HSE Integrated Care Programme for the Prevention and Management of Chronic Disease Newsletter

Issue 4
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Integrated Care Programme for the Prevention and Management of Chronic Disease

Welcome to the Summer 2024 edition of the HSE Integrated Care Programme for the Prevention and Management of Chronic Disease Newsletter

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I am delighted to see the progress being made across in all ICP CD sites. We have many interesting updates within this edition and are delighted to include an update from the Cavan Monaghan Respiratory Integrated Care Team, The SMILE 2 Service, Setting up a respiratory service Laois Offlay.

I wish to welcome Lisa Devine to our team ….

Particular focus for Q2 for us with all Community Specialist teams has been around the collection of metrics. The return of the metrics is crucial to maintain and secure funding to build on the model ongoing. It is heartening to see that the Metrics collected to date are showing a real positive impact supporting the CDM implementation and supporting the shift left in line with Slaintecare vision. As NCAGL, both the ICPCD team and I acknowledge that the manual collection of these required metrics is complex. We were delighted at the response to the recent metric webinars held for the CST Operational leads and our nursing colleagues there was huge engagement and information sharing.

The recordings of these webinars as well as FAQ's are available for viewing on the ECC hub .As a result of feedback from these webinars we are arranging further metrics webinars for each CHO area CSTs, details of same to be found on the on the last page of Newsletter. We will have a particular HSCP lead involvement in these from Dietetics, Physiotherapy and Podiatry and we continue to welcome any feedback

We would also like to bring to your attention the conference Integrated Health Care Advancing Health Service Reform in the Convention Centre in Dublin on Thursday the 05th of September from 8.30am-16.00pm. The theme is Access and Integration . There is a call out for abstracts for this conference and we would generatively encourage all teams to submit the submission deadline is the 02nd of July. See link https://surveys.hse.ie/s/HSEConference2024/

Please enjoy this issue of the ICP CD Newsletter please contact us with any comments or suggestions

Maireád Gleeson

General Manager, Office of National Clinical Advisor & Group Lead (NCAGL) for Chronic Disease & **Integrated Care Programme for Chronic Disease**

Email: mairead.gleeson1@hse.ie

Best Wishes,

Dr Sarah.O'Brien NCAGL

ICGP HSE National Clinical Lead in Diabetes

Dr Lisa Devine commenced her role as the new ICGP HSE National Clinical Lead in Diabetes in December 2023. Over the past ten years, in her role as a GP working in the Dublin and Wicklow areas she has witnessed the inception of structured chronic disease management through the diabetes cycles of care and its evolution into the chronic disease management program.

Her first priorities this year included participating in the new Model of Care for Type 2 Diabetes, published last month. She notes that 2024 brings huge opportunity to maximise the benefits of and expand the chronic disease management program. Education is a key part of this as Diabetes care is changing rapidly. The creation of a new GP training module on type 2 Diabetes and updating the ICGP Quick Reference Guide are key priorities for 2024.

Individualisation of care in Type 2 diabetes is all important as there is a significant range in terms of the age, healthcare status and co morbidities of people attending with type 2 diabetes. Empowering GPs and practice nurses to tailor treatment targets and care plans based on clinical factors and patient preference add huge value to the chronic disease landscape in Ireland. The creation of the integrated care hubs within the community further enables people living with diabetes to receive the right care in the right place at the right time. The continuing advancement of the hubs carry key opportunities and challenges and is a focus over the coming years. This process is assisted hugely by the new hub referral guidelines, also published last month.

Patient centred care is the cornerstone of chronic disease management and patient centred initiatives such as 'language matters' are of the upmost importance. Working alongside people living with type 2 diabetes and advocacy organisations is extremely rewarding.

Looking to the future, prevention is a key element of the future of type 2 diabetes care in Ireland. The inclusion of Prediabetes and more recently gestational diabetes in the GP prevention programme will reap future benefits and places Ireland as a key innovator in chronic disease management.

SMILE 2 SERVICE

Keeping patients healthier and at home for longer

People living with chronic disease are benefiting from SMILE 2, a virtual case management service which monitors their health remotely. Participating patients' health is monitored daily by a team of triage nurses through wearable devices, offering early intervention and care as needed. Monitoring devices included blood pressure monitors, oxygen monitors, weighing scales, and activity monitors (smart watches) which are allocated to participants based on their requirements.

