

Development of an Integrated Care Service

Background

- The new Integrated Care (IC) programme bridges care between acute and community services
- IC focusses on the management of chronic cardiovascular disease
- I am the new clinical lead for IC in a tertiary centre and 2 community Hubs in Dublin with a catchment of 300,000 people

Aims

- Develop rapid access for GPs to specialist opinion on chronic cardiovascular conditions
- Develop an Integrated Care team
- Develop cross-site hospital-community IT solutions to facilitate the provision of specialist care within the community



Multi-disciplinary care



Outcomes

Rapid access to Specialist advice

- GP-Consultant email query service developed
- GP-Consultant virtual clinic service developed

Integrated Care Team

- Funding secured for an Advanced Nurse Practitioner
- Training programme in chronic cardiovascular disease for Nurse Specialists in place

Integrated cross-site IT

- Remote access secured for community Hubs to the Hospital electronic patient record system
- Cardiology clinic, HF clinic, Cardiac rehabilitation in the community