The National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland: an overview of implementation

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Population Health Approach for Chronic Disease

- No Risk Factors
  - 30% CD undiagnosed
- Risk Factors
  - Undiagnosed
- Very High Risk Factors
  - Complicated
  - Complex/ Multi-morbid
- Diagnosed CD
  - 1 Million People

Care Setting
- Acute
- Shared Acute/Primary

Primary Care
Integrated Care Programme for the Prevention and Management of Chronic Disease

- Research evidence based.
- Focuses on Cardiovascular disease; Type 2 diabetes; COPD; Asthma.
- Encompasses three National Clinical Programmes
  - National Heart Programme
  - National Clinical Programme for Diabetes
  - National Clinical Programme for Respiratory
- GP Chronic Disease Contract.
- Aspects of MOC piloted in 43 Demonstrator Sites and 24 Sláintecare projects.
- Progress maintained during Pandemic.
Objectives of ICP CD

• 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
• Provide “End to End” spectrum of service mostly in the community.
• Develop a Model of Care.
• Secure resourcing to roll it out nationally.
• Support services to implement it.
Spectrum of services for Chronic Disease Prevention and Management

Health Promotion
Making Every Contact Count
Risk Stratification Population Health Management
Early Detection
GP & Practice Nurse Review
Care Plan
Diabetes Structured Patient Education & SMS
Prevention Programme
CD Dietitians
CD Podiatrists
Disease Registries
Diagnosis
CNS Integrated Care
CD Physiotherapy
Acute Specialties MDT
Hospital Outpatients
MDT Foot Care Team
Hospital Inpatient
Nursing Care
Palliative Care

Primary Care Setting
Hospital Care Setting
Model of Care for Prevention and Management of Chronic Disease
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.


5. National 3rd level SMS Curriculum for all HCWs.

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.

2021 UN Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases National Award

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).
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).
Specialist Chronic Disease Staffing for each Ambulatory Care Hub

- Additional Health Promotion and Smoking Cessation Staff in each area.

- Additional Acute Staff for aligned hospitals.

- Additional laboratory staff for GP access to echocardiography, spirometry and NT testing.

<table>
<thead>
<tr>
<th>Staffing per hub</th>
<th>WTE</th>
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<tbody>
<tr>
<td><strong>DIABETES</strong></td>
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<tr>
<td>CNS Diabetes</td>
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<tr>
<td>Clinical Specialist Podiatrist</td>
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<td>Senior Grade Podiatrist</td>
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<tr>
<td>Senior Dietitian</td>
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<tr>
<td>Staff Grade Dietitian (Weight Mgt/ DPP)</td>
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<td><strong>CARDIOLOGY</strong></td>
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<tr>
<td>CNS Cardiology</td>
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<tr>
<td>Senior Physiotherapist</td>
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</tr>
<tr>
<td>Cardiac Rehab Co-ordinator</td>
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<tr>
<td>Staff Nurse Cardiology</td>
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<tr>
<td>Cardiac Rehab Admin</td>
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<tr>
<td>Clinical Psychologist</td>
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<tr>
<td><strong>RESPIRATORY</strong></td>
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<tr>
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<tr>
<td>Senior Physiotherapist</td>
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<tr>
<td>CS Physio Rehab Co-ordinator</td>
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</tr>
<tr>
<td>CNS Rehab</td>
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<tr>
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<tr>
<td>GP Lead with Specialist interest</td>
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<tr>
<td><strong>Admin / Management</strong></td>
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<td>Administration staff</td>
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<tr>
<td><strong>Total per hub</strong></td>
<td>32.4</td>
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Ambulatory Care hubs: Key progress

- 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.

- Links between hospitals and community being established.

- Physical accommodation being provided.

- Clinical Leadership, Clinical Guidelines, Pathways, ICT Specifications, Service Agreements, KPIs developed.
Learning – Essentials for Integration and Shift to Primary Care

• Joint governance between Community and Hospitals.
• Strong national leadership.
• Strong clinical leadership at national and local levels.
• Funding for community expansion.
• Filling of essential service gaps.
• Early attention to enablers; ICT, Accommodation, Recruitment Processes.
• Population based equity of service development.