Chronic Disease Management (CDM): The Power of the 3 P's: Patients, People and Papers

Andrew W Murphy

GP Principal, Turloughmore, County Galway, Foundation Professor of General Practice & Director HRB Primary Care Clinical Trials Network Ireland

University ofGalway.ie

Aims

1. **Outline examples of the impact research has had on Irish chronic disease management *(and ?Registrar learning points)***

2. Discuss current research which emphasises the richness and busyness of current general practice

3. Suggest future research approaches compatible with busy working GP lives

Who are you? What was your teenage anthem?

Don't forget to refresh your options!

a. 1980's

b. 1990's

c. 2000's

d. 2010's

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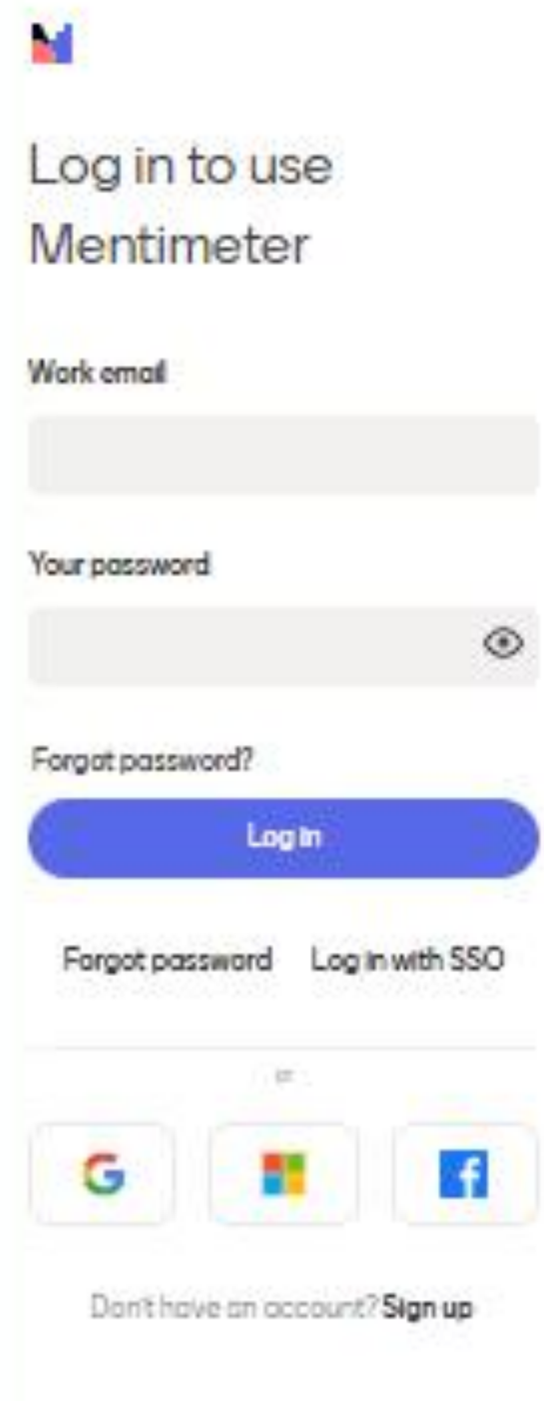

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BRITISH MEDICAL JOURNAL

LONDON SATURDAY OCTOBER 30 1948

STREPTOMYCIN TREATMENT OF PULMONARY TUBERCULOSIS

A MEDICAL RESEARCH COUNCIL INVESTIGATION

The following gives the short-term results of a controlled investigation into the effects of streptomycin on one type of pulmonary tuberculosis. The inquiry was planned and directed by the Streptomycin in Tuberculosis Trials Committee, composed of the following members: Dr. Geoffrey Marshall (chairman), Professor J. W. S. Blacklock, Professor C. Cameron, Professor N. B. Capon, Dr. R. Cruickshank, Professor J. H. Gaddum, Dr. F. R. G. Heaf, Professor A. Bradford Hill, Dr. L. E. Houghton, Dr. J. Clifford Hoyle, Professor H. Raistrick, Dr. J. G. Scadding, Professor W. H. Tytler, Professor G. S. Wilson, and Dr. P. D'Arcy Hart (secretary). The centres at which the work was carried out and the specialists in charge of patients and pathological work were as follows:

Brompton Hospital, London.—Clinician: Dr. J. W. Crofton, Streptomycin Registrar (working under the direction of the honorary staff of Brompton Hospital); Pathologists: Dr. J. W. Clegg, Dr. D. A. Mitchison.

Colindale Hospital (L.C.C.), London.—Clinicians: Dr. J. V. Hurford, Dr. B. J. Douglas Smith, Dr. W. E. Snell; Pathologists (Central Public Health Laboratory): Dr. G. B. Forbes, Dr. H. D. Holt.

Harefield Hospital (M.C.C.), Harefield, Middlesex.—Clinicians: Dr. R. H. Brent, Dr. L. E. Houghton; Pathologist: Dr. E. Nassau.

Bangour Hospital, Bangour, West Lothian.—Clinician: Dr. I. D. Ross; Pathologist: Dr. Isabella Purdie.

