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PHARMA SUMMIT 23

PARTNERING TO IMPROVE HUMAN HEALTH

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National Clinical Advisor & Group Lead for Chronic Disease

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The Integrated Care Programme for the Prevention and Management of Chronic Disease – Enhanced Community Care Programme

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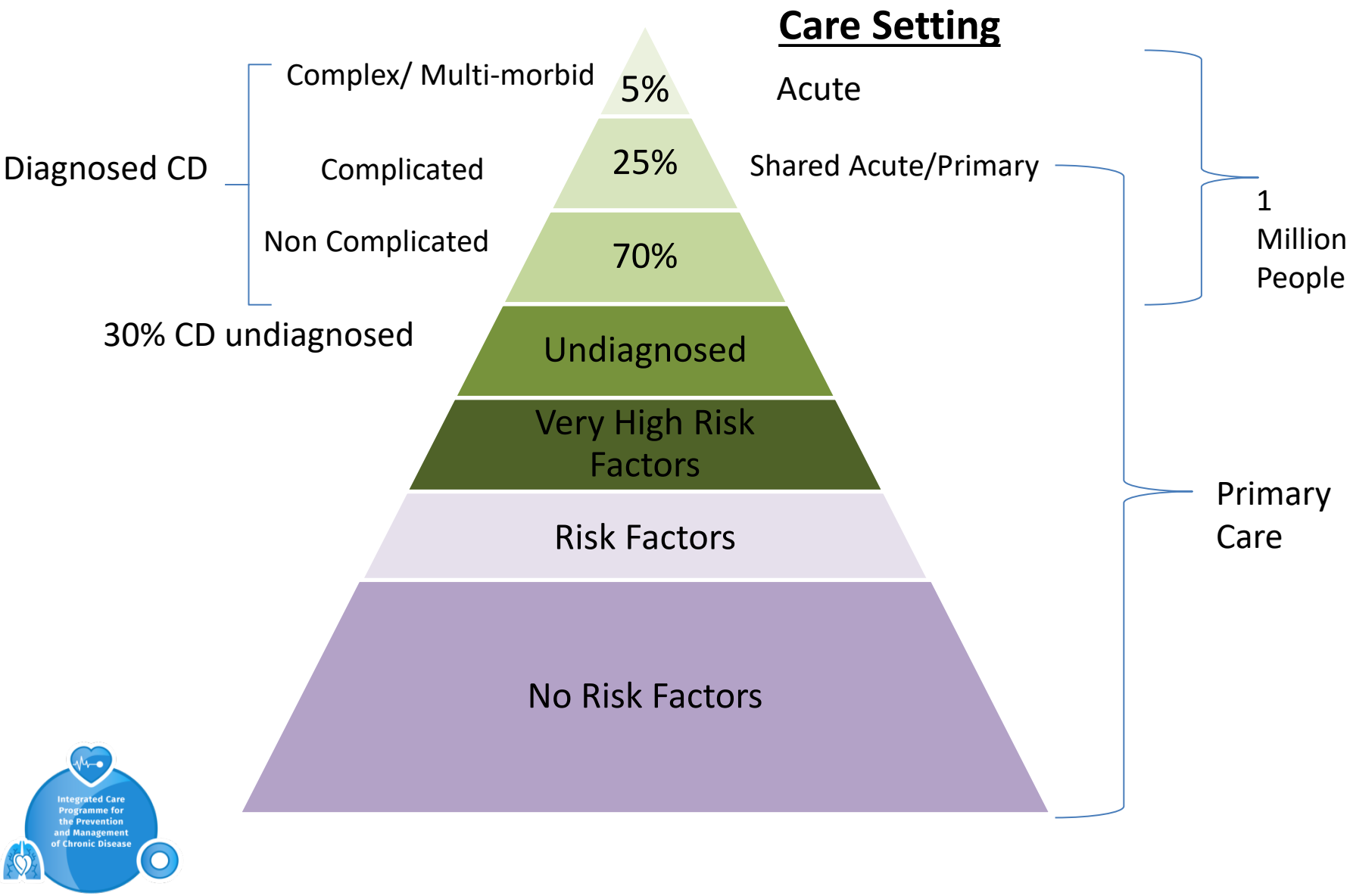
Office of the CCO
Health Service Executive

