First report of the Structured Chronic Disease Management Programme in General Practice

Introduction

The Enhanced Community Care Programme, together with the GP Agreement 2019, is a practical demonstration that the Department of Health Sláintecare policy is actively working to change Ireland's health service model to be less dependent on the acute hospital system by providing more care in the community, as close to home as possible which will allow our ageing population and those with Chronic Disease to maintain their independence and live well in the community. It not only supports our services to reduce the winter pressures on our acute hospital system but also is a local demonstration of active transformational change underway in bringing more enhanced community care services to towns and villages across Ireland.

The Chronic Disease Management Programme for General Medical Scheme (GMS) or Doctor Visit Card (DVC) patients was a key development included in the GP Agreement, which commenced in 2020, and is being rolled out to adult patients over a 4-year period with a target uptake rate of 75%.

The Programme, which is comprised of three components, envisages an uptake of 431,000 patients;

- 120,500 on the Opportunistic Case Finding Programme, involving the opportunistic assessments to detect and diagnose diseases at an early stage, so that they can be appropriately managed
- 253,500 on the CDM Structured Programme with 2 GP visits and 2 Practice Nurse visits a year
- 57,000 on the High Risk Preventative Programme with 1 GP visit and 1 Practice Nurse visit a year

The focus of this report is the first phase of implementation of the CDM programme commencing in 2020. It also encompasses modifications to the programme which were implemented in the context of the Covid-19 Pandemic. These occurred within the wider context of working towards implementing a whole system approach involving the development of 96 Community Healthcare Networks (CHNs) and 30 Community Specialist Teams (CSTs) for Chronic Disease and 30 Community Specialist Teams for Older People to support the implementation of integrated care across community and acute settings, in line with Sláintecare and the National Service Plan 2020.

At the outset, in line with the rollout of the eHealth agenda incorporated the GP Agreement 2019, the data returns from the GPs participating in the CDM were identified as critical to the success of the programme. A key requirement outlined in the GP Agreement 2019 was the development of a bespoke ICT and quality assurance system to improve outcomes and ensure the accuracy of the assumptions underpinning the CDM programme, thus supporting service planning and the effectiveness and efficiency of the service.

CDM data have been collected since the commencement of the programme in January 2020. This valuable data provides a much clearer indication of the risk factors for ill-health, the health behaviours and the levels of the major chronic diseases that are present in a vulnerable cohort of the population. Furthermore, in the longer term, this data will shed more light on the levels of GP engagement with the CDM programme in its initial stages to help with strategic implementation on an on-going basis. Such information will be valuable in supporting service planning, the judicious use of resources and targeting particular subsets of the population as the CDM programme is rolled out.

The first phase of the CDM allowed GP practices to opt-in to provide the service. The CDM was offered to individuals over the age of 75 years who had a GMS or DVC and who had one or more of the chronic diseases listed above.

In recognition of the impact of COVID-19 on individuals living with chronic disease in the community, the Modified Chronic Disease Management Programme (MCDM) facilitated early expansion of the programme to individuals over the age of 70 years who had a GMS/DVC and who had one of the

chronic diseases listed above.3 The MCDM is in line with the 2019 GP Agreement and supports GPs in their delivery of chronic disease preventative and management activities through the use of telehealth. Eligible individuals included those over the age of 70 years, with one of the chronic diseases listed above, who had a GMS/GP visit card.

The initial first cut analysis explored the extent, breadth and quality of the raw data. Following this review, edits to the data collection system were made to improve the quality of the data collected by the CDM.

The next phase of the CDM commenced in January 2021 to include individuals aged 65-69 who had a GMS/DVC and who also had one or more of the above-listed chronic diseases. This report analyses the baseline characteristics of these two cohorts, who had consultations from 24th January 2020 to 11th September 2021.

The development and implementation of this programme happened because of groups and institutions working together collaboratively, including the Department of Health & DPER, the HSE (Clinical Programmes, Primary Care, ICT, Public Health doctors and managers), the IMO and ICGP together with practice nurses and the wider practice teams.

Number of Consultations by Patient

As of 11 September 2021, there were 166,147 patients registered on the CDM system, with 2,218 GPs reporting cases across 1,080 practices. There were 382,084 consultations in total, with reductions in the number of consultations by date notable in March 2020, and in January and June 2021, coinciding with the onset of the coronavirus pandemic, and peaks of the 14-day incidence rate for waves 3 and 4. (Fig 1)