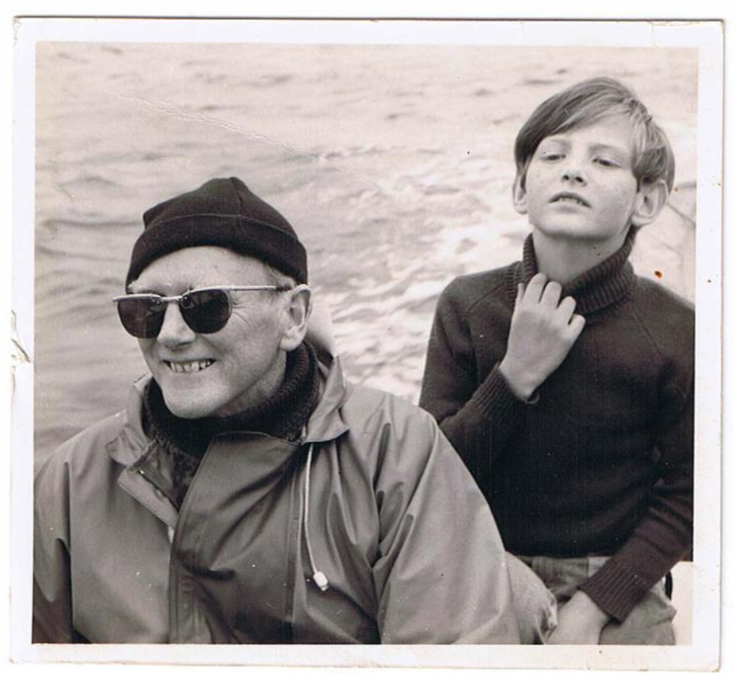
Killingbeck Hospital and Sanatorium, Leeds.—Clinicians: Dr. W. Santon Gilmour, Dr. A. M. Reevie; Pathologist: Professor J. W. McLeod.

Northern Hospital (L.C.C.), Winchmore Hill, London.—Clinicians: Dr. F. A. Nash, Dr. R. Shoulman; Pathologists: Dr. J. M. Alston, Dr. A. Mohun.

Sully Hospital, Sully, Glam.—Clinicians: Dr. D. M. E. Thomas, Dr. L. R. West; Pathologist: Professor W. H. Tytler.

https://www.bmj.com/content/2/4582/769

Mentors early



Prognosis:

May be sudden or rapid death. But more than 50% of the cases recover from a first attack, & then live for a varying number of years. Even a 2nd attack is not always fatal.

In a given case if the patient survives the initial shock & if pain does not recur in say 24, ultimate recovery is likely.

Treatment:

Complete rest in bed. Patient should be moved as little as possible & should not be disturbed greatly in the period of shock. A minimum of six weeks, longer in a bad case so that the myocardium may have a chance to recover.

Drugs:

Morphia in full doses, less than ½ gr useless for

M

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Dr Mark Walsh

Joined Practice 1984

Qualifications: MB MICGP MRCGP MRCPI

Interests: Family Medicine, Sports & Exercise, Diabetes Care, General Practice Training, Medical Education and Travel Medicine.

Mark Walsh: *What makes a good trainer?*

- An interest in people and the fostering of 'high quality' General Practice
- A sense of curiosity and ability to embrace new concepts and change

- Knowledge of one's own Practice Population
- Ability to give regular Structured Feedback
- Recognising the Trainee / Registrar as a colleague

- A Sense of Humour and a 'Listening Ear' when required
- Having something 'up your sleeve' for the 'flat tutorial'

Mark Walsh: *What makes a good trainee?*

- A genuine interest in the Training Practice and Patients – a sense of loyalty
- Willingness to "Go that Extra Mile" when appropriate

- Ability to function as a member of the Practice Team
- Brings new knowledge and concepts to the Trainer and Practice

- Being organised and preparing well for Tutorials e.g. Audit Projects
- Being tolerant when things don't go smoothly
- Having a life outside 'medicine'

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Racecourse vaccination centre opens this morning

BY MARY O'CONNOR

A team of vaccinators will begin innoculating healthcare workers at the Covid-19 vaccination centre at the Galway Racecourse this morning (Thursday).

The Ballybrit site, one of 37 such facilities throughout the country, opened today after extensive preparatory work. It is expected that the team there will begin vaccinating the general population by the middle of next month.

Tony Canavan, the chief executive of the seven public hospitals in the west and north-west, told this newspaper earlier this week that the physical and IT work was completed on the site on Tuesday evening. The vaccine teams moved out there yesterday (Wednesday).

"They will start vaccinating healthcare workers on Thursday," he said. "This allows us to start using the site and hopefully we will start vaccinating the general population there and any problems will be ironed out by then."

As part of the vaccine rollout, a vaccine hub will open at Unit 3 in Merlin Park Hospital this week. Thirteen GPs will use this HSE facilitity over the weekend to vaccinate people aged 85 years and older.

A number of satellite vaccination centres will also open in west Galway and the islands. The west Galway facility will be located in Connemara but it will be a while before this opens and the location has not been finalised.

Mr Canavan, who took over as the head of the Saolta University Health Care Group in September 2019 and presides over an annual budget of almost one billion euro, said the vaccination programme is a complicated exercise but it is "going very well".

