Enhanced Community Care (ECC)

Overview of the Integrated Model of Care for the Prevention & Management of Chronic Disease

Dr. Sarah M. O'Brien, Specialist in Public Health Medicine

Thursday, 1st September 2022

Integrated Care Programme for the Prevention & Management of Chronic Disease

Our population is ageing

1.3 million people

living with one of the following: CVD, COPD, diabetes, asthma

ICPCD

encompasses 3 programmes:

Heart, Respiratory & Diabetes

Objectives of the Integrated Care Programme for Chronic Disease (ICPCD)

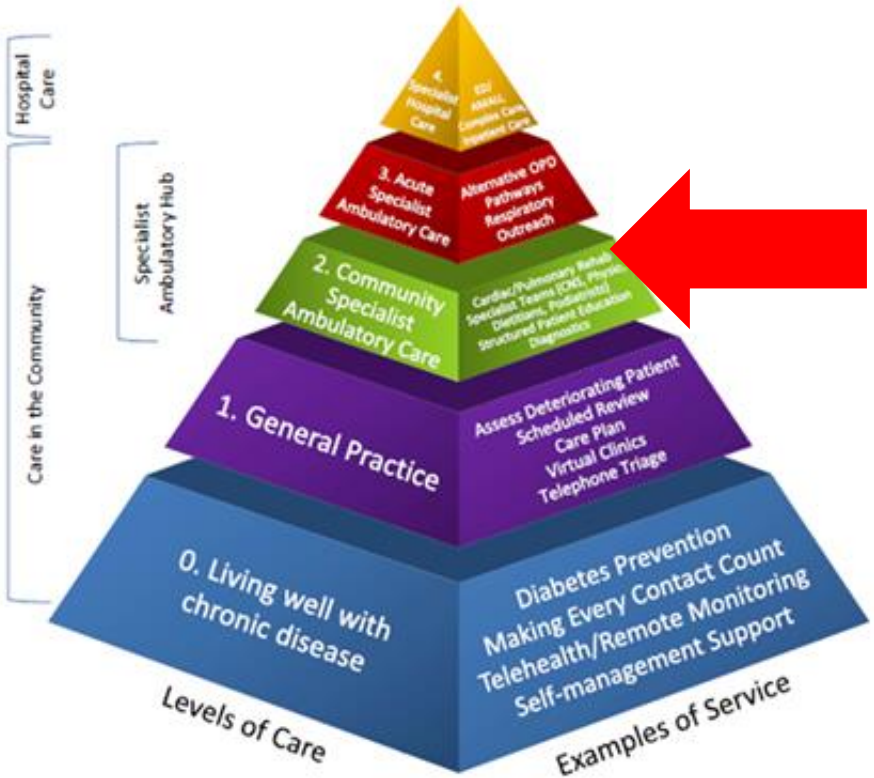
- **Maximise prevention**
- **Enable people to optimise self-management of their condition(s)**
- **Support the provision of GP-led primary care**

Model of Care for the Prevention & Management of Chronic Disease

- Five levels of care across community and hospital
- Enabling GP-led primary care
- Bulk of care provided in the community (Levels 0-3)
- Aspects of MOC piloted in 43 Demonstrator Sites and 24 pilot projects
- Aim is to provide “end-to-end” care for individuals living with chronic disease and multimorbidity in the community

Chronic Disease Community Specialist Teams (Levels 2 & 3)

- 30 ambulatory care hubs each with a Chronic Disease Community Specialist Team (CST) being established
- Each CST serves a population of approx 150,000
- Each CST linked to a local hospital
- The purpose of the CST is to provide timely & equitable access to diagnostics & specialist MDT opinions
- Support the GP to provide holistic, person-centred care as close to home as possible



Specialist Chronic Disease Resources

- 30 teams of dedicated specialist multidisciplinary chronic disease staff have been resourced
- Additional Health Promotion & Smoking Cessation staff
- 48 new Integrated Care Consultants who will work across hospital & community
- Additional nursing & HSCP acute posts
- Significant uplift in acute hospital staff to support the delivery of a direct GP access service to NTproBNP, echo and spirometry testing

Key Progress to Date

- ✓ GP Chronic Disease Management Programme in place
- ✓ Recruitment of acute and community posts progressing
- ✓ Physical accommodation is being provided
- ✓ National and local joint governance structures have been established
- ✓ Clinical leadership, clinical guidance documents, pathways, ICT, estates & equipment specifications, service agreements, KPIs developed
- ✓ Fully funded national programme which is now a national priority: 1430 new posts for chronic disease management

Video 1
Impact of the model of care: the patient perspective

Video 2
Dr. Joe Gallagher
The Integrated Model of Care: the GP Perspective

Enhanced Community Care (ECC)

