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Deputy Colm Burke,
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19th December 2023

PQ 50404/23
Question: To ask the Minister for Health further to Parliamentary Question No. 794 of 14 February 2023, to provide a summary of the analysis of the opportunistic case finding assessment under the chronic disease management programme in 2022, the number of patients diagnosed with asthma, type 2 diabetes, COPD or cardiovascular disease as a result of this assessment, in tabular form; and if he will make a statement on the matter.

Dear Deputy Burke,

I refer to the above Parliamentary Question that has recently been referred to the Health Service Executive (HSE) for direct response.

The introduction of the Chronic Disease Management Programme was launched in 2020. The aim of the Programme was to prevent and manage patient chronic diseases using a population-approach. The Programme identifies and manages GMS and GP visit card patients at risk of chronic disease or who have been diagnosed with one or more specified chronic diseases.

The Programme aims to improve the health and wellbeing of patients living with certain chronic diseases, its goals are to minimize symptoms, improve quality of life, and prevent unnecessary hospitalisations.

In March 2023, the second report into the implementation of the Structured Chronic Disease Management (CDM) Programme in General Practice was published and can be accessed here https://www.hse.ie/eng/services/news/media/pressrel/hse-publishes-second-report-into-the-implementation-of-the-structured-chronic-disease-management.html. Its key findings were;

- 91% of patients with chronic disease were not attending hospital for the ongoing management of their chronic condition, which was now fully managed routinely in primary care
- 91% of General Practitioners signed up for the CDM contract
- 83% of eligible patients (65 years and older) enrolled
- Around 800,000 reviews have been carried out by GPs and practice nurses
- Improving trend self-reported lifestyle risk factors - 13% of patients had given up smoking between first and third visit; of patients who were obese at their first visit, 1% of these had achieved normal weight and a further 13% of them had reduced weight and are now be in the overweight category rather than obese.

This reports refers to patients treated by GPs for the first two years of the programme and comprises 186,210 patients in total. It focuses particularly on patients (43,600) who have had at least three reviews in the first two years of the programme to describe trends in outcomes.

If you require any further information or clarification please do contact us.

Kind Regards

Yours sincerely,

Geraldine Crowley,
Assistant National Director,
Enhanced Community Care Programme &
Primary Care Contracts