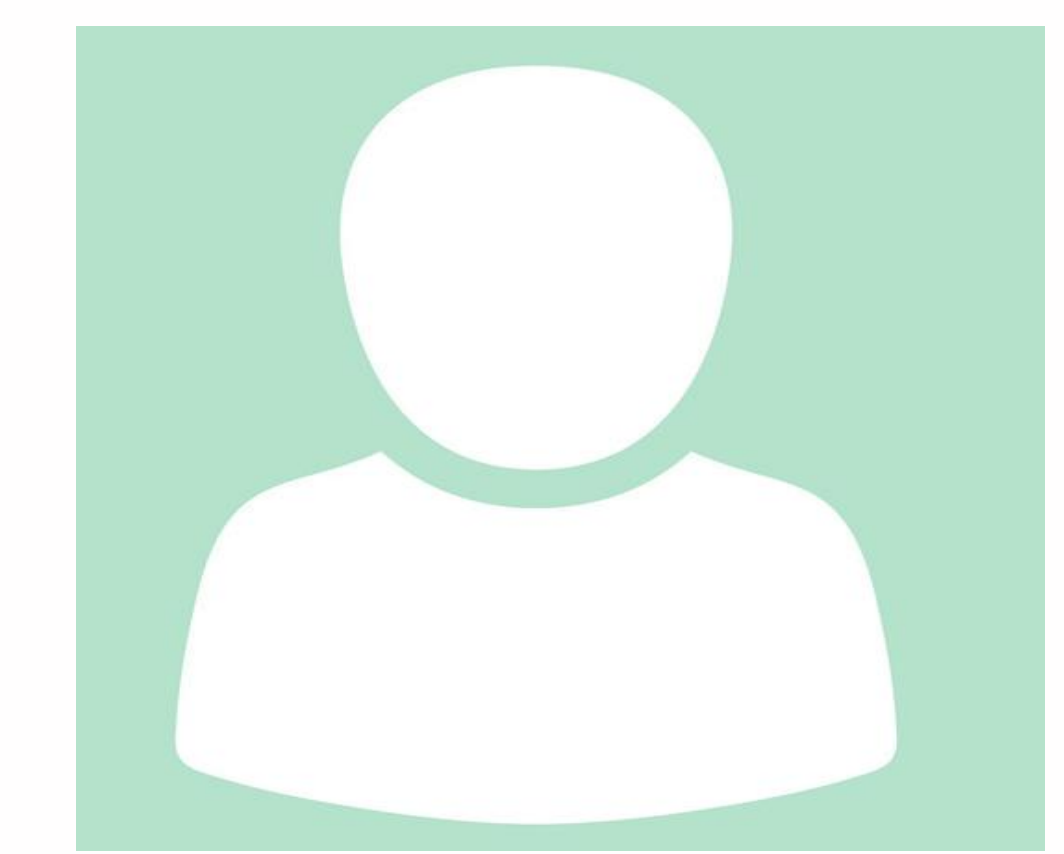
— Continued on Page 6

Shot in the arm – Mrs Monica Holland, aged 96, was the first person to receive the covid vaccine in Turloughmore Health Centre on Tuesday afternoon as the vaccine was rolled out across the county this week. Pictured also is her
who is in his forty second year of continuous medical practice in Turloughmore.

Power of the 3 P's: patients, people and papers

Ollscoil na Gaillimhe
University of Galway

Patient profile: Mrs SM



82 years; widower; GMS eligible

PMedHx:

Hypertension, **AFib**

Heart failure, CABG, kidney failure

Medications:

Amlodipine, nebiviol, warfarin, atorvastatin

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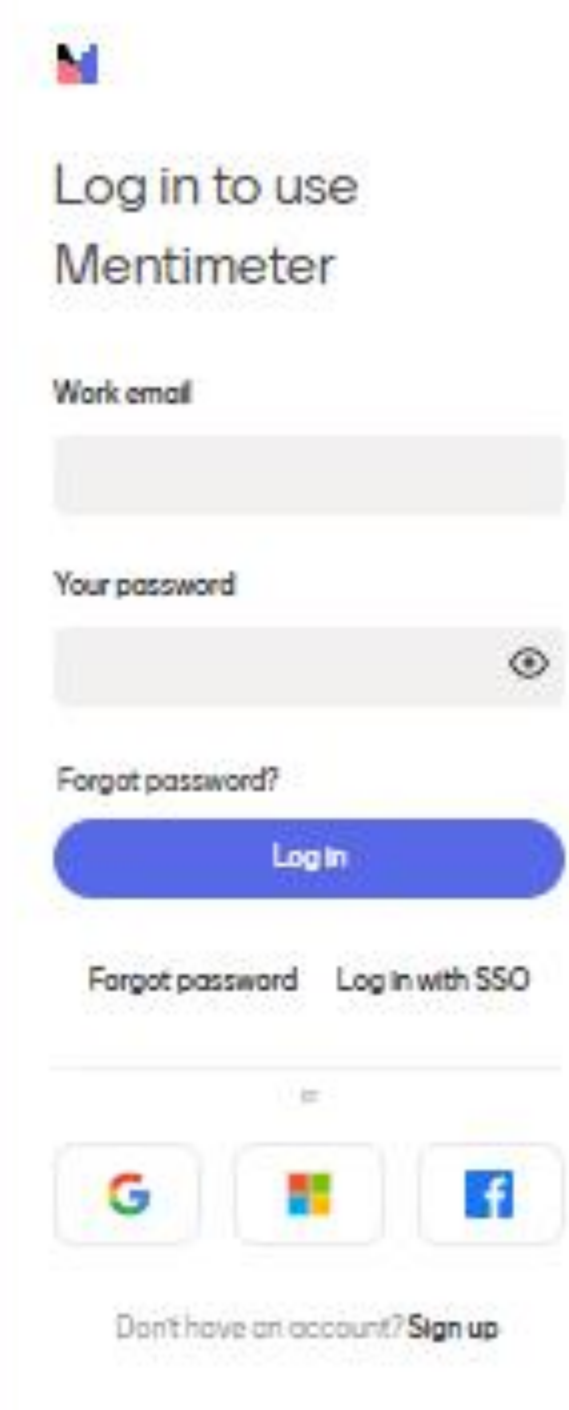