Integrated Model of Care for the Prevention & Management of Chronic Disease: the Cardiologist's perspective

Prof. Ken McDonald, National Clinical Lead Heart Programme

Thursday, 1st September 2022

New Care System: Maintaining Health in the Community

Change Driven by;

- Demographic Changes (older, frailer population; chronic illness and multi-morbidity)
- Economic need (hospital-dominated care major driver of costs)
- Capacity to provide (specialisation and diagnostics in the community, IT capacities)

Cardiology:

- Develop capacities to provide specialist care for prevention/ management of chronic CVD
- **<u>Evolve and train "new breed" of cardiologist</u>**
- At the same time, continue to support and develop hospital aspects of cardiology service

Re-orientated Model of Cardiovascular Health Care

Right Approach …….Right Place …….Right Time …….Right Outcome

Where care will be delivered?

- In the home
- eHealth (Virtual Consultations)
- In the GP surgery
- In day centres (diagnostics /Rx)
- In hospital OPD
- In in-patient services

Increasing Complexity

Who will deliver care ?

- Patient / Family
- Practice Nurses
- Specialist Nurses
- HSCPs
- GP
- Cardiologist

MoC for the Integrated Prevention/Management of Chronic CV Disease: Role of Cardiologist

Cardiology Footprint

- **Dominantly Level 2/3**
- **Role in Level 4 /1**

Integrated Cardiovascular Chronic Disease Service
Hub Level Activity

Case Type Examples

Example 1 Patient with dyspnoea:

- Patient presents to GP with dyspnoea (Level 1 Care)
- History of smoking and hypertension
- NTproBNP 450pg/ml
- Direct access to echocardiography for GP in hub (Level 2-3 Care)
- Echocardiogram: Left ventricular hypertrophy
- LA normal
- Report back to GP (Level 1 Care)
- GP arranges spirometry which confirms COPD (Level 1 Care with hub diagnostics)

Integrated Cardiovascular Chronic Disease Service
Hub Level Activity

Case Type Examples

Example 2 Patient with dyspnoea:

- Patient presents to GP with dyspnoea (Level 1 Care)
- History of smoking and hypertension
- NTproBNP 750pg/ml
- Direct access to echocardiography for GP in hub (Level 2 Care)
- Echocardiogram: Ejection fraction 35%
- Report back to GP and direct link into cardiologist from echo (Level 2-3 Care).
- Aetiology investigated (Level 4 Day case) and referred to Community Specialist Team for medication titration/self management education (Level 3-4 Care)
- Discharged back to GP for on-going care (Level 0-1)

What will the Cardiologist be doing?
Management / Leadership

- Day-to-day responsibility for acute hub CV activities
- Ensuring smooth links between CV Community Specialist Team activity and Level 4 / 1 activities
- Harmonising interaction between Respiratory and DM Community Specialist Team members with CV where appropriate
- Linking with emerging national group for integrated care cardiologists to spread knowledge and enhance impact
- Promoting role of Integrated Care Cardiologist

What will the Cardiologist be doing?
Clinical Duties

Hospital-Community Specialist Team Link

- Admission avoidance
  - Provide review for evolving non-emergency issues
- Early discharge
  - Opportunity to reduce LoS across the range of presentations

Community Specialist Team

- Specialist clinic to facilitate above
- Oversee nurse-provided clinics and CV service (Echo and Rehab)
  - Risk factor care / HF Care

Community Specialist Team-Primary Care Link

- Disseminate Specialist knowledge to GP in community

The Heart Failure Virtual Consultation

Caters for the older and frailer patient

Real-Time Virtual Consultation (VC) discussion between family doctor and HF specialist

Easy access to specialists for those in rural areas

Reduces hospital referrals

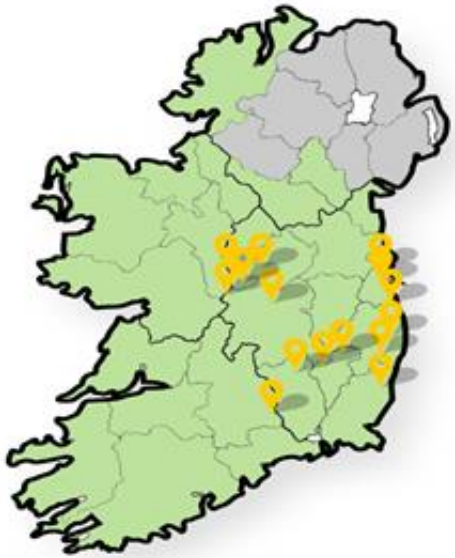
Flexible, and facilitates continuity of shared care

Impact of VC on every 100 cases referred

	Without VC Intervention	With VC Intervention (% reduction)
Hospital ED/AMU	12	2 (83% reduction)
Hospital OPD	78	12 (67% reduction)
GP-led care with no Specialist role	10	0 (100% reduction)
Total Hospital visits required	90	14 (86% reduction)

Virtual Consultation Service
The Patient View

Travel Miles Avoided for Patients/ Families



120,000 kms saved in travel

Patient Testimonials

Excellent service. It meant that my 83 yr old mother avoided a hospital visit.