The SMILE 2 Project (Supporting Multi-morbidity self-care through Integration, Learning and eHealth) is a two-year project funded under the Sláintecare Integration Innovation (SIIF) Round 2. It is a joint initiative between the HSE Enhanced Community Care (ECC) programme together with Chronic Disease Community Specialist teams (CD CSTs) partnering with Caredoc.

Dr Orlaith O'Reilly, Clinical Lead, SMILE 2 project, explained, "The SMILE 2 project is turning out to be a really exciting project with huge benefits for patients here in the South East. The project is providing remote monitoring and case management to very high need patients with several chronic diseases. We find that patients really appreciate this service and it has greatly helped them to better understand their condition and how to manage it, avoiding episodes of deterioration and the subsequent visits to hospital.

Mother of four and Nanny of nine, Eileen O'Donnell (70s) is living with COPD and Bronchiectasis. Eileen from Tipperary Town explains she has a history of respiratory infection traced to a bout of measles and whooping cough during her childhood. "While I am still getting used to, and trusting the project technology, it has made me much more confident. I am blessed to be part of this project. The SMILE project is my security blanket."

Preliminary data collated by the service show that for patients who have been in the project for at least six months:

- 48% have had less ED attendances this year as compared to before they joined
- 52% had less nights in hospital
- 79% have had to attend their GP less on an urgent basis.
- 64% have had a reduction in periods of deterioration in their condition, which set off the remote monitoring alerts

Text

Contact Agatha.Lawless@hse.ie for further information

DISCOVER DIABETES - Type 2 Self-Management Education (DSME) programme update

Healthy Food Balance Physical Activity

Key Milestones to date

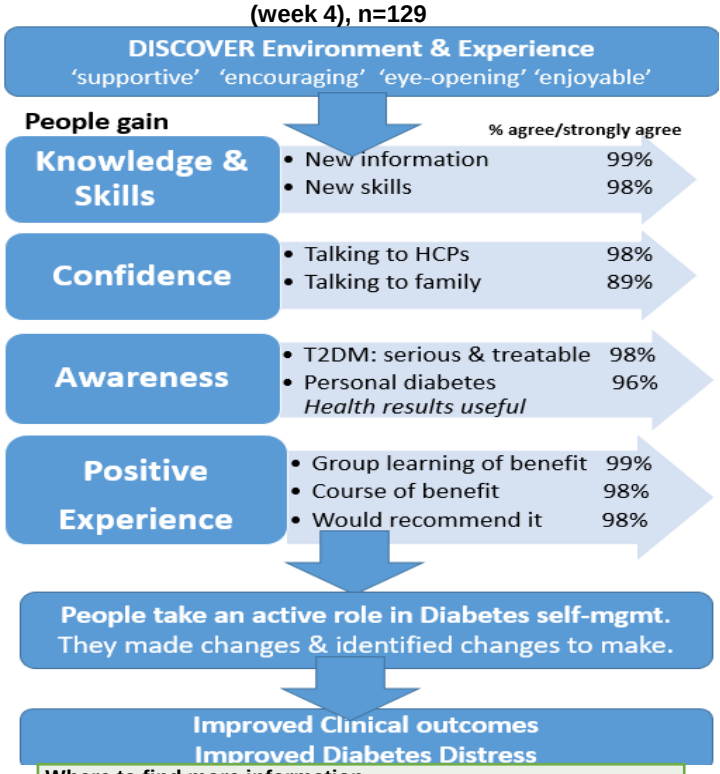
2018	Community Nutrition and Dietetic Service in CHO 4 & 5 in partnership with the ICPCD Self-Management Education Office developed a group DSME programme for individuals living with type 2 diabetes in Ireland. A one year pilot programme was designed and 12 programmes were by community diabetes dietitians. 180 people with type 2 diabetes participated and 161 completers were audited as to the programme impact. Completers attended at least 1 core sessions and at least one follow-up session.
2021	Sláintecare funding facilitated a national approach to the design, development and implementation of this programme. Programme has also been adapted for online delivery
2023	QISMET Accreditation Awarded: The programme meets the standards set for good practice in self-management education, ensuring the highest possible quality service is provided. www.qismet.org.uk
2024	Pilot evaluation results: HbA1c, body weight, BMI and levels of severe diabetes distress all statistically significantly improvement with participation. For those with HbA1c > 53mmol/mol, more than 2 in 3 reduce HbA1c by 6 months and 1 year, with ~50% of these reducing by ≥ 11mmol/mol at both time-points. Pilot Audit results were launched by NCP 28/02/2024 https://www.youtube.com/watch?v=iBoAYcJcqSM The Evaluation Report will be available at HSEland /ECC/ICPCD/Diabetes/Reports in summer 2024.