Policy impact: cardiovascular disease management in general practice

Journal of Psychosomatic Research
Volume 58, Issue 5, May 2005, Pages 403-415

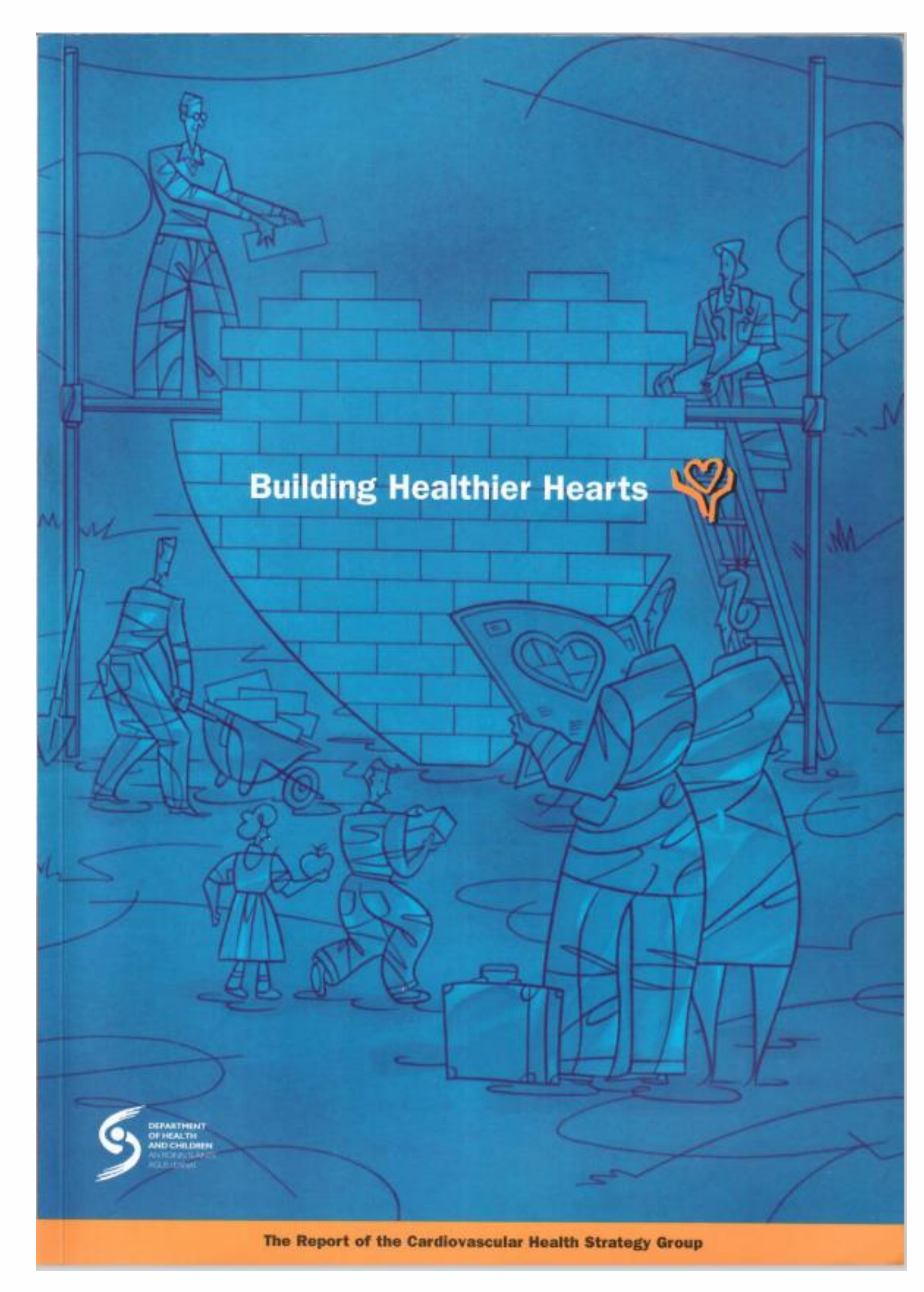
Original Article

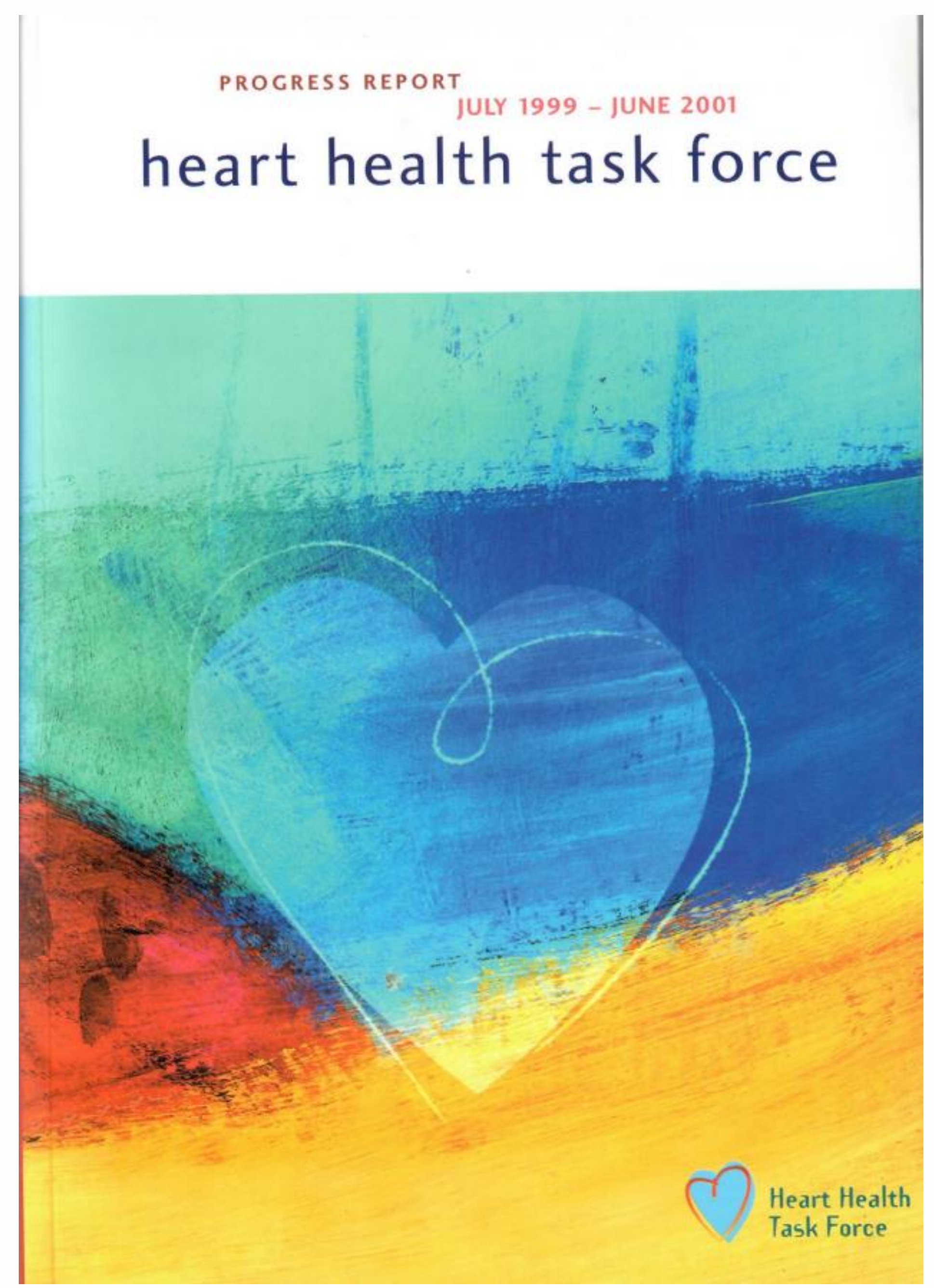
Secondary prevention of coronary heart disease: Patient beliefs and health-related behaviour

Molly Byrne [a], Jane Walsh [a], Andrew W. Murphy [b]

https://doi.org/10.1016/j.jpsychores.2004.11.010

Policy impact: cardiovascular management in general practice





Policy impact: cardiovascular disease management in general practice

RESEARCH

Effect of tailored practice and patient care plans on secondary prevention of heart disease in general practice: cluster randomised controlled trial

A W Murphy, professor of general practice,[1] M E Cupples, reader in general practice,[2] S M Smith, senior lecturer in primary care,[3] M Byrne, lecturer in primary care,[4] M C Byrne, lecturer in psychology,[1] J Newell, senior lecturer in biostatistics,[5] for the SPHERE study team

[1]Department of General Practice, National University of Ireland Galway, Ireland
[2]UKCRC Centre of Excellence for Public Health (Northern Ireland), Queen's University Belfast, Northern Ireland
[3]Department of Public Health and Primary Care, Trinity College Dublin, Ireland
[4]School of Psychology, National University of Ireland Galway, Ireland
[5]Health Research Board Clinical Research Facility, National University of Ireland Galway, Ireland