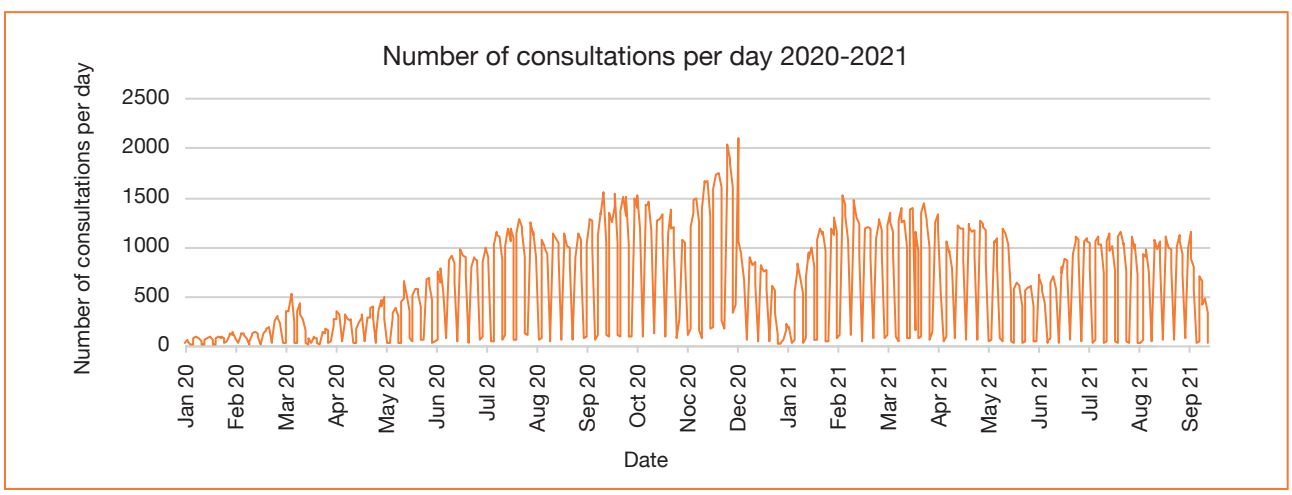

Figure 1: Consultations for 2020-2021 YTD (n=382,084)

The average number of consultations was 2.3. (Table 1)

Number of Consultations	1	2	3+	Total
Number of patients	59,619	55,588	50,940	166,147
Proportion	35.9%	33.5%	30.6%	100%

Table 1: Number of consultations by patient

Over 90% of consultations were in person and not by telephone, i.e. only 10% of consultations were reported as aligning with the MCDM model.

Demographics

In January 2021 the age cohort 65 to 69 years were included in the CDM Programme. Overall, there was a 16.6% increase in the numbers registered on the CDM between April and September 2021. Hence while all age groups reported growth, the most significant increase was in those age 65-69 (+84.7%). The mean age of the current cohort of patients in the CDM is 77.2 years, with a median age of 76.0 years, a range of 65.0-107.0 years and an interquartile range (IQR) of 72.0 - 82.0 years. Overall 28.6% of the population over 65 in the GMS/DVC scheme were included in the Programme up to September 11th 2021.

Men account for 53.7% of all patients registered and women accounted for 46.6%. In terms of ethnicity, 98.0% of individuals were White Irish, 1.2% are Other White, 0.4% were Irish Travellers, with Black Irish, Black African, Chinese, Other Asian, Other Black and Other accounting for 0.3%.

Uptake of the Programme

Uptake rates for programmes such as the CDM are notoriously hard to calculate as no definitive denominator for the number of people suffering from the specific chronic disease usually exists, and none exists in Ireland. The original prevalence estimates for GMS/CDM contract in 2018, were based on TILDA wave 3 data (2017) for over 50 year olds and QNHS 2010 data for 18 to 49 year olds, applied to the latest census data (2016). GMS population estimates were based on the 2018 PCRS data. Table 2 presents estimated uptake rates using estimates of chronic disease prevalence as a denominator. The uptake estimate uses the same TILDA wave 3 proportions applied to the 2016 census and updated with the 2021 GMS PCRS data.

The uptake of the CDM Programme by the eligible cohort is excellent. The older age groups in particular have very high uptake rates, it is to be expected that the 65 to 69 year olds have lower uptake rates, given this cohort were only eligible since January 2021, it is also likely that lower uptake rates will be experienced in the lower age groups ongoing.

Age Group	GP/DVC Population	Number enrolled in CDM by Sept. 2021	% GMS/DVC population enrolled	Number with chronic disease in initial estimate of GMS/DVC population	Estimated % uptake of CDM Programme in eligible population
65 - 69	99,360	14,998	15.0	33,551	44.7
70 - 74	182,934	47,424	25.9	61,722	76.7
75+	311,602	103,225	33.1	126,408	81.7
Over 65+	593,896	165,647	27.9	221,731	74.7

Table 2: Number of Patients in the CDM by age group, present of GMS/DVC population and uptake estimates

Clinical details

As of 11th September 2021, 262,109 diagnoses were registered relating to the eight chronic diseases. The most common chronic disease was ischaemic heart disease (IHD) (24.2%), followed by type 2 diabetes mellitus (DM) (21.9%) with cerebrovascular accident (CVA) (4.7%) and transient ischaemic attack (TIA) (4.7%) being the least common. (Table 3)

Disease	Asthma	COPD	TIA	CVA	IHD	Afib	DM2	HF
Number	23,638	31,432	12,352	12,416	63,385	43,215	57,385	18,286
%	9.0%	12.0%	4.7%	4.7%	24.2%	16.5%	21.9%	7.0%

