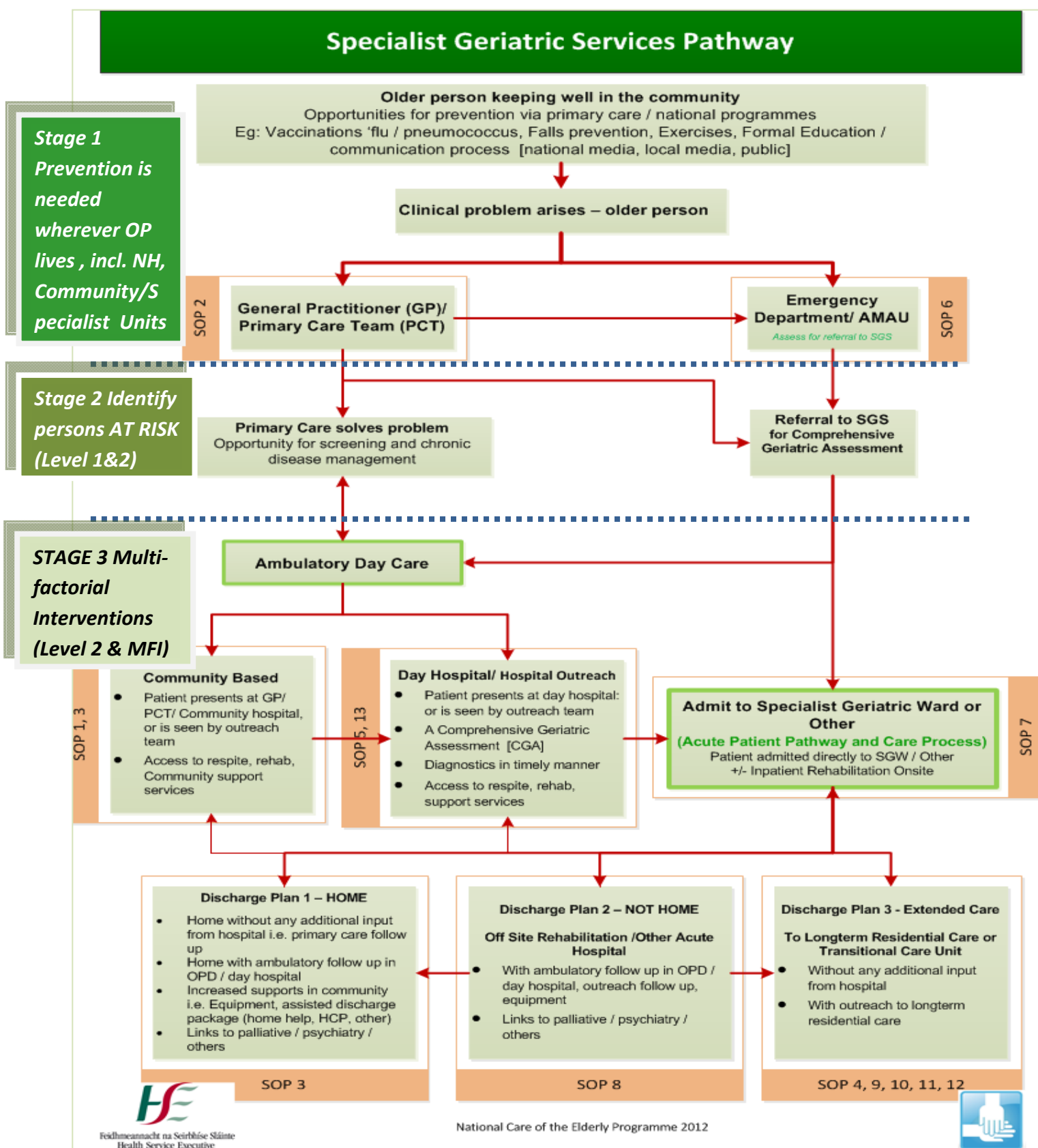
On behalf of (name your IC pathway)----- from the following settings : primary care, community care, hospitals /groupings or residential care I would like to express an interest in participating in the Pilot Falls and Bone Health ICP Implementation Programme. I will support the participants for the duration of the pilot project. The members of the Multidisciplinary Team are as follows:

1. -----(Geriatrician/relevant Medical Consultant)
2. -----(Specialist Nurse)
3. ----- (Pharmacist)
4. ----- (Health Promotion)
5. ----- (GP)
6. ----- (Physiotherapist)
7. ----- (Occupational Therapist)
8. ----- ()
9. ----- ()
10. ----- ()

Signature of Key Authorising Person (s) (usually CEO/Area Manager) and Date

Name and best contact details of **Key Contact Person(s)** (Lead/co-lead) for this Multidisciplinary Team.

Please send completed forms to Irene O' Byrne-Maguire/ Anne Marie Ryan, Joint National Project Co-ordinators at iobyrnemaguire@ntma.ie or annemarie.ryan@hse.ie for forwarding to the relevant Regional Implementation Team co-leads.



Schematic Integrated Care Pathway Model for National Falls & Bone Health Implementation Project (AFFINITY)

Stage of Care – 1. Prevention 2. Case Finding/AT RISK 3. Interventions	Community Setting	Hospital Setting
FALLS PREVENTION	Older person keeping well in the community 65 years and older	
	Clinical problem arises <i>Eg. Fall with suspect fractured hip</i>	
	Referral to GP/out of hours GP service/PCT	Or/and Referral to Emergency Department/AMAU
CASE FINDING/AT RISK (Level 1 Screening Assessment & Level 2 <i>if necessary</i> Multi-factorial Falls Risk Assessment)	Problem resolved with opportunity seized for screening and chronic disease management in clinic/at home/LRC or transitional unit	<ul style="list-style-type: none"> • If HIP FRACTURE, urgent referral to Orthopaedics & for Medical Assessment if necessary • Referral to Specialist Geriatric Service for Comprehensive Geriatric Assessment (CGA)
INTERVENTIONS (Level 2 Multi-factorial Falls Risk Assessment <i>if not already done</i> & Level 3 Multi-factorial falls Interventions)	<p>Ambulatory Day Care that is</p> <ul style="list-style-type: none"> • Community based i.e. GP/PCT/OPD/Community hospital/outreach team for respite, rehab, community supports • Day Hospital/Hospital Outreach for timely diagnosis/CGA/access to respite, rehab, community support such as equipment, HCP, home help etc <p>Offsite Rehabilitation/other acute hospital (Model 2/3/4) with ambulatory follow up in OPD/day hospital/hospital outreach with/without links to psychiatry/palliative/others</p> <p>Long term Residential Care Unit (LRCU) With/ without additional inputs from hospital outreach</p>	Admit to Specialist Geriatric Ward or Other +/- inpt rehabilitation onsite