Clinical Design & Innovation
Person-centred, co-ordinated care

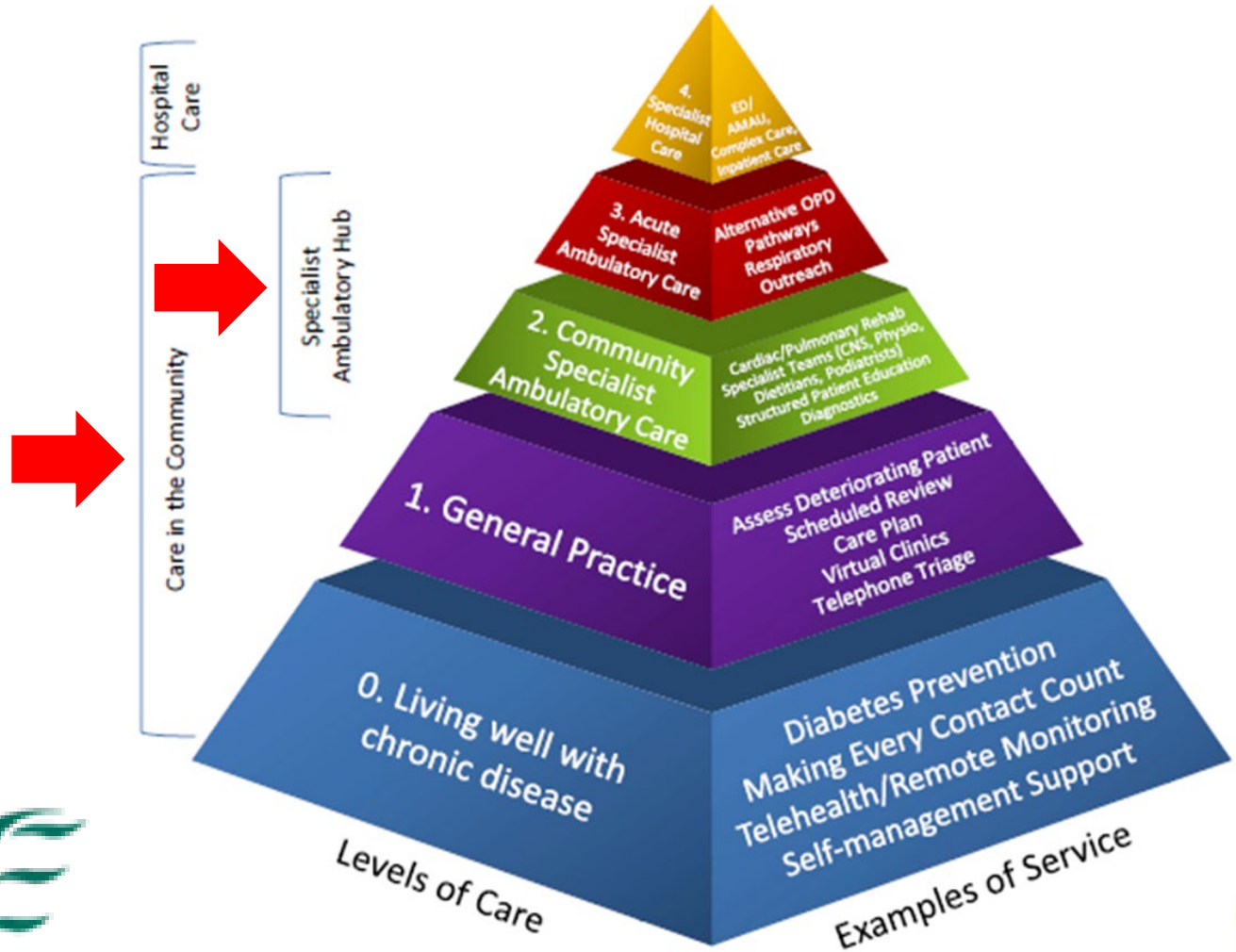
Population Health Approach for Chronic Disease



Objectives of Integrated Care Programme for Chronic Disease

- Stop people progressing up the Population Health Pyramid.
- Maximise prevention.
- Enable people to maximise self management.
- Support GPs to manage patients in the community by;
  - Paying for early detection, prevention and scheduled chronic disease management
  - Provide GP community diagnostics
  - Provide community ambulatory care specialist nurses and HSCP support
  - Provide rapid ambulatory specialist opinion

Model of Care for Prevention and Management of Chronic Disease



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Ambulatory Care Hubs – Levels 2 & 3

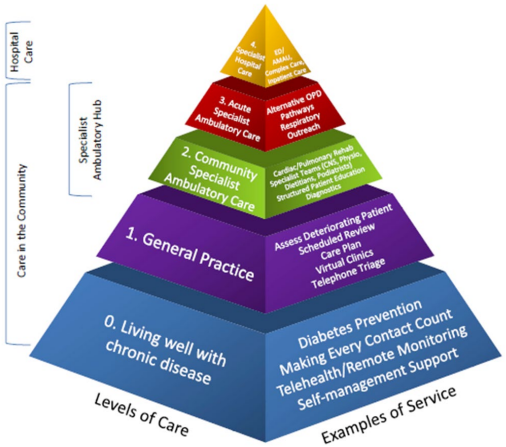
- Chronic Disease Ambulatory Care Hubs are being established, each serving approximately three CHNs (or a population approx. 150,000 people).
- 30 hubs associated with 25 hospitals.
- Each Ambulatory Care Hub is linked to a local hospital. Some of the larger hospitals are linked to a number of ambulatory care hubs.
- Ambulatory care hubs support access to diagnostics, specialist services and specialist opinions in order to support GPs manage patients in the community.
- Cardiac Rehabilitation, Pulmonary Rehabilitation, Diabetes Self-Management Education will be delivered in the hub, (cardiac and pulmonary rehabilitation also delivered in hospital sites under joint governance).

Process

- GP refers patient via Healthlink to Hub service.
  - community CNS / HSCP
  - SMS Programme e.g. cardiac/pulmonary rehab, diabetes education, diabetes prevention programmes
  - acute service specialist opinion (consultant and CNS/ HSCP Hub clinic)
- Staff member involves other speciality MDT members if appropriate.
- Refers to other specialty MDT if appropriate.
- Model = see and return to GP for ongoing care.