Table 3: Number and proportion of each condition (n=262,109).
COPD: chronic obstructive pulmonary disease, TIA: transient ischaemic attack, CVA: cerebrovascular accident, IHD: ischaemic heart disease, Afib: atrial fibrillation, DM2: type 2 diabetes mellitus, HF: heart failure

The mean age by condition was lowest for asthma (76.1 years) and highest for heart failure (80.1 years), in this cohort of those aged 65+ years (Table 4)

	Asthma	COPD	TIA	CVA	IHD	Afib	DM2	HF
Median	75	76	78	78	77	79	76	80
Mean	76.1	76.5	78.7	78.4	77.6	79.2	76.4	80.1

Table 4: Summary of age statistics by condition

Analysis of gender demonstrates that with the exception of asthma, for which females accounted for 62% of cases, and COPD for which there was a 50:50 split between sexes, males generally represented the majority of cases. This was particularly evident in IHD, Afib and DM with males accounting for 63%, 59% and 58% of cases, respectively. (Fig. 2)

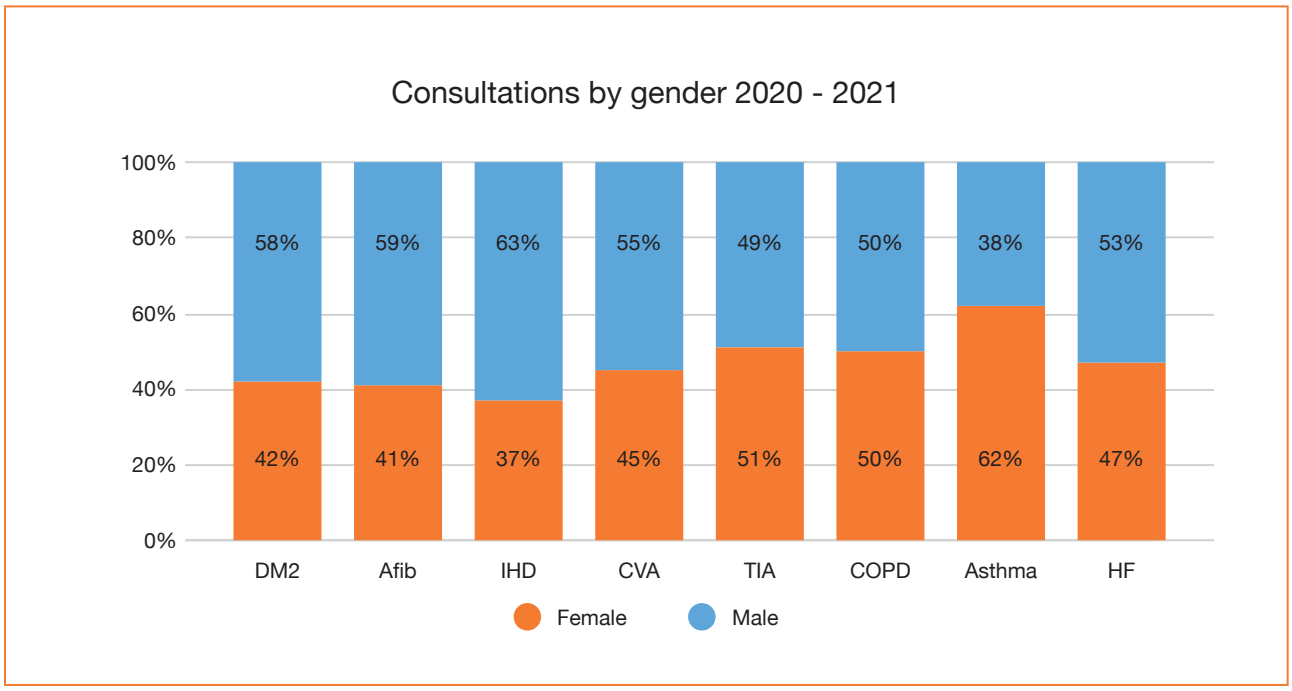

Figure 2 Chronic disease by gender

Chronic Disease Multimorbidity

Analysis of the number of patients and number of comorbidities showed that the majority of patients (59.8%) were recorded as having one of the eight chronic disease diagnoses covered in the CDM, with a decreasing proportion of patients associated with an increasing number of comorbidities. (Table 5)

Number of conditions	1	2	3	4	5	6	7	8
Number of patients	99417	44587	16947	3973	841	183	153	46
Proportion of patients enrolled	59.8%	26.8%	10.2%	2.4%	0.5%	0.1%	0.1%	0.03%

Table 5: Number of conditions by patient (n=166,147)

Age-stratified analysis follows the expected trend of increasing number of chronic diseases with increasing age, 19.7% of over 90 year olds having three or more chronic disease diagnoses compared to 9.3% of the 65-69 year old age-group.

