
CONFERENCE ABSTRACT

Measuring the implementation and impact of primary care integrated care projects.

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Introduction: The increasing prevalence of chronic disease in Ireland means there are increasing numbers of patients managing, in partnership with health services, their chronic disease. It is clear that most patients with the right supports can and want to manage their disease within their own local communities.

To support this, the Health Service Executive in Ireland has developed and initiated Demonstrator Projects for an enhanced primary care based service for patients with four chronic diseases: Diabetes, Heart Failure, COPD and Asthma. This service is delivered by integrated care clinical nurse specialists working with primary care teams to support these patients. The support includes face to face visits and the provision of information, education and monitoring of patients disease outcomes. This service will be delivered in selected sites across the country with the intention that in the future it will be delivered nationally.

Aim: Measuring impact of practice change on targeted population: It is important for the future development and planning of this integrated care service to measure the success of the implementation and the impact on patient outcomes of the demonstrator projects.

Therefore a number of measures, focusing in the initial phase on the role of the Clinical Nurse Specialist, are being developed. This involves the establishment of an advisory group with representation from the individual clinical programmes, Clinical Nurse Specialists, the chronic disease programme and primary care. This group, led by a Consultant in Public Health, is developing a suite of measures that will reflect the implementation of the enhanced service and the impact on patient outcomes. The challenge is to develop measures that reflect structure, process and outcome as this will give a balanced view of implementation but also importantly the impact of this service on patients. It is also important from a planning and feasibility focus to have good quality process measures, including activity measures. It is important that the collection and monitoring of these measures does not place undue burden on the integrated care team. These important factors have to be taken into account in the development and agreement of the suite of measures. This suite following targeted consultation will be finalised and agreed by the Integrated Care Chronic Disease Programme.

Timeline: To ensure the integration of these measures into the early stages of the establishment of the demonstrator projects the suite of measures will be developed, agreed and finalised for implementation from July 2017.

Outcomes: Although certain core measures are useful for trending and comparing impact over time the measures should evolve, adapt and expand in the future. There are a number of reasons for this including that initial data or information will inform developments in the service or that in the future with the addition of more members to the integrated care team for example allied health professionals that the focus of the measures changes to other team members roles.

The measures developed and agreed will inform the development, planning and delivery of integrated care services for chronic disease in Ireland in the future.

Keywords: integrated care for chronic disease; primary care; clinical nurse specialists; measuring implementation and impact; future planning
