

## POSTER ABSTRACT

# A gap analysis between the outline document for the integrated care programme and draft models of care for four chronic diseases in Ireland

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**Introduction:** In Ireland, an Integrated Care Programme for the Prevention and Management of Chronic Disease was established with the goal of treating patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. An outline document by the Integrated Care Programme describes the spectrum of services needed and the levels of service delivery required to implement the Programme.

National Clinical Programmes have also been established to improve specific clinical service areas including chronic disease. Doctors, nurses, allied health professionals and hospital managers with expertise in that clinical service area work together to develop standardised care pathways, clinical guidelines and models of care for the patient journey.

It is important that documents produced by the Integrated Care Programme and National Clinical Programmes for Chronic disease complement each other. A key target of the Integrated Care Programme is the completion of standardised models of care for each chronic disease programme to reflect all aspects of the Integrated Care Programme.

**Objective:** A gap analysis was undertaken between the Integrated Care Programme Outline Document and draft models of care of four major chronic conditions type 2 diabetes, asthma, COPD, heart failure. The objective was to facilitate alignment of the documents.

**Targeted Population:** The targeted population was all healthcare professionals, policy-makers and other parties interested in the prevention and management of chronic disease. As an introductory step, four main chronic conditions were chosen. Consultations with relevant stakeholders were undertaken and included clinical leads of the Integrated Care Programme, clinical leads and programme managers of the National Clinical Programmes for each of the four main chronic diseases, GPs and representatives from academia.

**Highlights:** A model of care is concerned with the delivery of services; clinical guidelines are concerned with treatment. Lesser detail on specific treatments is required for a model of care as readers can be referred to clinical guidelines as necessary.

To support effective integration, each model of care needs referral pathways between each level of service, which reflect the current healthcare organisational units of that country.

**Transferability:** The methods and findings from this gap analysis are applicable to models of care for all chronic diseases. Lessons learned from this exercise are informing current work with other chronic diseases.

**Conclusions:** This work involved professionals from many different backgrounds and the importance of a glossary of terms became quickly obvious. Clear definitions of terms such as 'model of care' were required from the outset to ensure everyone was speaking the same language.

Early face-to-face engagement with stakeholders proved important for later implementation of the findings of the gap analysis. Face-to-face meetings were valuable in conjunction with email correspondence.

In view of the diverse range of stakeholders interested in the area of chronic disease, the executive summary of all documents are important resources for many professionals and need to be targeted appropriately.

Finally, a national template for the development of future models of care would be useful to ensure a standardised approach by all.

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**Keywords:** model of care; integrated care; gap analysis; ireland; chronic disease

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