	1 Disease	2 Diseases	3 Diseases	3+ Diseases	4 Diseases	5 Diseases
	%	%	%	%	%	%
65-69	64.7%	25.5%	7.9%	9.2%	1.6%	0.3%
70-74	65.4%	24.6%	7.9%	10.1%	1.8%	0.4%
75-79	60.0%	26.9%	9.9%	13.1%	2.4%	0.8%
80-84	55.8%	28.2%	12.1%	15.9%	2.9%	0.9%
85-89	51.7%	29.9%	13.7%	18.4%	3.4%	1.3%
90+	49.0%	31.2%	15.4%	19.7%	3.2%	1.1%
65+ yrs	59.8%	26.8%	10.2%	13.3%	2.4%	0.73%

Table 6: Proportion of conditions diagnosed by age grouping

The GMS Contract groups multimorbidity into the categories of;

- Any one of the eight specified chronic disease,
- Any two of these diseases,
- Three or more of these diseases. (Table 6)

In the current cohort of over 65 year olds 59.8% had one of the specified diseases, 26.8 % had two of the diseases and 13.3% had three or more of these specified chronic diseases.

The interrelationship between each of the conditions is detailed in Figure 3 below which illustrates the percentage of individuals with a condition who have another of the eight specified conditions. Unsurprisingly patients with heart failure are more likely to have multiple conditions, only 14% of them just suffering from heart failure. Those with a history of TIA or CVA were most likely to be diagnosed with four or more additional conditions. Six per cent of patients with either TIA or CVA have four or more additional conditions.

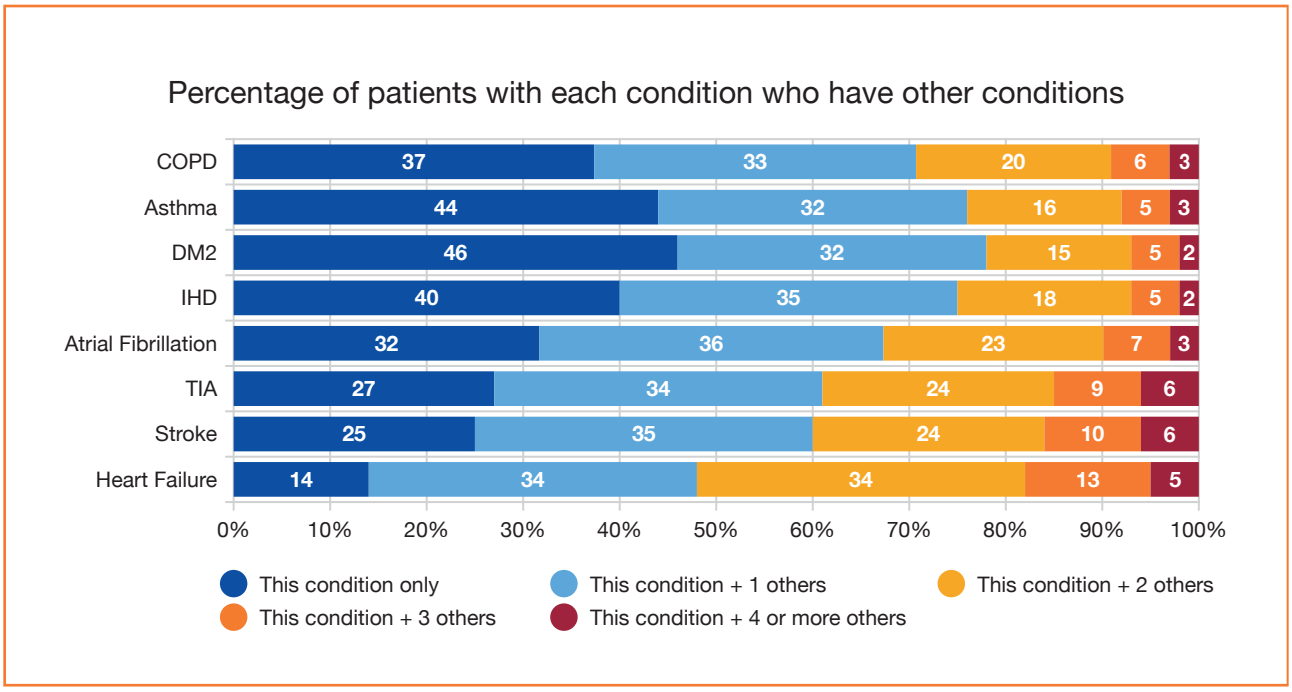

Figure 3 Chronic disease by gender

Other Co-morbid Conditions

The CDM dataset allows GPs to record a selection of additional serious co-morbidities that are not included in the CDM Contract. There have been an additional 61,512 entries recorded in this field to 11th September 2021. The most common entries are as follows: chronic kidney disease (23.4%), myocardial infarction (19.3%), serious mobility issues (10.3%), cancer (8.3%), dementia (7.9%) and hypertension (7.4%). While these conditions are not specified diagnoses under the Contract most of them are related to atherosclerotic disease and hence it is unsurprising that high numbers of patients with these diseases are enrolled in the programme. (Table 7)