Did not have to be placed on an endless waiting list for an Echocardiogram.

I was medically managed within my community. No long waiting lists or travel!

Excellent service. All I needed was a change of medication and did not have to go to hospital.

Opportunities / Ongoing tasks to maximise Impact of ICP on National CV Care

- **Audit**
  - Need to ensure harmonised service across country with local variance
  - Real opportunity to audit what we are doing in terms of standards of care, uniformity of outcome etc
- **New Graduate Opportunity**
  - Evolve understanding and appreciation of role
- **Hospital/Hub without IC Cardiologist**
  - Challenge
  - Units will find it difficult to evolve service to the level outlined previously
  - Existing Cardiology services will benefit by leveraging / supporting hub resources

The integrated model of care for the prevention & management of chronic disease

The role of the Integrated Care Consultant

Dr. Stanley DW Miller
National Clinical Lead for the Respiratory Clinical Programme

Lead for Integrated Respiratory Care
Mater Misericordiae University Hospital / CHO9

The role of the Integrated Care Consultant

1. Integrated working

- Working across community & hospital
- Providing end-to-end integrated care

2. Care as close to home as possible

- Collaborating with the GP & Specialist MDT
- Assess & manage patients who are living with complex chronic disease in the community

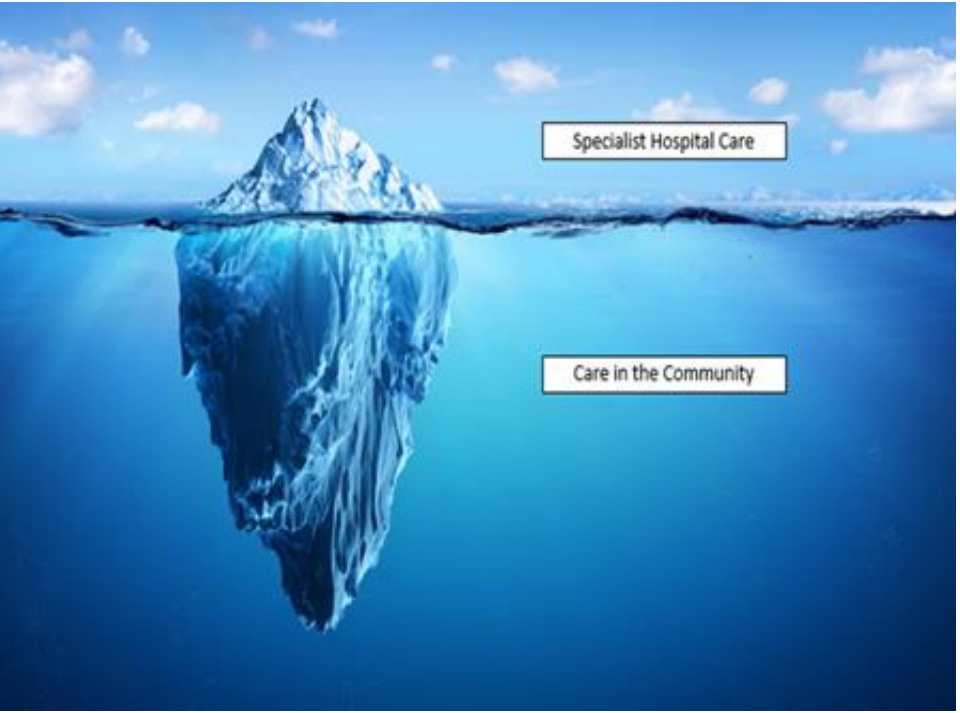
3. Leadership & Innovation

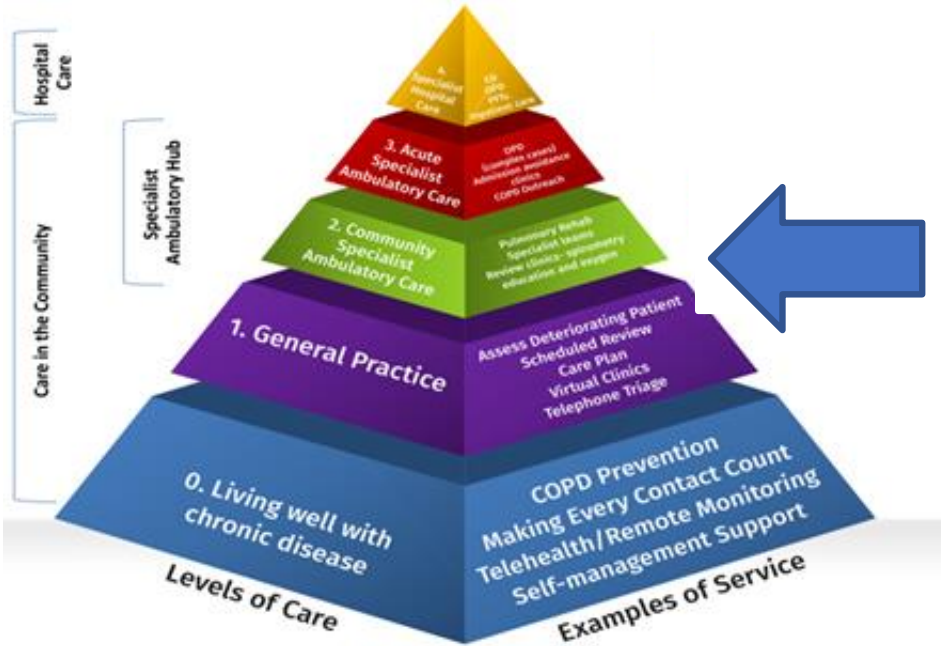
- Developing & implementing new pathways, referral modes, hospital outreach methods

4. Timely access to specialist opinion

- Hospital avoidance, where possible
- Early discharge home

COPD Integrated Service Model





Sláintecare Model of Care principles

Model in action: COPD and Pulmonary Rehabilitation

380,000
People living with COPD

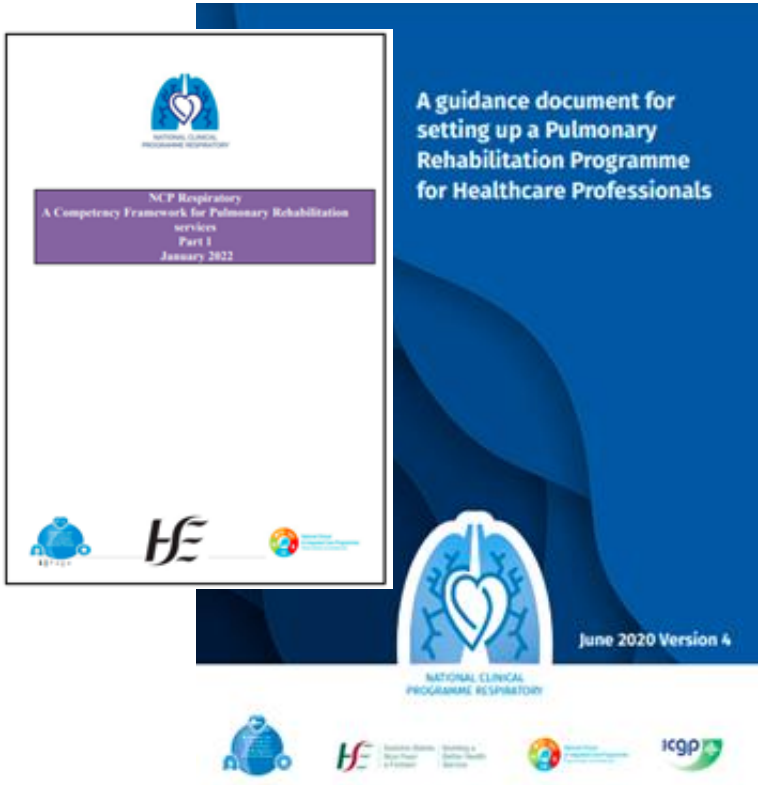
110,000
People diagnosed with COPD

30
Community Specialist teams and hubs

295
Community Specialist Respiratory staff funded

98
WTE to provide pulmonary rehab in the hubs

Pulmonary Rehabilitation



Model in action: COPD and Pulmonary Rehabilitation

I felt safe as I was monitored

I no longer have to stop on the stairs

I felt part of a group. It was great for company

"I was full of fear; afraid to be out on my own, but the online advice and exercise class restored my confidence and has given me a much better quality of life."

