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Deputy Colm Burke,
Dáil Eireann,
Leinster House,
Dublin 2.

11th March 2024

PQ 9610/24 - To ask the Minister for Health the total allocations for the chronic disease management programme since its establishment.

PQ 9611/24 - To ask the Minister for Health the number of patients currently being treated through the chronic disease management programme

PQ 9612/24 - To ask the Minister for Health the number of GPs contracted to work through the chronic disease management programme.

PQ 9613/24 - To ask the Minister for Health the number of nurses contracted to work through the chronic disease management programme.

Dear Deputy Burke,

I refer to the above parliamentary questions which were referred to the Health Service Executive (HSE) for direct response.

The GP Agreement 2019 provided for the introduction of an integrated model of a structured Chronic Disease Management (CDM) Programme. The GP Agreement (2019) provided €80m for new developments including roll out of the CDM Programme. The CDM Programme was launched in 2020 and has been rolled out on a phased basis (2020 – 2023). The aim of the Programme is to prevent and manage patients' 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 recognition of the additional workload arising for GP Practices under the Chronic Disease Management Programme funding was provided for in the GP Agreement (2019) to support the enhancement of Practice Nurse capacity. To support patients in managing their chronic condition(s) there are two scheduled reviews in a 12 month period as set out in the GP Agreement (2019). Each of the two scheduled reviews provides for a GP visit and a Practice Nurse visit. Practice Nurses are direct employees of the GP and are not contracted by the HSE. As a result we cannot give a definitive number of nurses directly engaged in the delivery of the CDM programme. It is expected that in the vast majority of GP practices participating in the programme, there is Practice Nurse resource engaged in the delivery of the programme.

As at end February, 2024 there are 2,402 GMS GPs signed up to provide the CDM Programme. This represents 95% of GMS General Practitioner contract holders.

Since commencement in 2020 to end January, 2024, 397,808 patients have been enrolled in the Treatment Programme; 65,216 patients have been enrolled in the Prevention Programme and 160,799 Opportunistic Case Finding patient assessments have been completed.

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 now attending hospital for the ongoing management of their chronic condition, which was now fully managed routinely in primary care

- 83% of eligible patients (65 years and older) were enrolled in the Treatment Programme. *[March 2024 Note: Latest preliminary data shows that this has risen to 89% for over 65 year olds and 80% for over 18 year olds.]*

- Improving trend self-reported lifestyle risk factors.

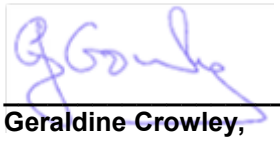
    - 13% of patients had given up smoking between first and third visit.
    - Of patients who were obese at their first visit, 14% of them had reduced weight and were now not obese at their third visit.
    - Of those who had inadequate physical activity at their first visit 48% had achieved adequate activity by their third visit.
    - 67% of people who had harmful drinking patterns at their first visit no longer did at their third visit.

- Improving Trend in Biometric Risk Factors

    - 44% of patients who had hypertension at their first visit no longer did at their third visit.
    - 42% of diabetic patients who were not achieving treatment targets at their first visit did achieve them by their third visit.
    - Of people not achieving their cholesterol targets at their first visit approximately 30% had achieved them by their third visit.

I trust the information provided above is of assistance to you.

Yours sincerely,



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