Other conditions	Number	% of other comorbidities
Chronic Kidney Disease	14,370	23.4%
Myocardial Infarction	11,870	19.3%
Serious Mobility Issues	6,341	10.3%
Cancer (stage 2 or higher) including melanoma	5,089	8.3%
Dementia including Parkinson's Disease	4,833	7.9%
Hypertension	4,570	7.4%
Significant Mental Illness (current)	2,148	3.5%
Osteoporosis	697	1.1%
Arthritis	641	1.0%
CABG/Stents/AAA/Dyslipidaemia	598	1.0%
Other Cancer including melanoma	406	0.7%
Other	9,949	16.2%
Total	61,512	

Table 7: Profile of other conditions

Lifestyle Risk factors

Smoking

As of 11 September 2021 smoking status was recorded in 166,146 cases. The majority (51.2%) are reported as never smokers, with a further 37.0% classified as ex-smokers and 9.0% recorded as current smokers. (Fig. 4)

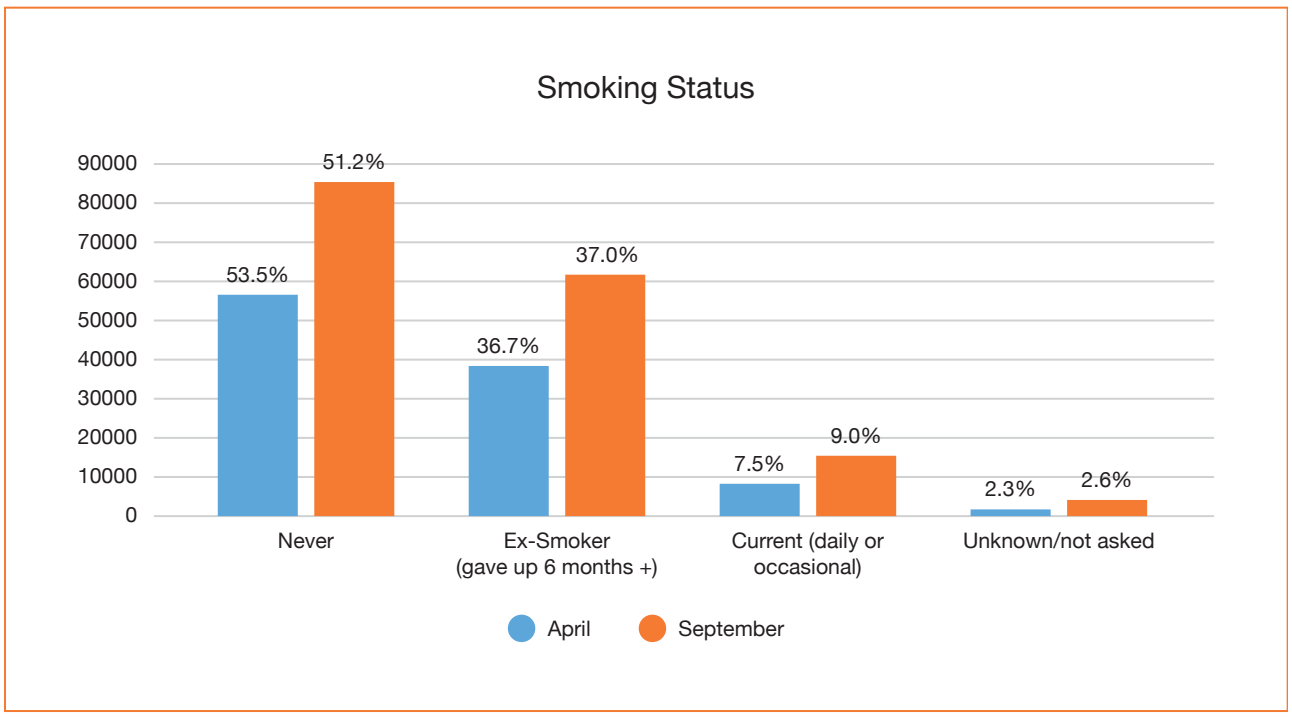

Figure 4: Smoking status (n=166,146)

There were 34,633 interventions recorded for 15,003 current smokers. The proportion of patients with no action documented was 10.0%, while the proportion of patients declining or not interested in an intervention was 43.2%. Since January 2021 most patients have had a number of visits, 45.1% of patients that received a smoking intervention (all of which are current smokers) had a subsequent smoking status reported. Of those, 85.9% remain current smokers. However, 13.4% were subsequently reported as non or ex-smokers. Smoking status was not recorded for the remaining 0.7%

Smoking Intervention	Number	% of interventions
No action documented	3745	10.0%
Patient declined /Not interested	16147	43.2%
Brief Intervention	13451	36.0%
Signposted to HSE QUIT services	2753	7.4%
Referred to HSE QUIT service	452	1.2%
Prescribed or referred for Stop Smoking medication	830	2.2%
Total records	38378	

Table 8: Details of smoking interventions conducted

Weight and BMI

As at 11 September 2021 there were 265,592 valid measurements for body mass index (BMI) corresponding to 165,828 patients. Of these 165,328 measurements were recorded on the first visit, 84,533 on the second visit, and 15,231 recorded on the third and subsequent visits. The mean overall weight was 78.5kg, with the average weight decreasing from 78.7kg at the first visit, to 78.3kg at the second visit and 77.2kg at the third or subsequent visits. The mean BMI was 28.2, with 39.8% being overweight (BMI ≥25 and < 30) and 33.0% being obese (BMI ≥ 30).

