Chronic Disease Management Programme

Who is the Chronic Disease Treatment Programme for?

The programme is for people who have a medical card or a GP visit card and have a specific chronic disease or diseases. The specific chronic diseases included in the programme are:

• type 2 diabetes • asthma • chronic obstructive pulmonary disease (COPD) • cardiovascular disease, including heart failure, heart attack (angina), stroke and irregular heartbeat (atrial fibrillation)

What are the components to the Structured CDM Programme?

There are three components within the Structured CDM programme:

1. Opportunistic Case Finding Programme (OCF)
2. Structured Chronic Disease Treatment Programme
3. Annual Chronic Disease Management Prevention Programme (PP)

What patients qualify under each of the programmes?

Different patients, determined by age, qualify for different components of the programme, depending on the year.

- 2022 = CDM Programme rolled out to include all people aged 18yrs and over.
- 2022 = Opportunistic Case Finding (OCF) and Prevention Programme (PP) for people aged 65 years and over.
- 2023 = Final /Phase 3 OCF and PP rolled out to include people aged 45 years and over.

CDM Phasing Table

Programme	2020	2021	2022	2023
Chronic Disease Treatment Programme	Age 70 and over	Age 65 and over	All adults age 18 and over	Programme continues
Opportunistic Case Finding Programme (OCF)	-	-	Age 65 and over	Age 45 and over
Annual CDM Prevention Programme (PP)	-	-	Age 65 and over	Age 45 and over

How does the programme work?

The programme is free and includes two set reviews in every 12-month period. Each review includes one visit with the practice nurse followed by a visit with your GP. You may see both during the same visit or at different times. These reviews may be in the GP practice, or because of the COVID-19 pandemic, they may be online or over the phone. If your review takes place in the GP practice, it will include tests such as blood tests. There is no charge to you for any tests that are part of your programme reviews. You can still visit your GP as normal outside of the scheduled programme reviews.

What is my care plan?

When you have your review, you can work with your GP to set your own goals. After the review, you will get a written care plan. This care plan will help you learn about your disease and the steps you can take to improve your self-management.

What information is kept about me?

As part of the Chronic Disease Treatment Programme, your GP or practice nurse will record certain information about you at each set review. This includes your: • name and age • chronic disease diagnosis or diagnoses • medical history • details of any symptoms or tests you have had since your last visit. Your GP will send certain personal information to us at the end of each review. This includes your name, address and medical card or GP visit card number and chronic disease history. Your personal information is stored safely and confidentially in line with data protection regulation. You will have full and open access to the personal information we keep about you, and you can request it from us at any time.

How does the HSE use my information?

We will use your information to help improve our understanding of chronic diseases. Your personal information will be anonymous: we will make sure you cannot be identified. This information will improve our ability to detect, treat and prevent chronic diseases. It will help us to deliver an improved service to people who have one of the chronic diseases listed in this leaflet. More information about how we use and store your information is in our Privacy Statement. This is available at your GP practice.

Can I leave the programme?

It is your choice to take part or not. You can leave the programme at any time by letting your GP know. This means that you will no longer receive set reviews and other care planning under the programme. You can always re-join the programme again later if you wish. Where can I get more information? If you have any questions about the programme, speak to your GP or practice nurse. Further information is available at hse.ie/chronicdisease

Other Services where I can get information or support to help manage my long term condition

Smoking:

Local Smoking Cessation Officer-Margaret Enright UHK (GP or Practice Nurse to refer you)
(Quit helpline 1800 201 203) and www.quit.ie

Self-Management Support: www.hse.ie/selfmanagementsupport
https://croi.ie/health/riskfactors/

https://www.asthma.ie/about-asthma/resources
http://copd.ie/living-well-with-copd/know-your-copd/

https://irishheart.ie/services-for-you/cardiac-rehab-for-all/

Healthy Eating: https://croi.ie/health/nutrition-and-dietary-information-2/

www.hse.ie/healthyeatingactiveliving
https://www.diabetes.ie/living-with-diabetes/living-with-type-2/food-diabetes/
https://www.diabetes.ie/are-you-at-risk-free-diabetes-test/get-sugar-smart/

Alcohol: www.askaboutalcohol.ie

Exercise : https://croi.ie/home-based-workouts/

https://croi.ie/physical-activity-and-exercise/

www.getirelandactive.ie

CDM Treatment Programme Patient Booklet

https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/chronic-disease-management-programme/chronic-disease-management-treatment-programme.PDF

CDM Prevention Programme Patient Booklet

https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/chronic-disease-management-programme/chronic-disease-management-prevention-programme.PDF