Correspondence to: A W Murphy andrew.murphy@nuigalway.ie

ABSTRACT

Objective To test the effectiveness of a complex intervention designed, within a theoretical framework, to improve outcomes for patients with coronary heart disease.

Design Cluster randomised controlled multicentre trial.

Setting General practices in Northern Ireland and the Republic of Ireland, regions with different healthcare systems.

Participants 903 patients with established coronary heart disease registered with one of 48 practices.

Intervention Tailored care plans for practices (practice based training in prescribing and behaviour change, administrative support, quarterly newsletter), and tailored care plans for patients (motivational ...

compared with the control group: 107/415 (25.8%) v 148/435 (34.0%), 1.56 (1.53 to 2.60; P=0.03).

Conclusions Admissions to hospital were significantly reduced after an intensive 18 month intervention to improve outcomes for patients with coronary heart disease, but no other clinical benefits were shown, possibly because of a ceiling effect related to improved management of the disease.

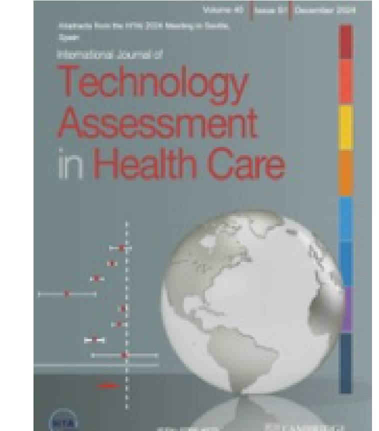
Trial registration Current Controlled Trials ISRCTN24081411.

INTRODUCTION

Despite the substantial potential to reduce the risk of recurrent disease and death among patients with established coronary heart disease, initial reports on the ...