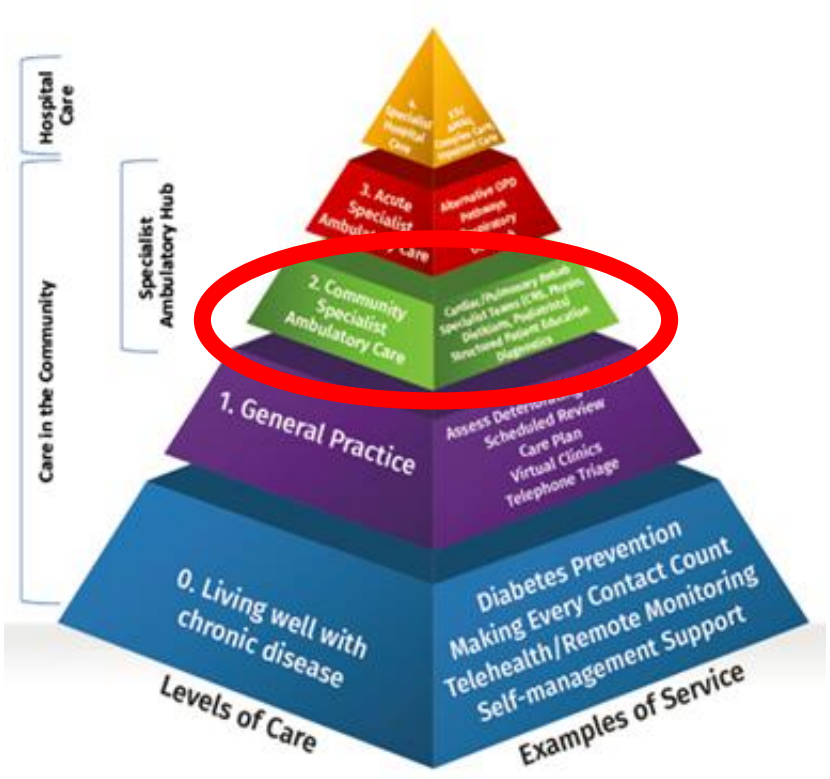
"I much preferred the home programme for the simple reason its just more relaxed because when you get up in the morning you don't have this feeling of having to rush to the hospital and then look for a parking space…"

Video 3
Model of care in action: delivering equitable and accessible person-centred care

Enhanced Community Care (ECC)

Implementing Integrated Diabetes Care
Professor Sean Dinneen
Clinical Lead National Clinical Programme for Diabetes

Diabetes Community Specialist Teams



Delivering high quality integrated diabetes care is about:

- ✓ Delivering person-centred care
- ✓ Working collaboratively as a multidisciplinary team
- ✓ Building closer links between general practice, hospital and community-based specialist teams with the ultimate aim of improving wellbeing and outcomes for those living with type 2 diabetes


Sláintecare.
The Patient Experience of Community-Based Diabetes Specialist Teams: A pilot
Lorna Hurley, Change Manager, Sláintecare Integration Fund, Project 153

Learning from Sláintecare Integration Project (2019) (CHO2 & CHO4)

Enablers & challenges to overcome

Challenges

- ✓ Need for ICT systems for care integration (hospital – community)

Overall:

- ✓ Positive Patient experience: "**locally delivered**"; "**accessible**"; "**patient-centered**".
- ✓ Positive GP experience: "**very accessible**"; "**flexible**"; "**source of expertise"**; "**team had direct links with hospital team**"
- ✓ Positive team experience: "**co-location & shared MDT space** "; "**co-ordinated appointments**"; "**responsive patient care**"; "**strong local integrated leadership**"

Conclusion

- This is the first time diabetes Community Specialist Teams (CST) have been established at CHN level
- Our results suggest patients considered this service to be **accessible and patient-centred**
- A set of recommendations has been developed based on the experiences of the CST, general practice staff and patients
- Learning can inform national implementation of Level 2 community specialist ambulatory care

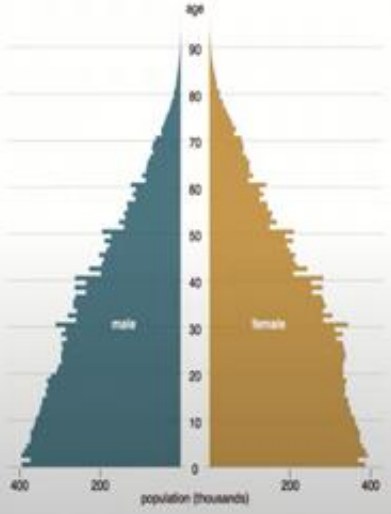
The integrated model of care for the prevention & management of chronic disease

Integrated diabetes care in action

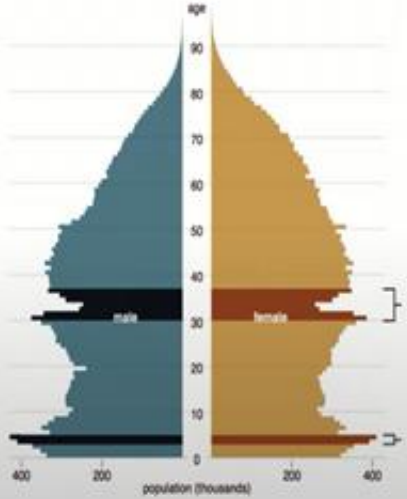
Ronan Canavan & Joanne Lowe
Consultant Endocrinologist & Diabetes Nurse Specialist
On behalf of East Coast Area Diabetes

