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WORKSHOP ABSTRACT

The Integrated Care Programme for the Prevention and Management of Chronic Disease: implementing a population health approach in Ireland.

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Orlaith O'Reilly[1], Maireád Gleeson[1], Maria O'Brien[1], Ellen Cosgrave[1], Margaret Curran[2], Sarah O'Brien[1]

1: Integrated Care Programme For The Prevention And Management Of Chronic Disease, Health Service Executive, Kilkenny, Ireland
2: Caredoc, Carlow, Ireland

The Integrated Model of Care for the Prevention & Management of Chronic Disease (MoC) provides a population health approach to the prevention & management of chronic disease (CD). This model is currently being rolled out across Ireland at scale. This workshop aims to explore the Irish experience of implementing integrated care as part of a population health approach to the prevention and management of CD.

Our current, hospital-centric method of delivering health services is not sustainable, nor is it patient-centred. The MoC takes a generic, multi-morbidity approach to the prevention and management of four major CDs: type 2 diabetes; asthma; COPD; cardiovascular disease. It aims to shift care to the left by enabling GP-led primary care and empowering patients to self-manage their CDs.

Aim: To describe our real-world experience of implementing at scale a MoC that places an emphasis on the delivery of a person-centred, equitable health service as we work to improve population health in Ireland

Objectives:

1. To describe our MoC, and the evidence underpinning it, which is currently being implemented across Ireland

2. To discuss our successes

3. To discuss our challenges and potential solutions

4. To describe importance of involving patients as partners in care

5. To discuss the future of integrated care in Ireland

We anticipate that this workshop will appeal to a broad international audience and range of integrated care professionals (from primary care, community care to acute care, public health physicians, commissioners and health service managers) – as well as to patients themselves. It may be particularly relevant to those working in CD care.

A.Presentations & Speakers (7 mins per presentation: 50% of workshop)

1.Overview of the Integrated Model of Care for the Prevention & Management of CD (Dr. Sarah O'Brien)

2.Ensuring a population health approach to the delivery of care: delivering direct GP access to diagnostics as part of the Integrated MoC (Dr. Maria O'Brien)

3.The first report from the Structured CD Management Programme in General Practice (Dr. Orlaith O'Reilly)

4.Staff recruitment, retention and development: how to support the workforce in delivering integrated care (Maireád Gleeson)

5.Involving patients in care: identifying and implementing PROMs as part of the MoC (Dr. Ellen Cosgrave)

6.Building on the model: the development of an integrated virtual case management service for multimorbid patients with CD (Margaret Curran)

B.Interactive discussion (50% of workshop): How can we ensure a population health approach to the prevention & management of CD to ensure no one gets left behind? (All)

23 min small group work using post-its and flip charts, 20 min feedback and large group discussion

C.Sum up of learning and closing remarks (5 min)

•We are implementing an integrated MOC that takes a population health approach to the prevention and management of chronic disease

•This model is already demonstrating evidence of positive impact

•We must now build on this model, using data to support population profiling, stratification and the identification of unmet need, to deliver an integrated health service that is responsive to population need