BMJ: first published as 10.1136/bmj.b4220 on 29 October 2009. Downloaded from https://www.bmj.com/ on 7

https://doi.org/10.1136/bmj.b4220



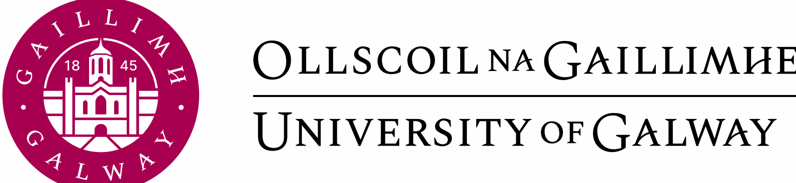
The cost-effectiveness of the SPHERE intervention for the secondary prevention of coronary heart disease

Published online by Cambridge University Press: **29 June 2010**

Paddy Gillespie, Eamon O'Shea, Andrew W. Murphy, Mary C. Byrne, Molly Byrne, Susan M. Smith and Margaret E. Cupples

Show author details

https://doi.org/10.1017/s0266462310000358



Policy impact: cardiovascular disease management in general practice

https://doi.org/10.3399/bjgp15x685681

Organisational intervention versus usual care: all-cause mortality, 4.7–6 years.

Study or subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight, %	Risk ratio M-H, random (95% CI)
Cupples 1999[15]	47	342	65	346	24.5	0.73 (0.52 to 1.03)
Munoz 2008[17]	18	167	21	152	8.3	0.78 (0.43 to 1.41)
Murchie 2003[16]	100	658	128	660	51.1	0.78 (0.62 to 0.99)
Murphy 2014[18]	34	235	39	243	16.2	0.90 (0.59 to 1.38)
Total (95% CI)		1402		1401	100.0	0.79 (0.66 to 0.93)
Total events	199		253			

Heterogeneity: $\tau^2 = 0.00$; $\chi^2 = 0.57$, df = 3 ($P = 0.90$); $I^2 = 0\%$

Test for overall effect: $Z = 2.74$ ($P = 0.006$)

Risk ratio M-H, random, 95% CI

0.01 0.1 1 10 100

Favours (experimental) Favours (control)

Edel Murphy et al. Br J Gen Pract 2015;65:e460-e468

https://doi.org/10.3399/bjgp15x685681

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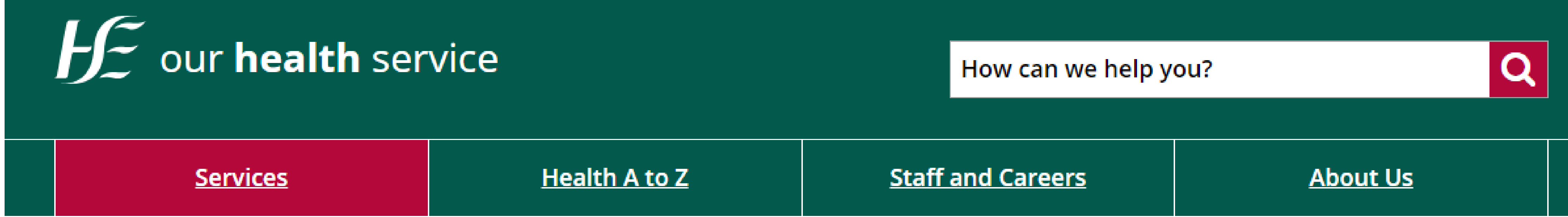
Policy impact: Chronic disease management in general practice



Home > All Health Services > Everyday Care > Primary Care > **Chronic disease management programme**

- Primary Care
  - Enhanced Community Care
  - Community Healthcare Networks
  - **Chronic disease management programme**
  - Lymphoedema
  - Community Funded Schemes
  - GP Out of Hours
  - Primary Care Teams
  - Children First
  - General Practice Nursing

Enhanced Community Care: Chronic Disease Management programme

The Chronic Disease Management programme is for people who have a medical card, GP Visit card or a Health Amendment Act card and have a specified chronic disease such as a cardiovascular disease, COPD, asthma and type 2 diabetes.

The programme emphasises:

- lifestyle and medical risk factor control
- disease management
- the creation of a patient care plan

Your GP (family doctor) will work with you to develop this plan.

Annual chronic disease management prevention programme

The Annual chronic disease management prevention programme is for people who have a medical card, GP Visit card or a Health Amendment Act card and have a diagnosis of hypertension or who are at high risk of cardiovascular disease or diabetes and all adults aged 18+ diagnosed with gestational diabetes or pre-eclampsia since January 1, 2023.

The Third Report of the

Structured Chronic Disease Management Treatment Programme

In General Practice

Third CDM Treatment program Report: *Baseline (2025)*

- 97% of GP's participating
- 91% of patients receiving routine CDM in community

- 405, 131 participants
- 58% with 3 or more reviews
- 89% are 65+ years
- 50% have CVD; 24% Diabetes, 14% Asthma and 12% COPD
- One third have 2 or more conditions