Implementation - Level 0

1. Making Every Contact Count Framework developed.
2. Making Every Contact Count training programme in brief intervention, on health service and medical colleges websites.
3. National 3rd level MECC Curriculum for all HCWs.
4. National Self Management Support Framework.
5. National 3rd level SMS Curriculum for all HCWs.
6. Structured Self-Management Education, Support and Prevention Programmes e.g. Diabetes, Diabetes Prevention and Pulmonary and Cardiac Rehabilitation.

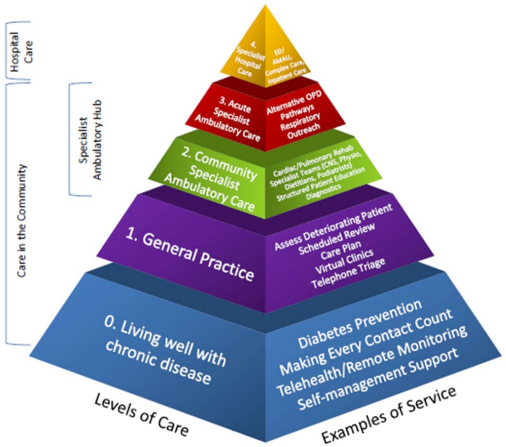


Implementation - Level 1

1. National GP contract for Chronic Disease (CVD, Diabetes and Respiratory) – Structured Care Programme, Preventive Programme and Opportunistic Case Finding Programme, Care Plans.

2. Direct GP access to diagnostics for Chronic disease - NTPro-BNP, Echo and Spirometry.

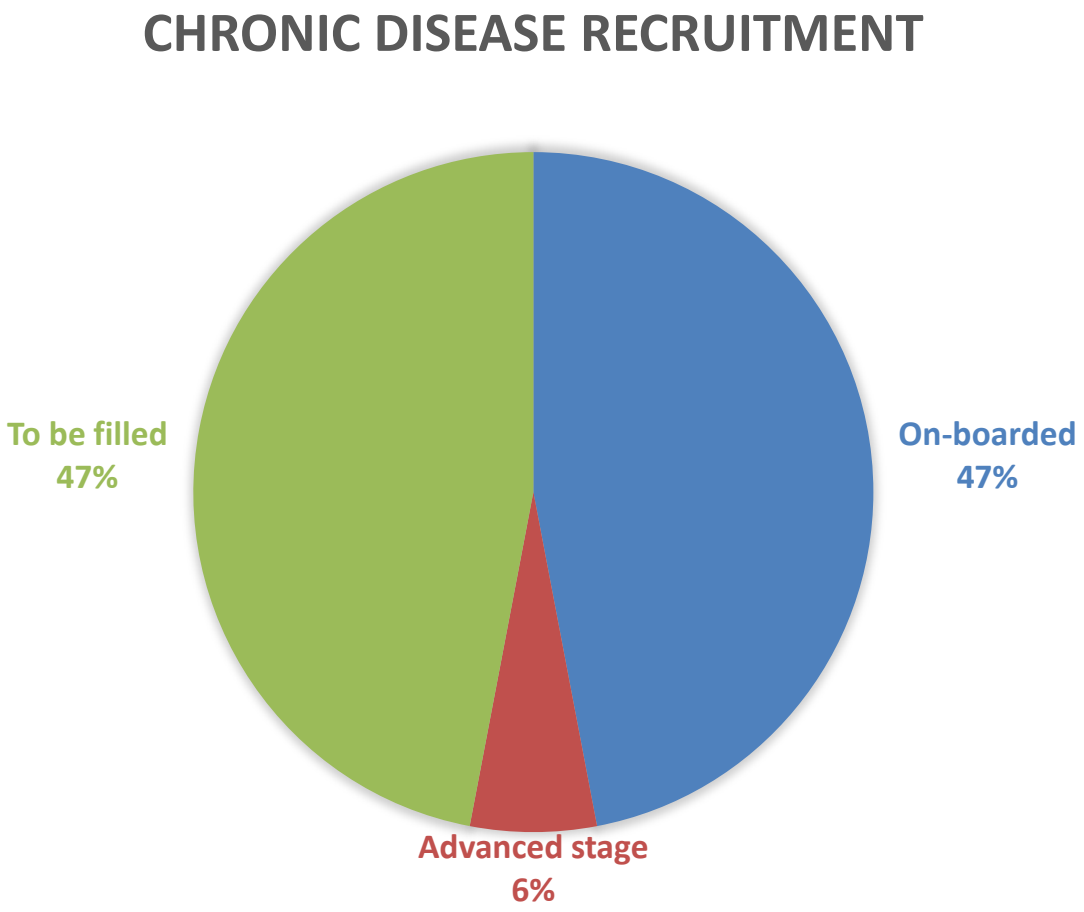
3. Virtual Consultant to GPs clinics (over 90% effective in reducing hospital attendance).