Demographic pyramid for the UK over the last 100 years. *(ONS)*

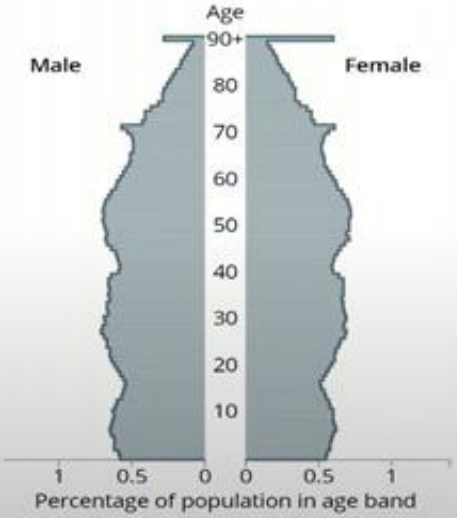
1911



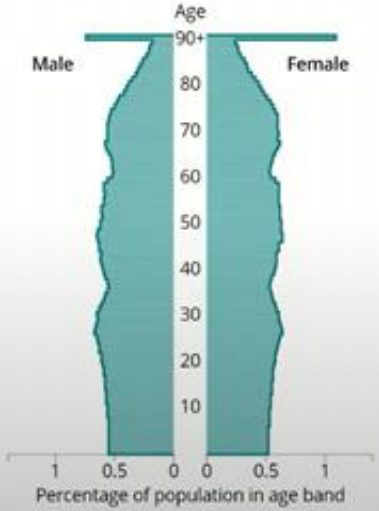
1950



2018

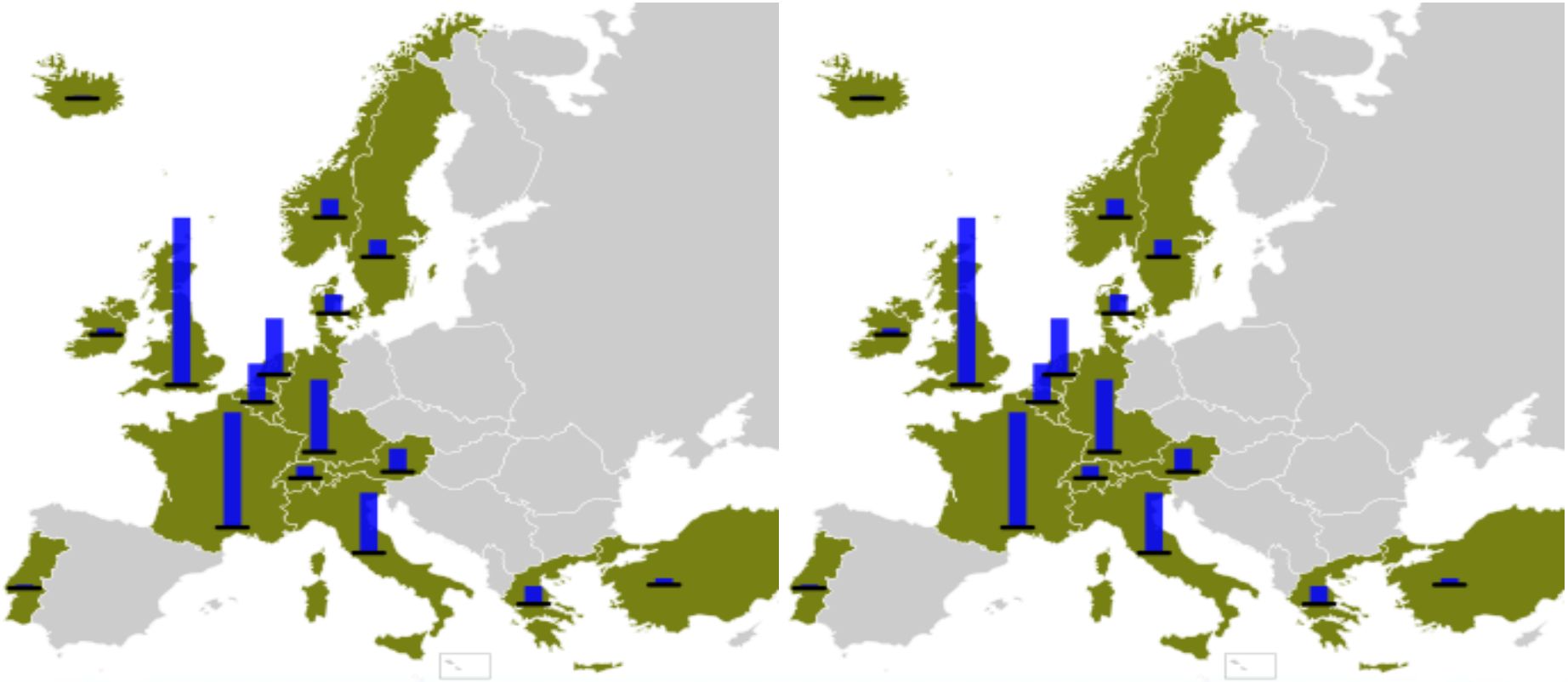


2038

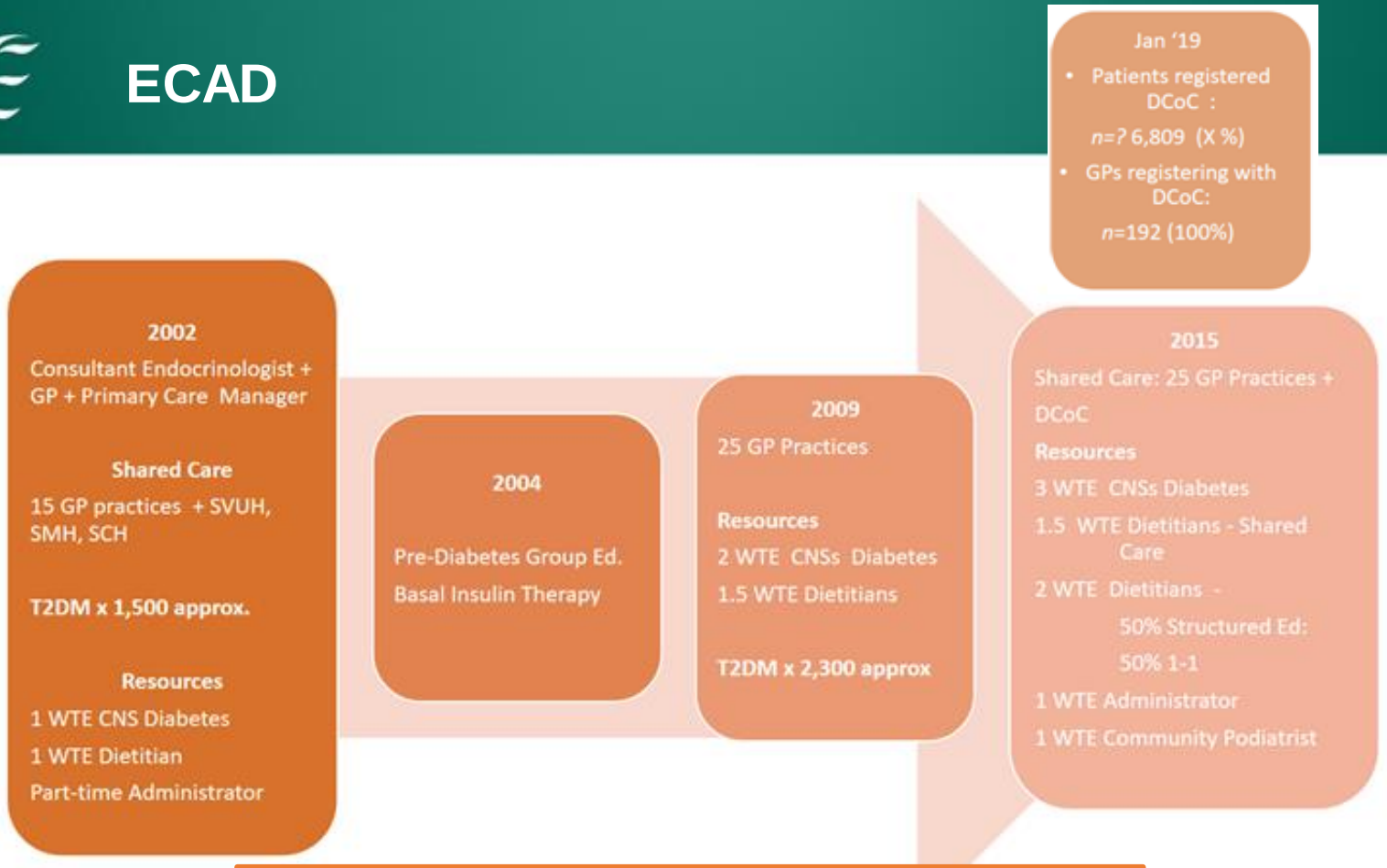


Increasing diabetes

ECC = Marshal plan for long term health in Ireland



ECAD



Audits: 2004, 2006, 2012, 2015, 2019

Education since DCoC

Course	Courses Delivered *n*	GPs *n*	*PNs n*
Foundation Series of Modules in Diabetes Care in the Primary Care Setting	4	25	37
Certificate in Diabetes Care (CiDC), Warwick University	1	10	13
ECAD Annual Conference	2	2018: 41 2019: 32	2019: 25 2019: 39