Nadine Drew, Senior Community Dietitian, delivering a programme (CHO 5)

"The class has helped me to understand my diabetes and how to help myself"

"Educator is so inspirational, loved the course, very motivational and encouraging"

Service user evaluation of client experience and satisfaction (week 4), n=129



What is the DISCOVER DIABETES – Type 2 Programme? It is :

- a community based clinical intervention, fully aligned with the national Sláintecare programme goals of right care, right place, right time and the goals of the ICPCD (i.e. models of care, integrated care pathways, GP Contract).
-delivered by trained community dietitians.
-an **in person** 4 session programme (2.5 hours for 4 weeks)
- or **an online** 6 session course, over 6 weeks (1.5 hours for 6 weeks) with follow-up sessions offered at 6 months, 12 months.

Who can access DISCOVER DIABETES – Type 2?

Eligible participants are those with a confirmed diagnosis of type 2 diabetes. It is open to private patients and those with a GMS/GPVC and is FREE for all to attend. For people with pre-diabetes the Diabetes Prevention Programme is available via Healthlink referral also.

How can people access the DISCOVER DIABETES – Type 2?

By GP referral to the community dietitian in the community specialist teams. For GP practices using healthlink simply choose **T2DM- Self Mgmt Programme** on the drop-down menu (in areas where it has been activated).

Where to find more information
Type 2 diabetes information on the HSE A-Z https://www2.hse.ie/type-2-diabetes
HSE type 2 diabetes courses information video https://www.youtube.com/watch?v=VQHRfl3tJg4

Dietitian Development group/educators: CHO 4: Annemarie O Connor, Dr Ciara McGowan, Freda Horan, Yvonne O' Brien, Maria Browne, CHO 5: Dr Annemarie Tully, Deirdre Howlin, Mary O Sullivan, Maureen Murray, SMES office: Dr Karen Harrington, Margaret Humphreys. **Thank You to:** People living with diabetes participating. DISCOVER DIABETES – Type 2 Implementation Group of community dietitians, Community Dietitian Managers, ICP community diabetes dietitians, chronic disease dietitians. Admin support: Siobhan O' Farrell, Nicola Mulcahy, Linda Hennessy. Sláintecare Project /SME Office Dietitians: Sarah McEvoy, Cliona Twohig, Aoife Ward, Liz Kirby, Orla Brady. Dr Christel Hendrieckx (Australian Centre for Behavioural Research in Diabetes/Deakin University). Dr John Kearney (Technological University, Dublin). Dr Cormac Sheehan (HSE/UCC, Cork), National Advisory Group for Sláintecare Project 154.

New HSE Resource Developed to Support Self-Management

Self-Management support is an important component of the Integrated Care Programme for the Prevention and Management of Chronic Disease and is key to delivering person-centred care whereby people living with chronic conditions are supported to become active partners in their own healthcare.

The role of health care professionals in supporting service users to self-manage is vital. By providing information and support, health care professionals can help people to understand their condition and to develop the confidence and skills to self-manage. This in turn can lead to improved health outcomes, improved service user experience, reductions in unplanned hospital admissions and improved adherence to treatment and medication. Self-Management Support is an ongoing part of the treatment of a chronic condition.

The National Self-Management Support Coordinator Team have created a new resource designed to support Self-Management. ***'Tips for Self-Managing your Health when Living with a Long-term Health Condition'*** is a practical booklet which explains Self-Management, its benefits and where people can get more information and support. The 14 tips in the booklet cover many topics including the following:

- learning about your condition,
- getting the most from your appointments,
- medication management and the importance of keeping a medicine list,
- looking after your mental health,
- setting SMART Self-Management goals and action planning to achieve these goals.

There is also a section for service users to take notes and to store information such as appointment letters, a medicines list or personal action plans.
The booklet is available to download here and printed copies can be ordered from your local HSE Self-Management Support Coordinator.