Implementation Ambulatory Care hubs – Levels 2 & 3

- Fully funded National Programme is a national priority; 1430 new posts for Chronic Disease.
- Recruitment of Chronic Disease Community and Acute posts progressing.
- Establishing and convening national and local joint governance structures.
- Physical accommodation being provided.
- Clinical Leadership, Clinical Guidelines, Pathways, ICT Specifications, Service Agreements, KPIs developed.

Ambulatory Care Hub - Recruitment



Model of Care for Prevention and Management of Chronic Disease

GP Contract Chronic Disease
- Commenced Implementation January 2020

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Treatment Programme Selected Conditions

- Diabetes Type 11
- COPD
- Asthma
- IHD
- CVA
- TIA
- Heart Failure
- A.Fib

- Treatment Programme commenced January 2020 with older ages first.
- Opportunistic Case Finding and Prevention Programme commenced January 2020 with older ages first.
- All Programmes in place since January 2023.

Structured Chronic Disease Management Programme in General Practice

Treatment Programme

- Selected conditions
- Two scheduled reviews per annum
- Physical exam & specific blood tests
- Medication review
- Joint care plan
- Self-management support
- Appropriate referral

Opportunistic Case Finding Programme

- GP notes risk factors pertinent to CD
- OCF assessment: physical exam & blood tests
- Outcome:
  - NAD: OCF in 5yrs
  - High risk: Prevention Programme
  - New diagnosis: Treatment Programme

Prevention Programme

- Definition of "High risk"
- One scheduled visit per annum
- Physical exam & specific blood tests
- Medication review
- Joint care plan
- Self-management support
- Appropriate referral

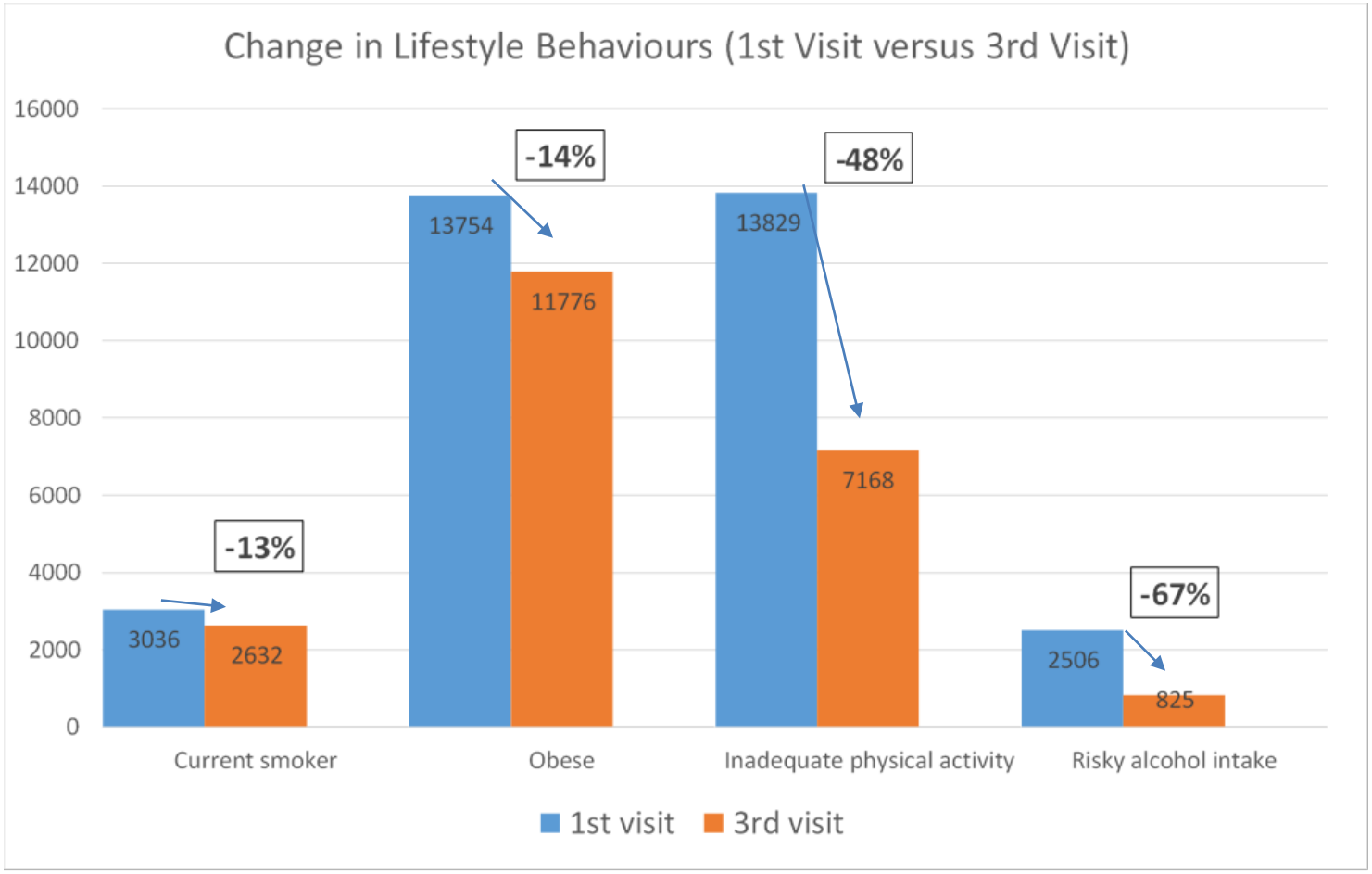
Prevention Programme

- " At High Risk" defined as;
  - Qrisk ≥ 20
  - Hypertension
  - Pre diabetes (HbA1c = 6% – 6.4%)
  - NT-pro BNP (*B Natriuretic Peptide*)
    - (NT - pro BNP ≥ 125 pg/ml or BNP ≥ 34 pg/ml)