Activity

Weekly CNSs & Endocrinologist Consultations

Year	Total Patients Discussed *n*	Average Patients per Week *n*
2017	149	3
2018	247	5
2019 (Q1-3)*	189*	5 *

Consultant-led Remote Clinics 2019

Remote Clinics *N*	Total Patients Reviewed *n*
3	13 (T1 x 1)

EAST COAST AREA DIABETES PROGRAMME

Consultant-led Community Diabetes Clinic

HSE EXCELLENCE AWARDS FINALIST IN "INNOVATION IN SERVICE DELIVERY" CATEGORY
& SHORTLISTED IN "IMPROVING PATIENT EXPERIENCE" CATEGORY

Target Group

- People with Complex T1 / T2 Diabetes.
- Newly diagnosed with complications.
- Opted out of Secondary Care.
- Patient requires urgent re-engagement with care.

Clinic Format

Community-based Clinic in South Wicklow providing access to specialist diabetes care.

Integrated Aspect

Access to:

- Consultant Endocrinologist
- CNS Diabetes.
- Diabetes Podiatry.
- Onward referral as appropriate.

Outcomes

ClinicAttendance

This clinic produced
100% attendance rate
in population of
serial non-attenders (N=18)

Demographics

- 72% Male & 28% Female
- 89% T2DM - 11% T1DM
- Average age 57 years.
- 22% had Anxiety / Depression, 11% Intellectual Dis, 11% Frailty
- HbA1c Range 45 - 138 (ave 95)

Improvements Noted

- Improved patient engagement with care and with clinicians.
- Increased compliance with drug regimens.
- Reduction in hypos.
- Enhanced engagement & collaboration across Primary & Secondary Care settings.

Seirbhís Sláinte Nios Fearr á Forbairt | Building a Better Health Service

RK/Sept21/CCC

Integrated care in action

- **Patient A, 74 years of age**
- Type 2 diabetes
- Significant co-morbidities
- Living alone
- Glucose levels – very high sugars (indicated by HbA1c 87 mmol/mol.)


TSB
Daily Mirror
PRIDE OF

Integrated care in action

- Intermittent continuous glucose sensor applied for & approved.
- Commenced Degludec/Tresiba® insulin Mon, Wed, Fri. with cRGN administering this.
- Educated using the safety needle
- **Outcome on review**
- Continue three times weekly Tresiba 6 units + other oral medications.
- Continue using Libre as usual.
- Encouraging no biscuits.
- Community dietitian to see.
- Average glucose improved to Moderate/ High glucose (HbA1c 71)
- **The ECAD service has enabled a person-centred approach to managing this patient's care – working across community and the ECAD service to deliver diabetes care as close to home as possible**

Integrated care in action

- **Patient B, aged 40 years**
- Complicated type 2 diabetes
- Poor glycaemic control, intolerant of diabetes meds
- Tresiba basal insulin 44 units
- Encourage to maintain exercise. Dietetic review in GP surgery.
- Add Novorapid 6 iu with evening meal
- Phone for insulin titration
- **Outcome on review**

Young person with complex type 2 diabetes -> the integrated diabetes service has facilitated ongoing community review and multidisciplinary input which has allowed for positive patient engagement, earlier identification and management of complications

ECAD Team

- Dr Gráinne Ní Ghairbhí, GP, Newtown, Co WW
- Dr Lisa Devine, GP, Carlton Clinic, Bray, Co WW
- Dr David Slattery, Endocrinologist, SMH
- Dr Wan Mahmood, Endocrinologist, SCHL
- Bríd O'Dwyer, CNS Diabetes, SVUH
- Adrienne Doherty, GM, Primary Care, HSE
- Dr Niamh O'Meara, PC Psychologist, HSE
- Sarah McEvoy, Senior Diabetes Dietitian, ECAD
- Marie Monaghan, Senior Diabetes Dietitian, ECAD
- Celine Honahan, Integrated Care Diabetes Dietitian
- Anna Doherty, Community Diabetes Podiatrist, WPCC
- Deirdre Hall, CNS Diabetes, ECAD
- Joanne Lowe, CNS Diabetes, ECAD
- Claire Dingle, CNS Diabetes, ECAD

Thank you!