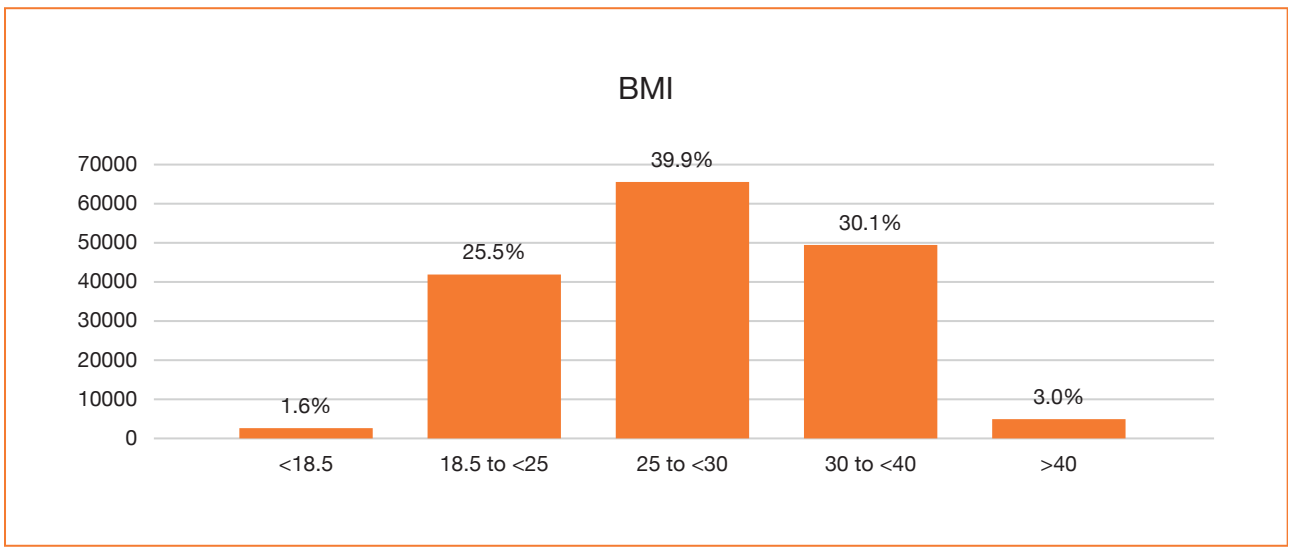

Figure 5: BMI profile of CDM population

Overall, 280,216 weight interventions were recorded; 68,487 interventions related to 45,698 normal weight individuals (BMI 18.5 to <25); 130,292 interventions related to 72,049 overweight individuals (≥=25 and ≤=30); and 81,437 interventions related to 60,970 obese individuals (BMI ≤18.5 or ≥30). Brief advice/intervention accounted for 50.0% of the interventions, 4.9% of interventions sign posted patients to the weight management service, 1.6% of interventions referred patients to a dietitian. Referral to a dietitian increased from 1.3% (1741) of interventions for patients with an overweight BMI to 3.5% (2841) of interventions for patients with an obese BMI. Almost 15% of interventions were declined by patients and no action was documented in 31% of records. (Table 9)

Weight Intervention	Normal	Over-weight	Obese	Total	% of records	% of interventions
Brief advice/ intervention	51052	101146	49888	202086	50%	72%
Pt declined/ not interested	12774	23432	23585	59791	15%	21%
Signposted to healthy living/ weight management service	4661	3973	5123	13757	3%	4.9%
Referred to dietician		1741	2841	4582	1%	1.6%
No action documented	37766	50098	35514	123378	31%	
Total Interventions	68487	130292	81437	280216		
Total Records	106253	180390	116951	403594		
Number of individuals	45698	72049	60970	178717		

Table 9: Interventions based on weight risk profile

Physical Activity

Physical activity is recorded in the CDM system in 2 ways;

The number of days per week on which 30 minutes or more physical activity is achieved. This is then categorised into:

- 0 days
- 1 to 4 days
- 5 to 7 days
- No information available

Those patients categorised as 0 to 4 days do not meet recommended activity levels and hence are categorised as “inadequate” physical activity. These patients are then assessed as to whether they achieve 150 minutes of moderate intensity physical activity or 75 minutes of vigorous physical activity per week. If they meet either of these criteria they are then considered as having “adequate” physical activity achieved in the week.

Up to September 2021 162,014 patients were asked about whether they achieved 30 minutes or more physical activity on one or more days during the week. Of these 73,100 (45%) had adequate physical activity recorded.