GP CDM Programme Results

- 320,000 patients enrolled January 2023.
- Over 800,000 reviews by January 2023.
- 83% uptake.
- 91% of GPs participating.
- GP clinical systems adapted to support 3 programmes.

Integrated Care Programme for the Prevention and Management of Chronic Disease



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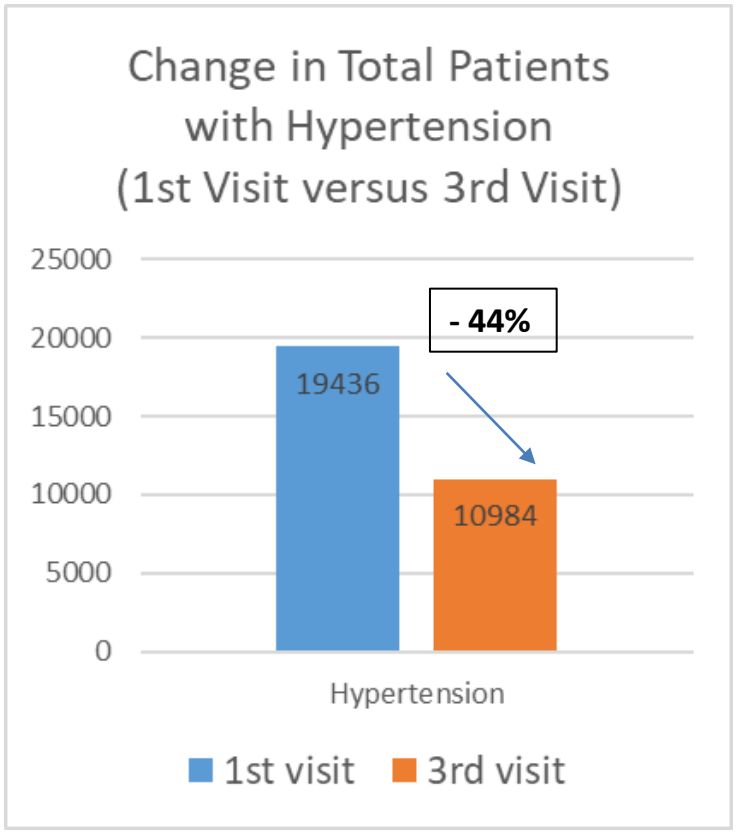
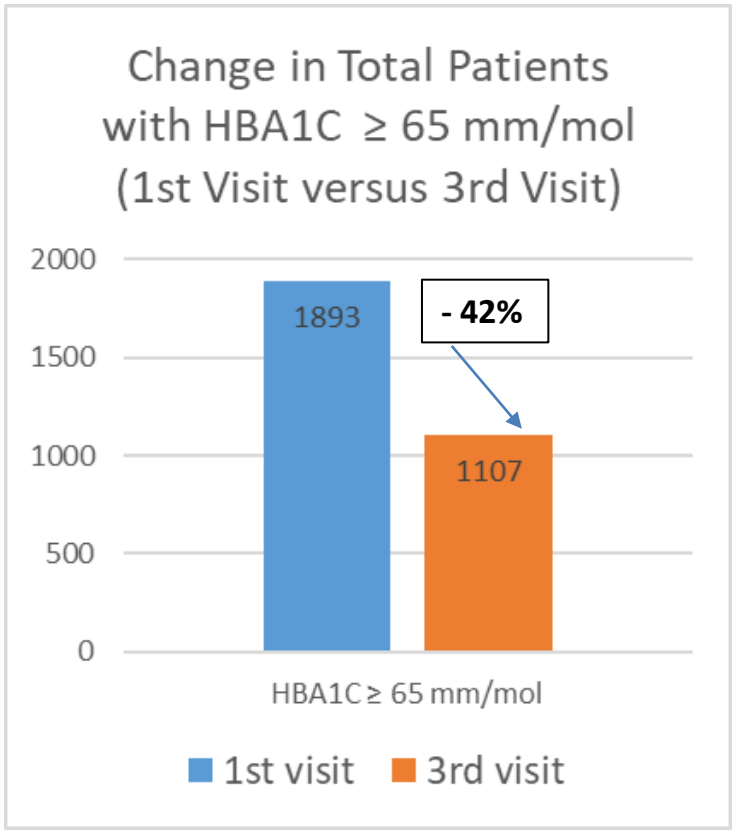
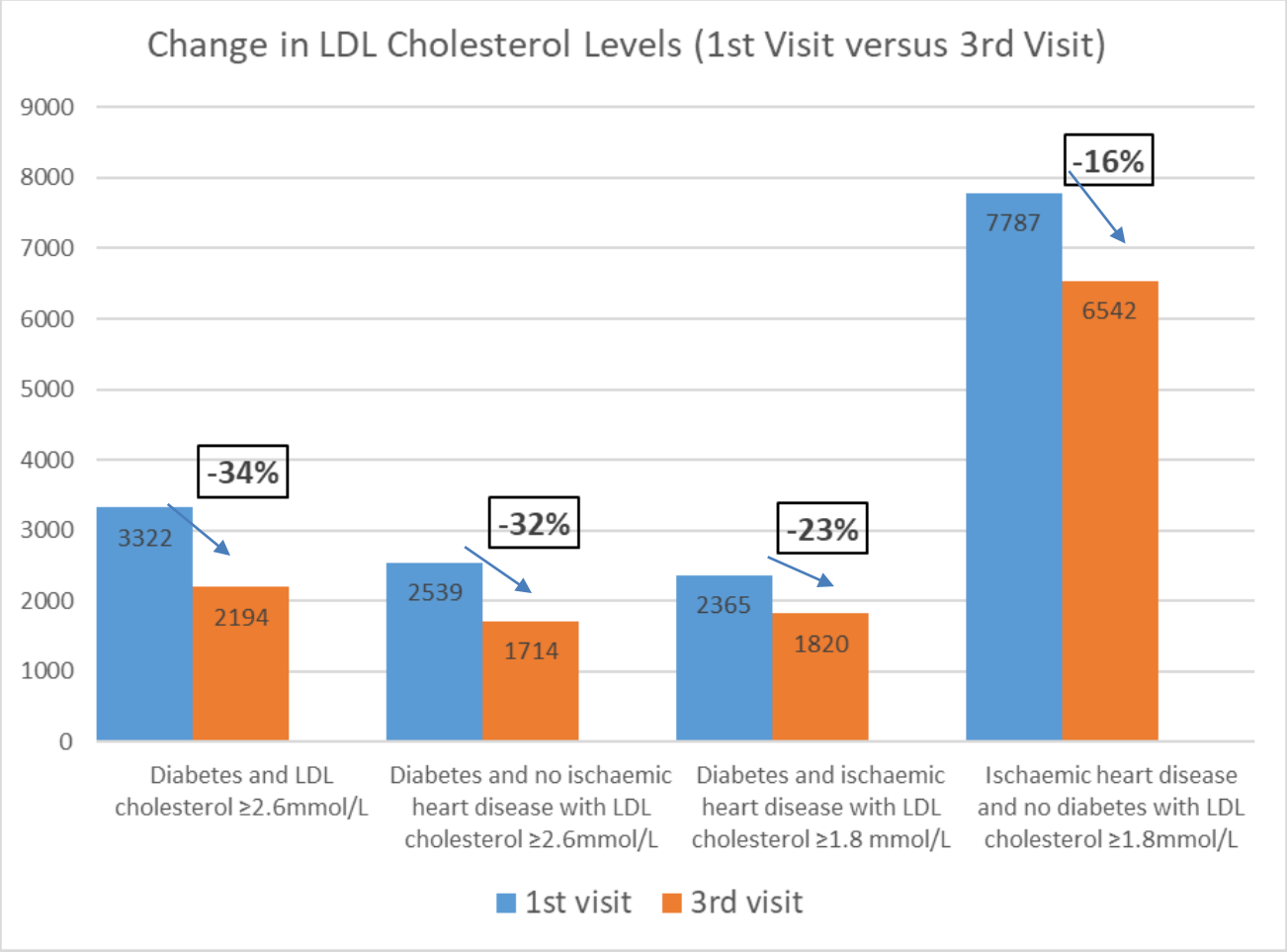
Changes in Hypertension and HBA1C Levels