Text

The Self-Management Support coordinators are working with HSE digital to update the Self-Management Support webpages. The information, programmes and resources listed on these webpages help our colleagues to support Self-Management and help our service users to better self-manage and live well with their chronic condition. For more information go to www.hse.ie/selfmanagementsupport

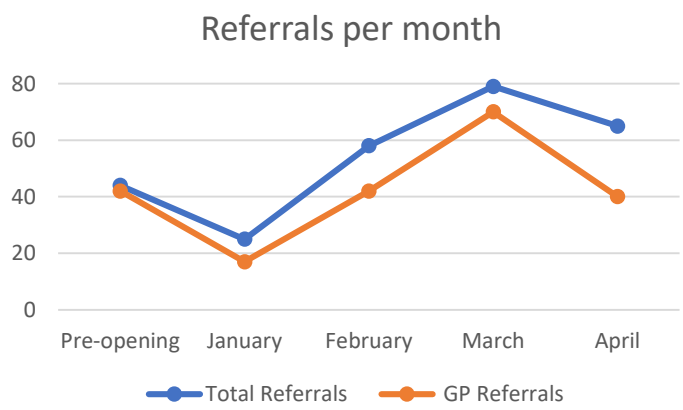
Self-management Support

Living Well
A programme for adults with long-term health conditions
Your toolkit for better health

Setting Up Respiratory
(Laois/Offaly)

Setting up a new service is never easy but I've always loved a challenge. We started with a list of have-nots, rather than things we had. There has never been a testing service in the Laois/Offaly area. We had always relied on the generosity of our neighbours, with patients going to Mullingar or St. James'. This made setting up a chronic service more challenging. Being employed as a member of hub staff, with no hub to do PFTs, with no PFT space or equipment, means using your imagination somewhat. But, with the support of a fantastic team nothing is insurmountable, and that we had in spades. My name is Fiona Keegan, Senior Respiratory Physiologist Fiona.keegan2@hse.ie and I've worked as a respiratory physiologist for aeons.

Thanks to physiologists around the country for being so generous, sharing their protocols and advice which has meant we got up and running fast. Not having testing space meant either waiting until somewhere suitable for PFTs became available, or doing what we could, with what we had. After hours spent with the ops lead, Elmary, we found a space for PFTs for the future and decided on primary care centres (PCCs) for now. Having no integrated hub doctor meant doing what reporting I could myself, and asking for help from the hospital team (who have been generous with their time) when needed. Our service will evolve as premises, personnel, and equipment becomes available.



Spirometry, bronchodilator response and FeNO are available since January, close to the patients, in the PCCs. We take referrals by Healthlink and email. PFTs will come down the line but this is working very well for now. It took 12 week from the start to get up and running and we made changes as we went along. Using a detailed interview and questionnaires, coupled with the results, it is usually possible to make a diagnosis. We are a paperless service so everything from referral to report sharing, is electronic, though patients still get appointment letters.

The huge numbers of respiratory infections, including Covid since I've started has meant that cancellations and rebooking has taken up a lot of time and wasted appointments. This is starting to improve now, thankfully. We've been able to see some of the patients that had been travelling to other hospitals for testing.

GPs like the service being close to home and respiratory referrals on Healthlink have been coming in thick and fast and increasing each month as more GPs hear about the service. 100% of patients seen have reported on the satisfaction form that they're very satisfied with the service provided.

We continue to grow as a team, with the integrated care respiratory consultant joining us later in the year and availability of PFTs at some point. Onwards and upwards!

Cavan Monaghan Respiratory Integrated Care Report

The Slaintecare Implementation Strategy has been an ambitious National Project orientated towards the peoples' expectations for an optimised care tailored to their needs.

The National Clinical Programme Respiratory, as part of the Integrated Care Programme for Chronic Disease working alongside the Enhanced Community Care Programme and the HSE Modernised Care Pathways Programme, continues to be focused on the implementation of the Integrated Models of Care for COPD and Asthma. These Models of Care use an end-to-end patient-centred integrated approach for the prevention, early detection, slowing of disease progression, and the provision of optimal management for people with COPD and Asthma. The models are very much in keeping with the Sláintecare vision of 'Right Care, Right Place, and Right Time'. Community Specialist Respiratory Teams within Integrated Respiratory Services are already functioning around the country and this new way of working is already shifting patient care to the left, away from our acute hospitals.

Despite the challenges to introduce and implement an innovative approach, the Cavan/Monaghan Integrated Respiratory Team has made decisive steps that rewarded both the patients' expectations and the team's vision. The essence of the successful first few steps lies in the value of team work.

The Cavan/Monaghan team has been privileged to be staffed with experienced and knowledgeable clinicians that have an excellent understanding of the key principles of the model. This is because most of them had been working in the region in roles that facilitated the pilot project for Integrated Care for at least 2 years before 2022, when we officially started running the programme. The team members have been working in two parallel groups, one in Cavan and one in Monaghan, shaping the idea of a decentralised care, away from hospital and close to patients' homes, without lacking expertise or accuracy in diagnosis and management.
Our services include Consultant Clinics, ANP Clinics, CNS Clinics, Physiotherapy Clinics, Pulmonary Rehabilitation (PR), and Respiratory Physiology. We also have access to Smoking Cessation, Self Management Support, COPD Ireland Exercise Programme and Social Prescribing.