Number of days activity achieved	30 minutes activity	%
0 Days (Inadequate)	22,417	13.8%
1-4 Days (Inadequate)	49,748	30.8%
5-7 Days (Adequate)	73,100	45.0%
Unable to be physically active	16,749	10.3%
Total	**162,014**	

Table 10: Activity assessment based on number of days/week of physical activity

Those with inadequate physical activity were subsequently assessed as to whether they achieved either 150 minutes of moderate activity or 75 minutes of vigorous activity per week. Of these 18% were recorded as having adequate activity levels, 9% had no information available and 73% had inadequate activity levels. Overall approximately 53% of individuals had adequate physical activity within the week, as measured by these parameters.

In total there were 150,273 separate records based on physical activity, with interventions documented in 120,963 (80.5%) of these. The most common intervention related to brief advice on the benefits of activity. (Table 11)

Physical Activity Intervention	Number	%
Given brief advice / brief intervention on benefits of physical activity	86379	57.5%
No action documented	29310	19.5%
Patient declined / not interested	28379	18.9%
Signposted to “get active your way”	6205	4.1%
Total Records	**150273**	

Table 11: Interventions for those with inadequate activity levels

Alcohol

An alcohol risk score was calculated for 166,040 patients, with 266,446 measurements undertaken in consultations between January 2021 and September 2021. Non-drinkers accounted for 51.5% of patients, 43.2% of patients had normal alcohol consumption, 4% had increased risk patterns and the remaining 1.3% had high risk/harmful drinking patterns. The alcohol risk score was computed according to the Audit C scale. (Table 12)

Alcohol risk score	Number	%
Non-drinker	85443	51.5%
Normal (1-4)	71792	43.2%
Increased risk (5-7)	6722	4.0%
High risk (8-12)	1989	1.2%
Harmful (>12)	94	0.1%
Total	**166040**	

Table 12: Alcohol risk score recorded at consultations

High risk or harmful drinking reduced as patients received more consultations with their Doctor i.e. 1.5% of patients on their first visit had high risk or harmful drinking, 0.9% at their second visit and 0.6% at the third visit. Similarly the proportion of non-drinkers or those with normal levels of alcohol consumption increased from 94% of those at their first visit, to 95.7% at their second visit and 96.9% at their third visit.

The CDM Programme requires GPs to carry out an alcohol intervention on those at increased risk and those with high risk/harmful drinking patterns. Those at increased risk received 17,436 interventions (6722 individuals) and those at high/harmful risk received 5,447 interventions (2083 individuals) i.e. some patients received more than one intervention. (Table 13). 22,883 interventions were carried out and recorded in these patients.

Action	Increased Risk		High Risk	
Brief Intervention	4162		-	
Complete Full Audit Assessment	10499		3307	
No Action documented	16		8	
Patient declined/not interested	1869		1168	
Referral to HSE Drug and Alcohol confidential helpline	71		66	
Referred to specialist substance misuse service	56		53	
Signposted to AskAboutAlcohol	779		853	
Total responses (including none documented)	17452		5455	

Table 13: Interventions based on alcohol risk score

Brief interventions were carried out in a large proportion of those with increased risk. Much smaller proportions of interventions were referring to the confidential helpline or substance abuse service, though a higher proportion of those with high risk and harmful drinking were referred to these services. A significant proportion of interventions were declined by patients with increased risk, and this was particularly noticeable among those with high risk profiles. The assessment of alcohol risk behaviour is complex and intervening successfully, particularly with those at high risk is particularly difficult. However it is very encouraging that large numbers of patients in the increased and high risk categories have completed the full Audit assessments done by the GPs and very few of these patients had no action documented.

Discussion

This initial baseline report is a preliminary description of the activity and basic demographics, morbidity and lifestyle risk factors among patients enrolled aged over 65 in the first 20 months of the CDM programme.

The roll out of the CDM programme has been very successful, with high uptake rates in the older cohorts who are currently eligible. Approximately two-thirds of patients had at least two reviews between January and September 2021. An increase in numbers registered was noted in the six months between April and September. This was more marked naturally among the 65 to 69 years age group for which the programme had just commenced in January 2021.

The CDM Programme had hoped for an uptake rate of 75% at its inception. The uptake rate as of September 2021 among the over 65 cohort was 74.7%. It is very encouraging to note that the uptake rate is higher in the older cohorts, currently there is an uptake rate of 76.7% in the 70 to 74 year old cohort and an uptake rate of 81.7% in the over 75 year old cohort. These enrolment rates correspond to 15% of the current GMS/DVC population in the 65 to 69 year old group, 26% in the 70 to 74 year old group and 33% in the over 75 year old group.

It's particularly important that those over 70 years have a high uptake rate of the programme, given the experience of these older patients during the Covid pandemic. It is a credit to both General Practitioners and to the HSE for extending a modified programme to those aged over 70 and for accelerating the programme in 2020 to all those over 70. GPs were working in very pressurised circumstances over the last two years and achieving excellent uptake rates, and such a high proportion of the service being provided in person was very valuable in protecting these vulnerable patients with chronic disease.

The data has provided interesting insights regarding the specific chronic diseases. For example, ischaemic heart disease was the most common diagnosis, followed by diabetes type 2 and atrial fibrillation. Important information regarding multimorbidity in this Irish population cohort was demonstrated; almost 40% of patients enrolled in the programme are suffering from more than one chronic disease. As expected this increases with age. Multimorbidity was found most often in patients suffering from heart failure followed by those suffering from stroke/TIA. This is not surprising considering that these three conditions are often the result of ischaemic heart disease, diabetes or hypertension.

