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CONFERENCE ABSTRACT

# Irish Integrated Care Programme for Chronic Disease - Supporting General Practice

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**Introduction**: Ireland has an ageing population and challenges in caring for people with chronic disease. The prevalence of major chronic diseases of heart disease, diabetes, respiratory disease will increase by 20% by 2022. Since 2008 Irish Health Services suffered severe austerity measures with funding reduction of 24%. Ireland has no organised system of chronic disease management in Primary Care. GPs not rewarded for active management, many patients rely on hospital OPD management .

**Description of policy context and objective**: Government policy has mandated the Integrated Care Programme for Chronic Disease (ICP CD). The objective is to "provide a full spectrum of care including prevention, early detection, management in Primary Care and appropriate Secondary Care services". Care is to be delivered at "the lowest level of appropriate complexity".

A new GP contract for chronic disease management is being developed. The contract will reward GPs for proactive health promotion, risk assessment and early detection of chronic disease, scheduled proactive management according to national clinical guidelines. ICP CD is developing and piloting a suite of supports to GPs.

**Targeted population**: Population targeted is the 700,000 people who suffer from significant heart disease, diabetes or respiratory disease. Stakeholders are patients, GPs, practice nurses, community specialist nurses, hospital specialist nurses and hospital specialists. Community services developed for 50,000 population networks.

**Highlights**: Programme innovative initiatives;

- Projects in diabetes, respiratory disease and heart failure; clinical nurse specialists and physiotherapists to work between clusters of General Practices (50,000 population) and local hospital specialist providing improved diagnosis, knowledge transfer to GPs, support for managing complex patients and rapid access to specialist opinion.

- Community podiatrists and dieticians to support community models of care. (1 per 50,000)

- National Framework and training for implementing risk factor assessment and brief intervention "Make Every Contact Count".

- National Framework, training and local sign posting for Self Management Supports.

- Virtual Clinics between hospital specialists and GPs for case presentation, support of management and knowledge transfer.

- Rapid specialist email opinion.

- Specialist clinic in GP settings (under development).

Virtual clinic operational; demonstrated 85% reduction in OPD referrals. Recruitment of clinical nurse specialists, physiotherapists, podiatrists, dieticians rapidly ramped up. New job descriptions and KPIs agreed nationally. Blueprints for the new contract developed.

**Transferability**: To enable General Practitioners to manage complex conditions requires systematic supports to be developed. The initiatives outlined are replicated in many parts of the world and have demonstrated the ability to transfer when adapted to local health systems.

**Conclusions**: Key findings, lessons learned;

- Clinical leadership and national policy critical.

- Demonstrate the effectiveness but rapidly scale up to population.

- Partnership with General Practitioners, Royal Colleges essential.

- Stakeholders consultation essential.

- GPs, practice nurses eager to manage patients in Primary Care if supported.

- Significant changes in practice for GPs require contractual changes and financial alignment.

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**Keywords:** general practice; knowledge transfer; integrated care

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