The COPD outreach team had already opened the way towards the vision with early supported discharges and hospital avoidance. The next step was the specialised follow up with input from our Physiotherapists, CNSs and ANPs. Optimization of management, early identification of relapses, patient education and encouragement to be involved in their own care. Joint assessment of the above clinicians with the Consultant is facilitated when a case is more complicated.

At the same time the team has tried to further improve the cooperation with the GPs and support them in their challenging role. The links have traditionally been very good and this proved massively helpful on the two meetings, within the last year, were the new model was explained and the pathways of referral, along with the clinical governance principles, were presented to assist them in their role and in identifying patients with COPD/Asthma. The CDM Respiratory Team have also met with over 40 of the Cavan/Monaghan GP Practice Nurses on 2 occasions in September 2023 and May 2024. We provided information on our service and advice on managing their respiratory patients.

The ultimate objective is to expedite early assessment for people with a confirmed or borderline diagnosis of COPD or Asthma and provide a plan of action for their management avoiding attendances to the hospital and relieving the waiting lists. Apparently this is mutually beneficial for both the patients and the hospital. The patients have timely access to expert care preventing deterioration of their primary disease while at the same time the hospital can save resources and redistribute them for other acute needs. The hospital waiting lists are already experiencing the relief, regarding Asthma and COPD cases, in three different ways:

1. Cases with an exacerbation are identified by the team in ED / AMAU and an early review in the hub are facilitated
2. Cases admitted in the hospital are reviewed by the team and a plan is provided upon their discharge with review of the challenging cases in the hub
3. Cases referred by the GPs to the hospital clinics are absorbed in the Integrated clinics, without being delayed/stuck on the waiting list, if they fulfil the criteria

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The above, not only gives the opportunity for the hospital to breath but also utilises in a wise way the hub resources regarding quick access to diagnostics, with the Spirometry and – when required – full PFTs.

The timely and seamless access to PFT diagnostics has an indirect but significant impact to the waiting lists as, many times, the GPs would refer to the hospital clinic for this particular reason. The open access, for the GPs, to spirometry will significantly reduce the unnecessary referrals to the acute setting.

With the aforementioned actions we have **already removed over 300 patients from the acute hospital respiratory waiting lists** and we are able to manage 300-400 patients at any time.

The Integrated Team can also identify cases with more complex backgrounds and facilitate quicker access to our hospital specialist services, including biologics, phenotyping for Lung Volume Reduction - - Surgical or with Bronchial Valves - and bronchoscopies or pleural procedures when required. On top of that, The Hub has recently purchased Ultrasound devices to assist CNSs, Physiotherapists and the Respiratory Consultant in confirming respiratory diagnosis which will save onward referral to the hospital services. This model is working well in the UK and there is already a plan to run teaching sessions on use of this technology for our team and expand training to the other teams across the country. The above demonstrates a nice and effective cooperation between the hub and the hospital, bridging the gaps and reducing unnecessary delays.

The aforementioned activities can only happen because of our well established fortnightly MDT Meetings and CPD with the hospital respiratory team. The MDT meetings have helped many patients to avoid hospital admission and avail of the team services to manage their needs, respond to acute episodes and understand their issues with COPD or Asthma and associated comorbidities. We can discuss up to 10 cases at an MDT meeting and which is also an excellent opportunity for learning and development.

The expanded role of the Integrated Team can also be found in the Pulmonary Rehabilitation programme. The Integrated Hub is running an ongoing rolling program in Cavan, with cohort programmes running in numerous sites across both counties - Monaghan Town, Clones, Cootehill, Bailieboro and Killeshandra. This has greatly improved access for patients and reduced travel time and has proved its value and benefit through the increased completion rates of the 8 week program. The extension of pulmonary rehab across numerous sites has impacted significantly on our waiting list, with longest waiters being reduced from over 2 years to just under a year. Further to that, the hub is well-linked to community supports in the Cavan/Monaghan area and Pulmonary Rehabilitation can get extended for many patients through the COPD Ireland Exercise programmes that are being delivered in locations on Cavan and Monaghan. Feedback from patients is excellent – “The support of the respiratory team has been a huge benefit to us and we are managing to look after mum in her own home”, “I am very happy with the Respiratory Clinic Service in Monaghan because it is so convenient in my area and the staff are very helpful at all times”. “Thanks for the excellent respiratory service, my husband has remained at home and has a good quality of life”.