Table Six demonstrates that almost 60% of the patients enrolled in the CDM are suffering from one of the specified chronic diseases, almost 27% was suffering from two and 13% were suffering from three or more of the specified diseases. This mirrors very closely the initial predictions of the CDM Programme, based on the TILDA wave three data which estimated 56% would suffer from one chronic disease, 28% from two and 16% from three or more.

The CDM data gives information on the current risk factor profiles for the lifestyle risk factors of smoking, alcohol, BMI and physical activity.

Only 9% of enrolled patients are current smokers. An important part of the CDM Contract is that GPs will offer a suitable intervention for patients who are current smokers: only 10% of patients eligible for an intervention had no action documented. It is notable that 43% of smoking interventions were declined by patients. However since January 2021 most patients have had a number of visits, including smoking intervention for current smokers. It is encouraging to note that of those with a subsequent smoking status recorded 13% have now become ex-smokers.

Addressing overweight and obesity is a difficult area for all clinical practitioners but is clearly an important area given increasing obesity levels nationally and its close relationship to the development of chronic disease. The average BMI of patients enrolled in CDM was 28.2 which is in the overweight category, 33% of those enrolled were classified as obese with a BMI of ≥30. GPs carried out over 200,000 weight interventions with patients, only 11% of patients declined an intevention and this shows excellent engagement in Making Every Contact Count for this risk factor by GPs with their patients. However no action was documented in 31% of consultations, this is an area which needs to be improved. Most patients had more than one review since January 2020 and encouragingly patients average weight decreased by 1.5 kilogrammes between the first and the third visit.

The results on physical activity are encouraging: 52% of patients enrolled in the CDM were reported as having adequate levels of physical activity. Only 19% of patients declined an intervention on physical activity.

The majority of patients in the CDM are non-drinkers (51.5%), and a further 43.2% have normal drinking patterns. However 4% of patients have drinking patterns which put them at increased risk and 1.3% have high risk or harmful drinking patterns. It is very encouraging that GPs carried out the Audit risk score on over 99% of patients, which allowed those with abnormal drinking patters to be identified and focussed on for intervention. GPs then carried out a large number (13,806) of full audit assessments with these patients. This demonstrates a high engagement in this aspect of Making Every Contact Count by General Practitioners, despite this being a difficult area in which to engage patients. Unfortunately 28% of patients with increased risk drinking patterns and 56% of patients with high risk/harmful drinking patterns declined any intervention at that time. However it is encouraging to see that those with high or harmful drinking patterns reduced from 1.5% on the first consultation to 0.6% on the third visit, emphasising the value of doctors continuing to engage this small proportion of patients who need their help.

Conclusion

The Chronic Disease Treatment Programme commenced implementation in January 2020 and has been taken up by 91% of General Practitioners. Uptake by patients has been excellent with approximately 75% of currently eligible (65 years and older) patients enrolled, increasing to almost 82% of those aged 75 years or older.

Expected patterns of chronic conditions and multimorbidity have been confirmed. GPs have actively engaged patients with appropriate lifestyle interventions and have embraced Making Every Contact Count. Promising trends in lifestyle risk behaviours have been shown with increasing numbers of reviews.

This first report explores some baseline characteristics. Further analyses will be done to describe clinical characteristics, interventions and trends.

The Chronic Disease Treatment Programme continues to be implemented, with the whole GMS adult cohort commencing the Disease Management Programme in January 2022 and the Opportunistic Case Finding and Prevention Programme commencing in the 65 year old and over cohort in January 2022. Further reports will include these cohorts and provide valuable information for practitioners and service planners.

Appendix – Glossary of Terms

Acronym	Description
Afib	Atrial fibrillation (A-fib) is an irregular heart rhythm.
AUDIT scale	The AUDIT represents an effective screening tool for alcohol consumption. It is commonly utilised to identify patients who have hazardous alcohol consumption levels or who have active alcohol use disorders.
BMI	Body Mass Index (BMI) is a person's weight in kilogrammes divided by the square of height in metres.
CABG	Coronary Artery Bypass Grafting
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebrovascular accident.
DM2	Diabetes Mellitus, Type 2
GMS	General Medical Services Scheme
PCRS	The Primary Care Reimbursement Service (PCRS) is part of the HSE, and is responsible for making payments to healthcare professionals, like GPs, dentists and pharmacists, for the free or reduced costs services they provide to the public.
CDM	Chronic Disease Management
DVC	Doctor's Visit Cards (DVC)
GMS/GP Visit Card	General Medical Services (GMC) /General Practitioner (GP) visit card
HF	Heart Failure
IHD	Ischaemic Heart Disease
IQR	InterQuartile Range
TIA	Transient Ischemic Attack
TILDA	The Irish LongituDinal Study on Ageing (TILDA) is a large-scale, nationally representative, longitudinal study on ageing in Ireland.

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