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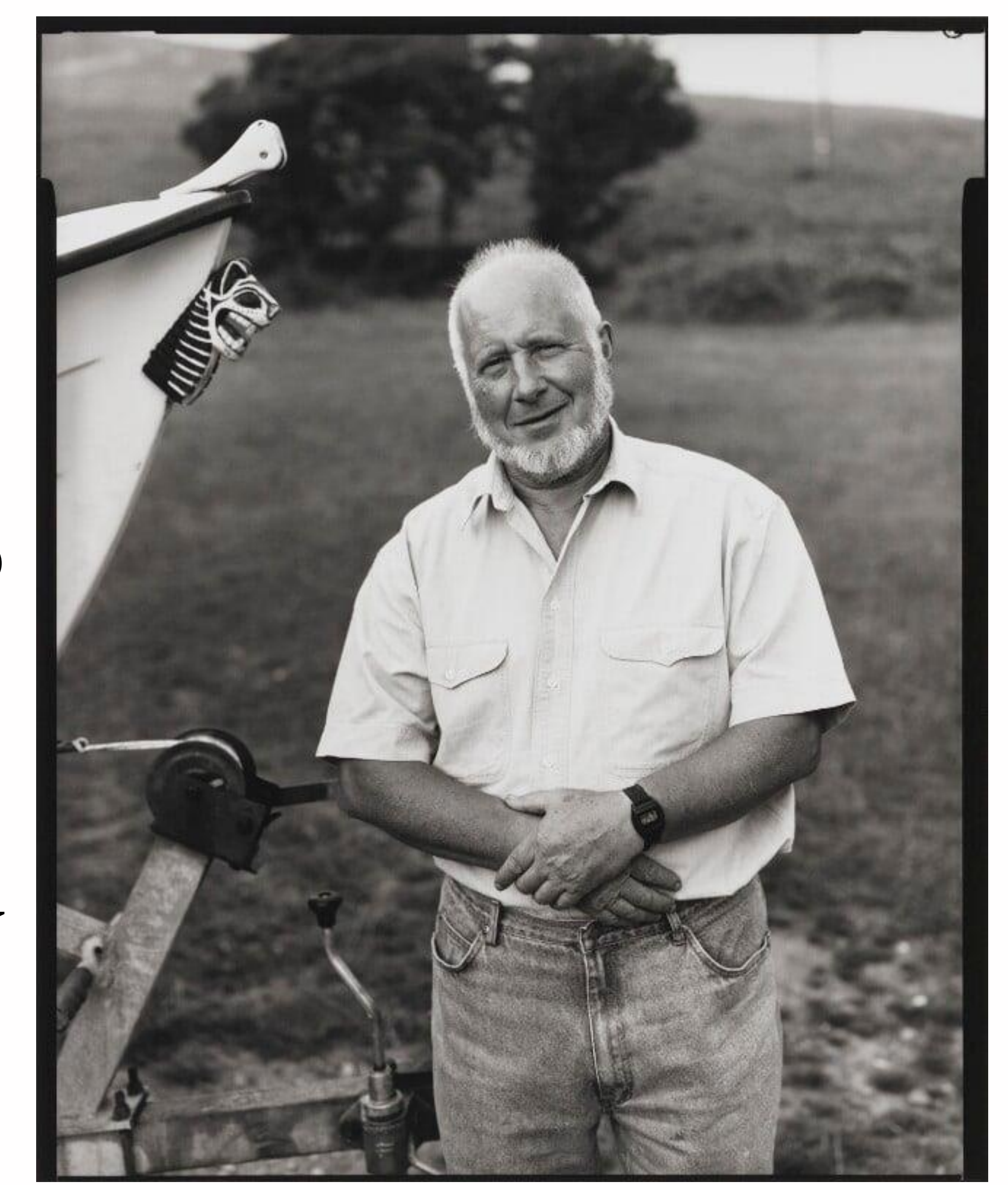
Third CDM Treatment program Report: *Impact (2025)*

LATEST UPDATE 2025:

645,000 REVIEWS COMPLETED FOR OVER 400,000 PATIENTS

30% fewer ED attendances
26% fewer admissions
33% fewer GP O/O/H

(Possible) Registrar Learning Points



- Who is eligible and what happens in CDM?
- What are the known outcomes?
- What is the financial impact of successfully CDM?

- GP scholarship in CDM and beyo

David Mant, Paul Little, Mgt McCartney

- Who are ***your*** heroes …..and do you tell your Registrar about them?

PRACTICE OBSERVED

Twenty five years of case finding and audit in a socially deprived community

Julian Tudor Hart, Colin Thomas, Brian Gibbons, Catherine Edwards, Mary Hart, Janet Jones, Margaret Jones, Pam Walton

Abstract

Objective—To evaluate audit and case finding (whole population care) in a community over 25 years.

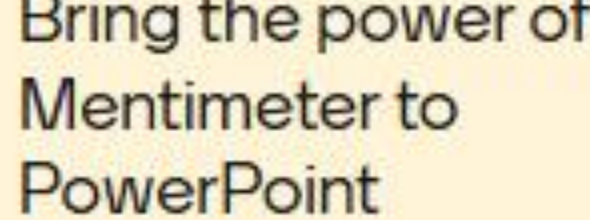
development of structured process, may diminish health outputs.

Introduction

https://doi.org/10.1136/bmj.302.6791.1509

OLLSCOIL NA GAILLIMHE
UNIVERSITY OF GALWAY

Do you think CDM should be extended? If, to what?



