SUSTAINING CHRONIC DISEASE MANAGEMENT PROGRAMME IN IRISH GENERAL PRACTICE

From successful implementation to sustainable, integrated and equitable delivery

POLICY MESSAGE

Ireland's Chronic Disease Management (CDM) Programme has established a structured, proactive model of care in general practice. Our qualitative study shows that sustaining its benefits now depends on addressing three implementation pressures: workforce capacity and workload; fragmented IT and communication; and uneven access to community resources.

POLICY ACTION

The Department of Health and HSE should: (1) align workforce and service capacity with CDM activity; (2) strengthen information and communication across general practice, community services and patients; and (3) use population-based planning to identify and address inequalities in access and implementation.

Why action is needed

Introduced by the HSE in 2020 under Enhanced Community Care, the CDM Programme represents a significant shift towards structured, proactive management of chronic illness in general practice. It includes biannual reviews, medication reviews, personalised care planning and referral pathways. The programme has achieved strong uptake among general practices and patients. The policy challenge is now to ensure that implementation remains effective and sustainable.

The study identified a gap in Ireland-specific evidence on how the programme is experienced and implemented in practice. It shows that programme design alone is not sufficient: sustainable delivery depends on the workforce, information systems, community supports and organisational conditions surrounding general practice.

What the study found

48 semi-structured interviews; 22 with general-practice staff and 26 with patients and carers; explored experiences of delivering and receiving CDM care and identified barriers and facilitators. Findings were mapped to Practical Robust Implementation and sustainability model (PRISM)/Chronic Care Model frameworks.

WHAT IS WORKING	WHAT IS UNDER PRESSURE
• Stable funding • Standardised electronic templates • Protected consultation time • Regular patient-centred reviews/Patient Empowerment • Continuity of care *"It gives you a bit of peace of mind. You know they know what they're doing. And they're telling you you're alright at the moment." Pt 3.*	• Increased workload for healthcare providers • Fragmented IT and communication between general practice and community/integrated-care services • Variable access to community resources • Fragmented patient information • Lack of COPD-specific resources in general practice *"We've an aging population.....We're going to have more and more people who will be eligible for CDM and we need to fund for that and make sure that the GP practices have capacity to manage it..."* GP 10

Gap: Although the programme has successfully established a proactive model of chronic disease care, long-term sustainability remains a challenge. The next phase should therefore focus not only on maintaining programme activity, but also strengthening the supports that allow high-quality, coordinated and equitable care to be delivered.

Priorities for policy action

Match workforce capacity to CDM activity

Workload pressures and unmet training needs indicate a need for service and workforce planning that reflects the activity generated by CDM. Department of Health and HSE to

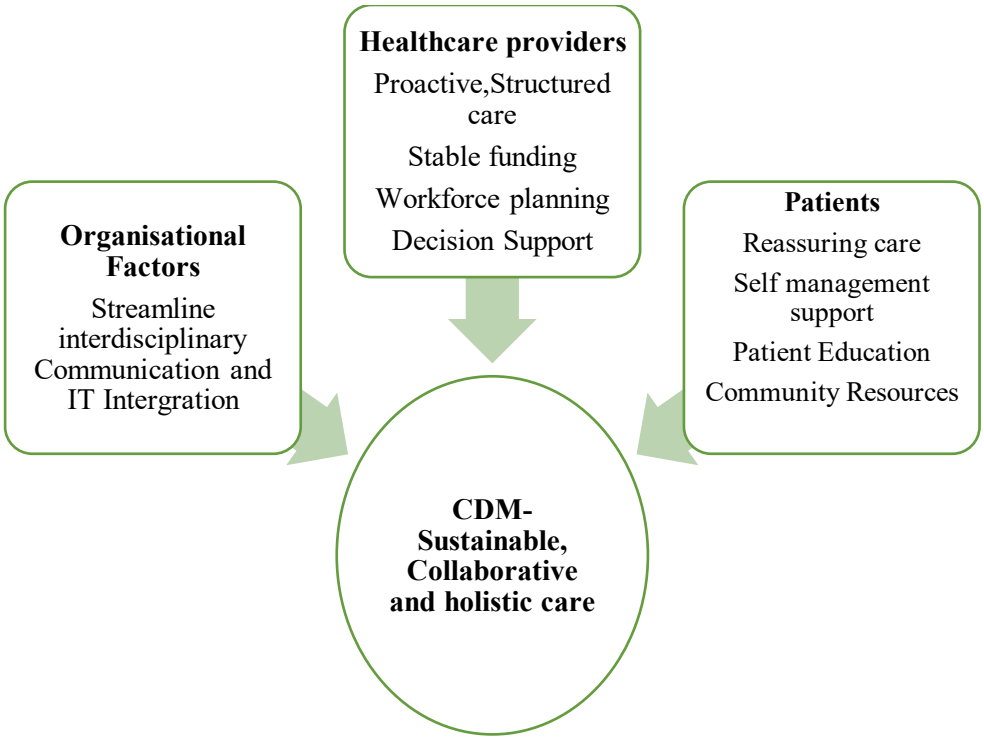
undertake a CDM workforce and workload assessment and use the findings to inform service planning, capacity and funding. Capacity planning should consider GP and practice-nurse workload, protected consultation time, training requirements and the administrative demands of programme delivery.

Integrate IT systems and patient information to enhance coordinated care

Fragmented IT and communication between general practice and community services can undermine coordinated care. Patients also experience fragmented information during follow up. Therefore; HSE needs to establish consistent information and communication pathways between general practice, community services and patients, including clearer referral and feedback processes and appropriate sharing of patient information.

Make CDM population-based and equitable

The study found variable access to community resources and gaps in condition-specific diagnostic and management supports. While the national implementation has improved access to care, some populations i.e. older adults, socioeconomically deprived, rural and private populations continue to be disadvantaged. For sustainability, HSE should use population-based planning and available CDM information to identify geographic and population differences in access, capacity and implementation, and target support where gaps are greatest.



Conclusion: The Chronic Disease Management (CDM) Programme represents a significant shift to delivery of structured, proactive and patient-centered care for chronic conditions within general practice in Ireland. Success should therefore prioritise: sufficient workforce and training; protected time for meaningful reviews; connected information across care settings; equitable access to community and condition-specific supports; and routine monitoring of implementation, patient experience and variation.