

A Community Virtual Ward Supporting Integrated Care for Older Persons with Complex Health and Social Care Needs

Abstract

Introduction

The aging population within the Republic of Ireland is increasing exponentially to approximately 20,000 per year. As a result there is an increase in frail older persons living within the community with increased risks of emergency department (ED) presentations and hospital admissions. Better co-ordinated care with targeted specific interventions can assist with admission avoidance and unplanned hospital admission and is seen as key to supporting patients at home. The use of virtual wards have increased in popularity in providing a framework for risk stratification and supporting integration of care across primary and acute settings.

Practice change implementation

In January 2015 a community virtual ward was implemented within North Dublin operating on a traffic light system of red (high risk), amber (moderate risk), green (low risk). A number of assessment tools reviewing frailty, function, cognition and risk of a hospital admission were used to determine overall risk and response to interventions overtime.

Targeted population and key stakeholders

The model of care focused on older persons > 65 average age 81.6 years (SD + 5.7 years) living at home with 2 or more co-morbidities and evidence of clinical or functional decline within a 30 day time frame. Key stakeholders included the clinical case manager older persons, primary care services, older persons services, acute hospital specialist gerontology as well as the Day Hospital, the ED, frailty intervention therapy team (FITT), hospital bed management, Royal College of Surgeons Ireland, School of Nursing and Midwifery, Nursing and Midwifery Planning and Development Unit (North Dublin)

Timeline

The initiative is ongoing with plans to expand due to the development of an integrated care team within North Dublin.

Outcomes

A total 85 patients have been through the community virtual ward with evidence of a significant reduction in the median unplanned hospital admissions (1, IQR 0-1) in comparison to the number of unplanned hospital admissions prior to CVW interventions (0, IQR 0-0, $z=4.79$, $P=0.001$). ED presentations were also reduced (ED presentations pre median 1= IQR 0.2 ED presentations post median 0, IQR 0-1 $z=4.52$, $P<0.001$) which is statistically significant.

Sustainability

The model is sustainable as it focuses on care in the home supporting the expansion of an integrated care team working across primary and secondary care.

Transferability

As it focuses on integration of care including risk stratification, timely service mobilisation and monitoring the model is transferable to areas such as palliative care, disabilities and mental health.

Conclusion

The CVW offers solution to integrated care for older persons with complex care needs in supporting patients at home during critical periods of illness and functional decline.

Location

Ireland

Year

2016

Related Integrated Care keywords

- JOINT/ COMMON ASSESSMENT

Pervasiveness

Small scale in a region

Status

Completed

Links

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