Integrated Care Programme for the Prevention and Management of Chronic Disease



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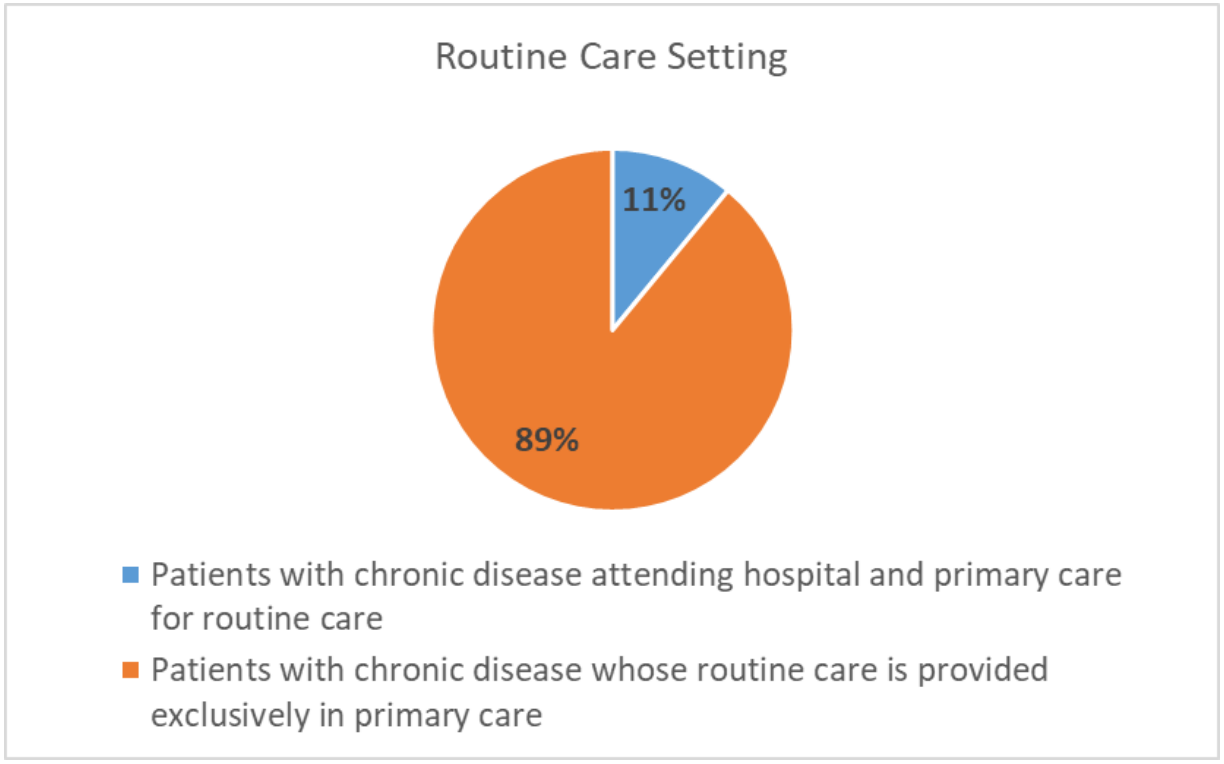
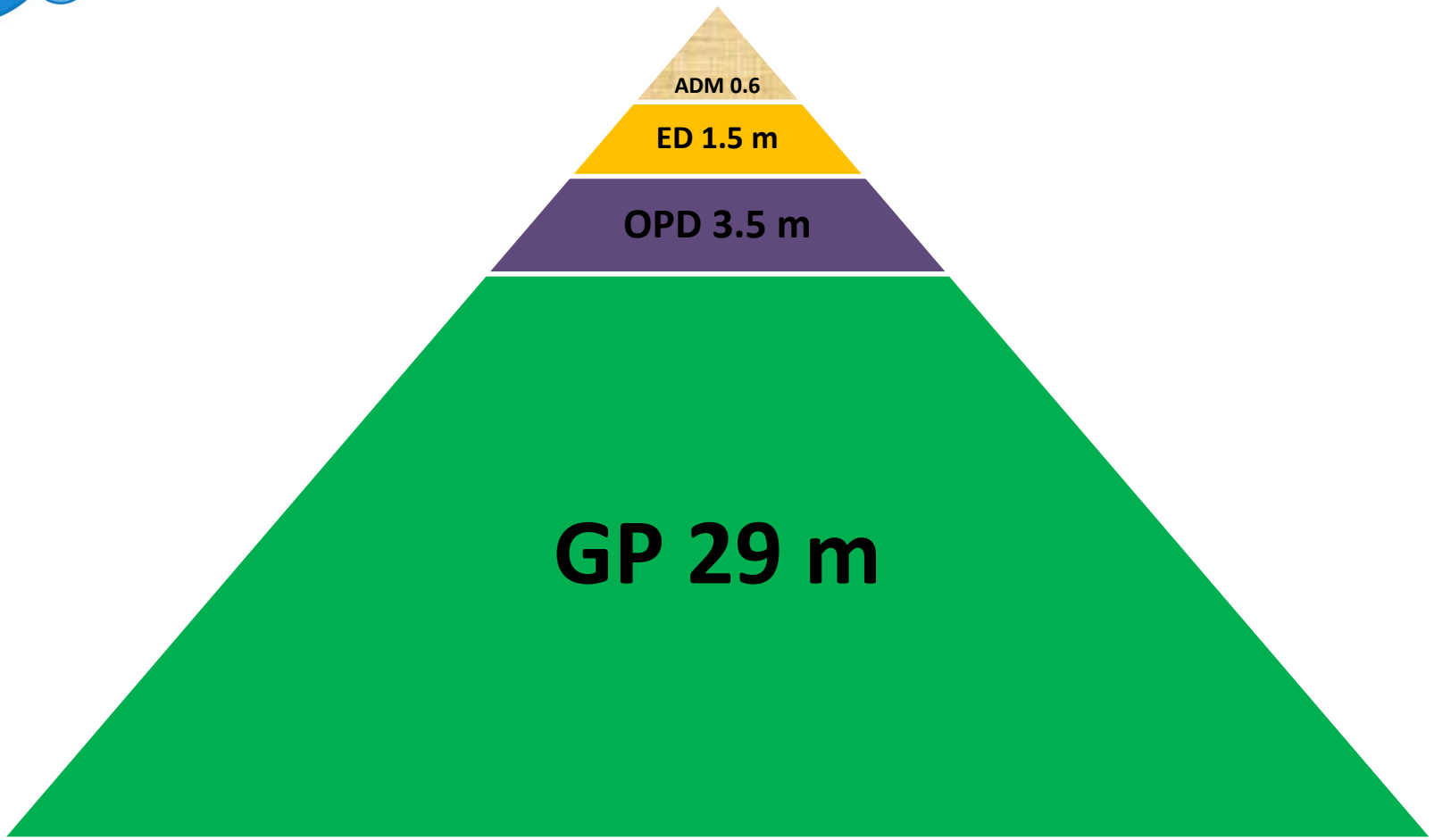
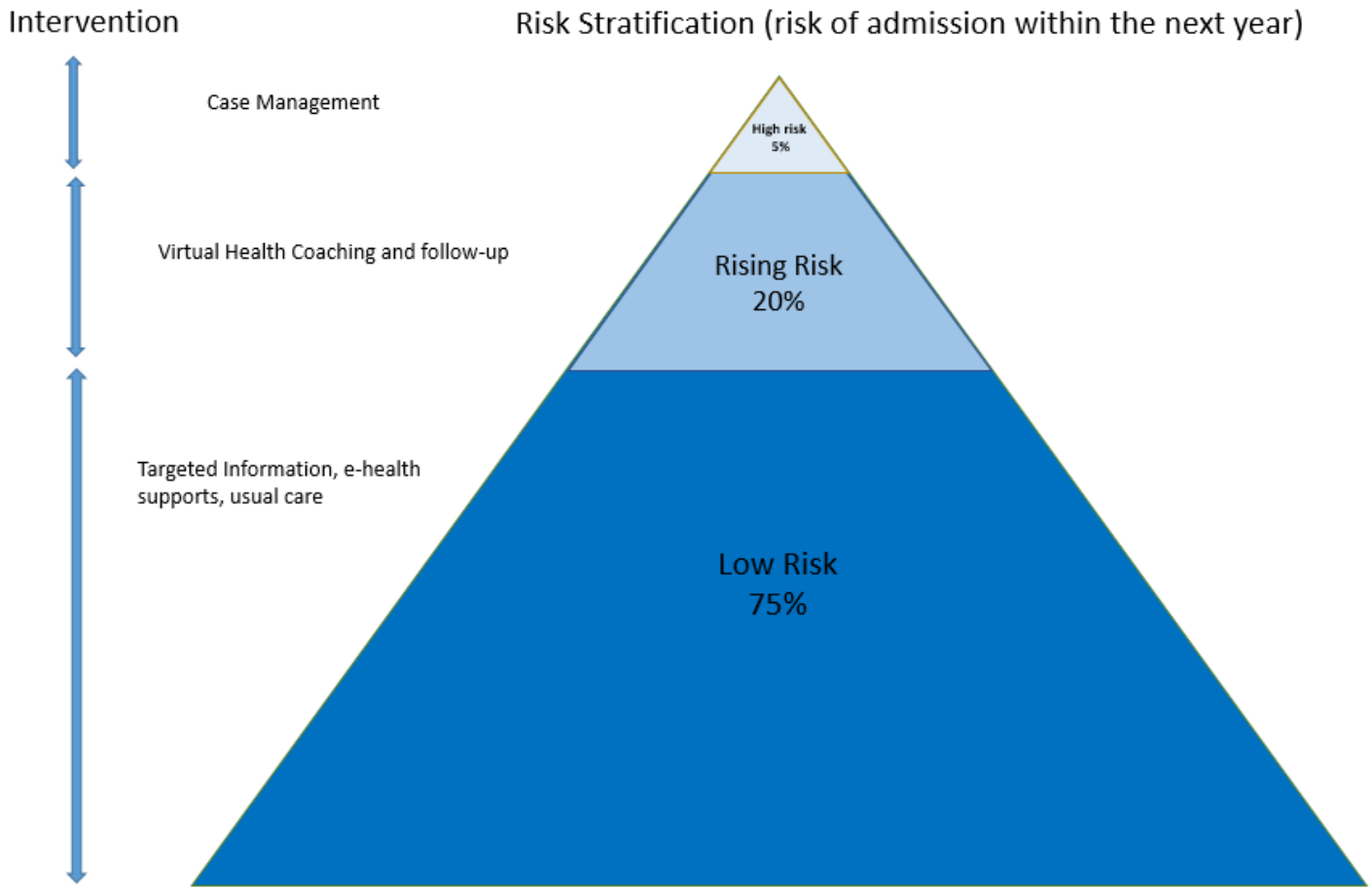
Setting for Routine Care Delivery



Proportion Of Patients Seen by Service Per Year



Population Health Management = Risk Stratification and Interventions



- Lots of movement by patients between the strata each year
- Needs ICT predictive system

Future Developments

- Population Health Management being explored to provide additional support to multimorbid/complex patients.
  - Pilots underway
  - Virtual Case Management/Coaching allows more people to be supported.
  - Flatten the triangle
  - Not enough HCW to deliver everything face to face anymore

- General Practice central to the health system – 29 m versus 6 m attendances annually.
  - Increased number of conditions to be covered by CDM
  - GPs need additional practice staff resources
  - Supported Quality Improvement Programmes
  - Ambulatory Care Hub services fully operational to support GPs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