We feel that our first steps have been, so far, successful and promising that we will ultimately manage to serve the Slaintecare Fundamental Principles. This, is only happening because of our enthusiastic and committed team members as following:

Dr Dimitrios Ampazis, Integrated Care Respiratory Consultant

Felicity McFadden, ANP Respiratory

Berenice McGuirk, CNS Respiratory

Caitriona McCabe, CNS Respiratory

Kirstyn Daly, CNS Respiratory

Clare Lynch, Clinical Specialist Physiotherapist

Eugene Quigley, Snr Physiotherapist

Olivia Clarke, Senior Physiotherapist

Clare Ferguson, Senior Respiratory Physiologist

Fiona Gilliland, Operational Lead

Webinars / Training/ Events

NCP Heart	The Model of Care for Integrated Cardiac Rehabilitation was launched via webinar on 18 October last. A recording of the webinar is available to view here and the document itself, the *Model of Care for Integrated Cardiac Rehabilitation,* is available here.
NCP Diabetes	The National Clinical Programme for Diabetes Webinar Recordings : 8/5/2024 Adult Type 1 Diabetes Mellitus National Clinical Guideline (rapid update 2024) Integrated Model of Care for people with Type 2 Diabetes (newly updated 2024) https://www.youtube.com/watch?v=InBt4a1vo5I
	The Diabetes Technology Network UK/Association of British Clinical Diabetologists (ABCD) has expanded access to Glooko Academy to Ireland. It is a FREE online educational programme available to all diabetes healthcare professionals. It provides educational videos and information help clinicians upskill and stay up to date with Diabetes Technologies. Topics include : Connected Pens (new course), Continuous Glucose Monitoring, Flash Glucose Monitoring, Pumps Continuous Subcutaneous Insulin Infusion, Self-Monitoring Blood Glucose (SMB) and Virtual Consultations. For more information on how to access these courses please go to https://go.glooko.com/academy
NCP Diabetes	• Trusted information on diabetes is available at www.hse.ie/diabetes • Book a place for people with type 2 diabetes on a local diabetes support course at www.hse.ie\diabetescourses • A comprehensive directory of recourses to support people living with diabetes is available at https://cnh.hseland.ie/icpcd/type-2-diabetes-resources/ • Are you a dietitian who is new to the hub? Contact the Self-Management Education office at John.Cowhig@hse.ie for training opportunities related to DISCOVER DIABETES-Type 2, the National Diabetes Prevention Programme, the Best Health weight management programme, Behaviour change training and group facilitation.
ICP CD Webinar Metrics OP Leads Project Officers	To support collection of the National Metrics for the Integrated Chronic Disease Tuesday the 14th of May 2024 @ 12.00 (Not Recorded)
ICP CD Webinar Metrics Nursing	To support collection of the National Metrics for the Integrated Chronic Disease Thursday the 16th of May 2024 @ 13.00 https://cnh.hseland.ie/news/ecc/ (on the hubs and resources page) https://www.youtube.com/watch?v=3alTq6R6FAY (on YouTube)

Schedule of CD-CSTs engagements IPC CD Metrics Webinars

CHO 7	**CD- CST Engagement ICP CD Metrics Webinar** **Tuesday the 18th of June 11.30 -12.30**
CHO 1	**CD- CST Engagement ICP CD Metrics Webinar** **Friday the 21st of June 11.00 -12.00**
CHO 5	**CD-CST Engagement ICP CD Metrics Webinar** **Thursday the 4th of July 12.00 – 13.00**
CHO 6	**CD-CST Engagement ICP CD Metrics Webinar** **Thursday the 4th of July 15.30- 16.30**
CHO2	**CD-CST Engagement ICP CD Metrics Webinar** **Friday the 05th of July 14.00-15.00**
CHO9	**CD-CST Engagement ICP CD Metrics Webinar** **Tuesday the 09th of July 11.30- 12.30**
CHO3	**CD-CST Engagement ICP CD Metrics Webinar** **Tuesday the 09th of July 15.00-16.00**
CHO4	**CD-CST Engagement ICP CD Metrics Webinar** **Wednesday the 10th of July 10.00-11.00**
CHO 8	**CD-CST Engagement ICP CD Metrics Webinar** **Wednesday the 10th of July 15.00-16.00**