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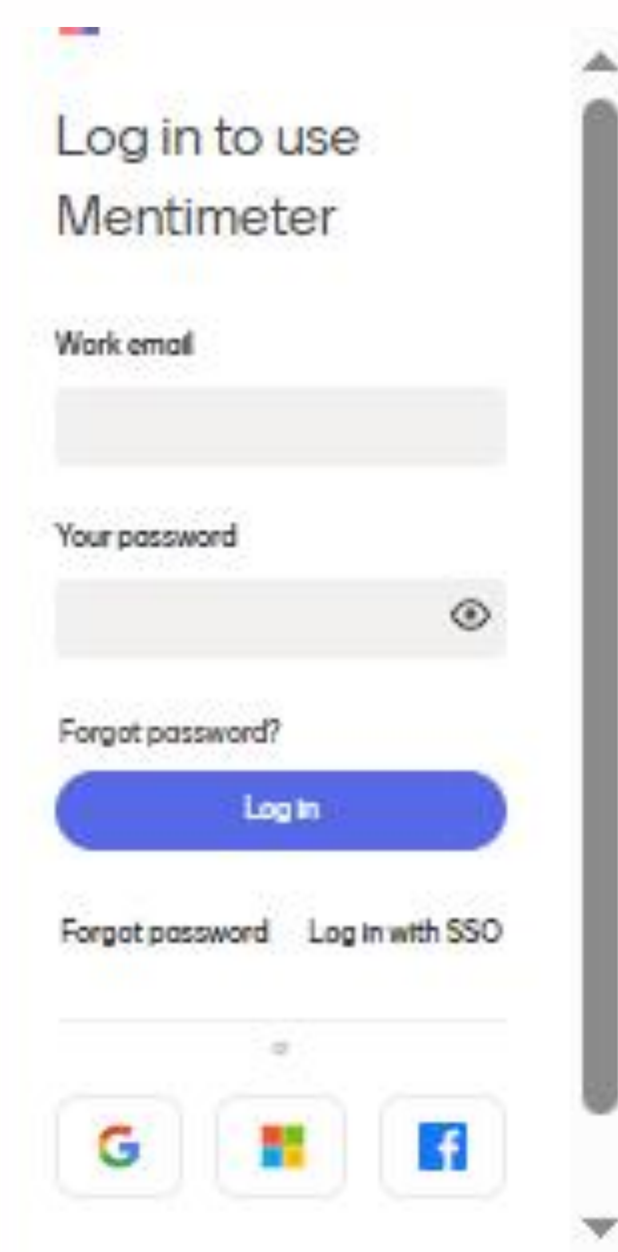
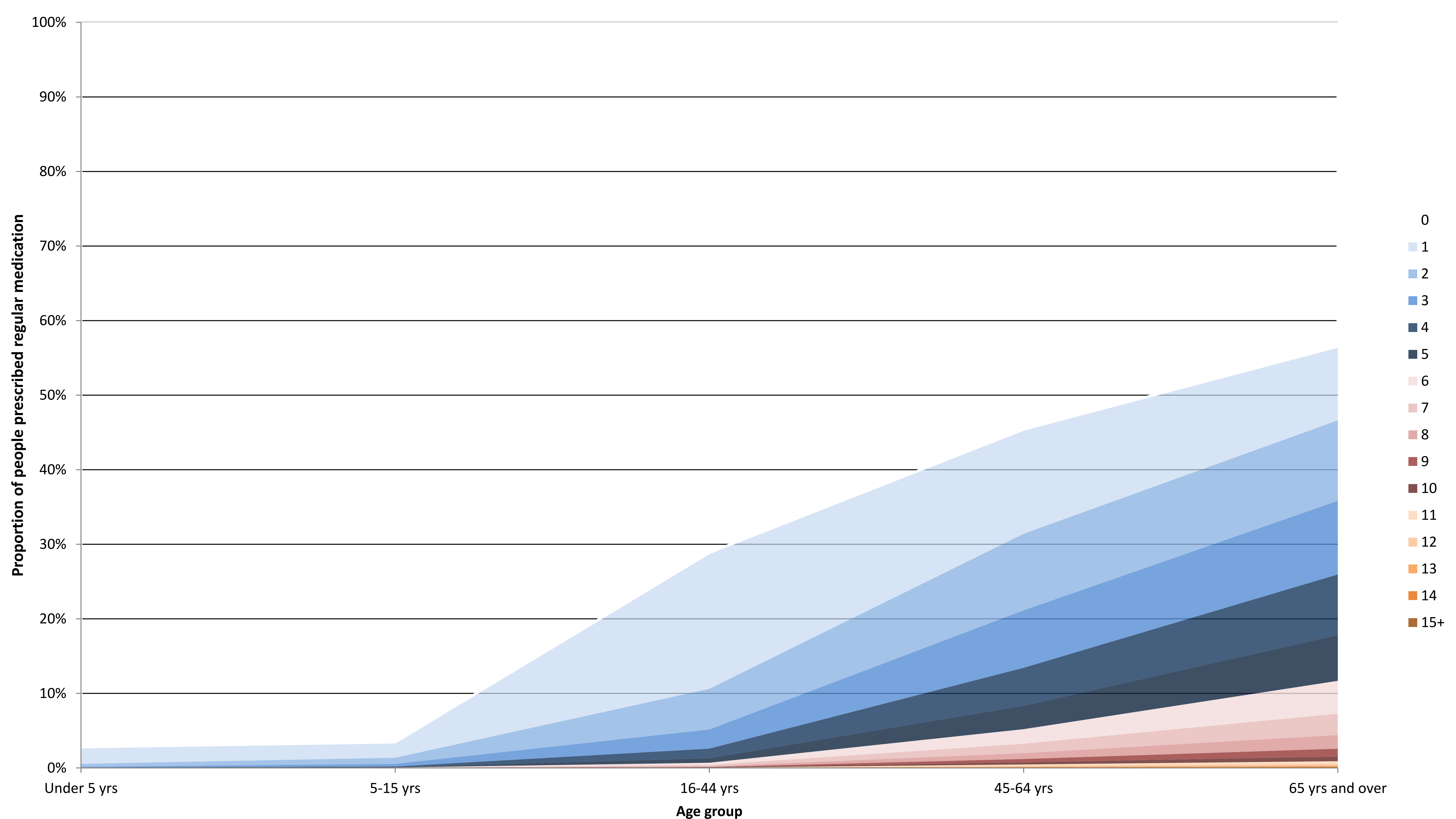


Proportion of GMS population by number of regular medicines



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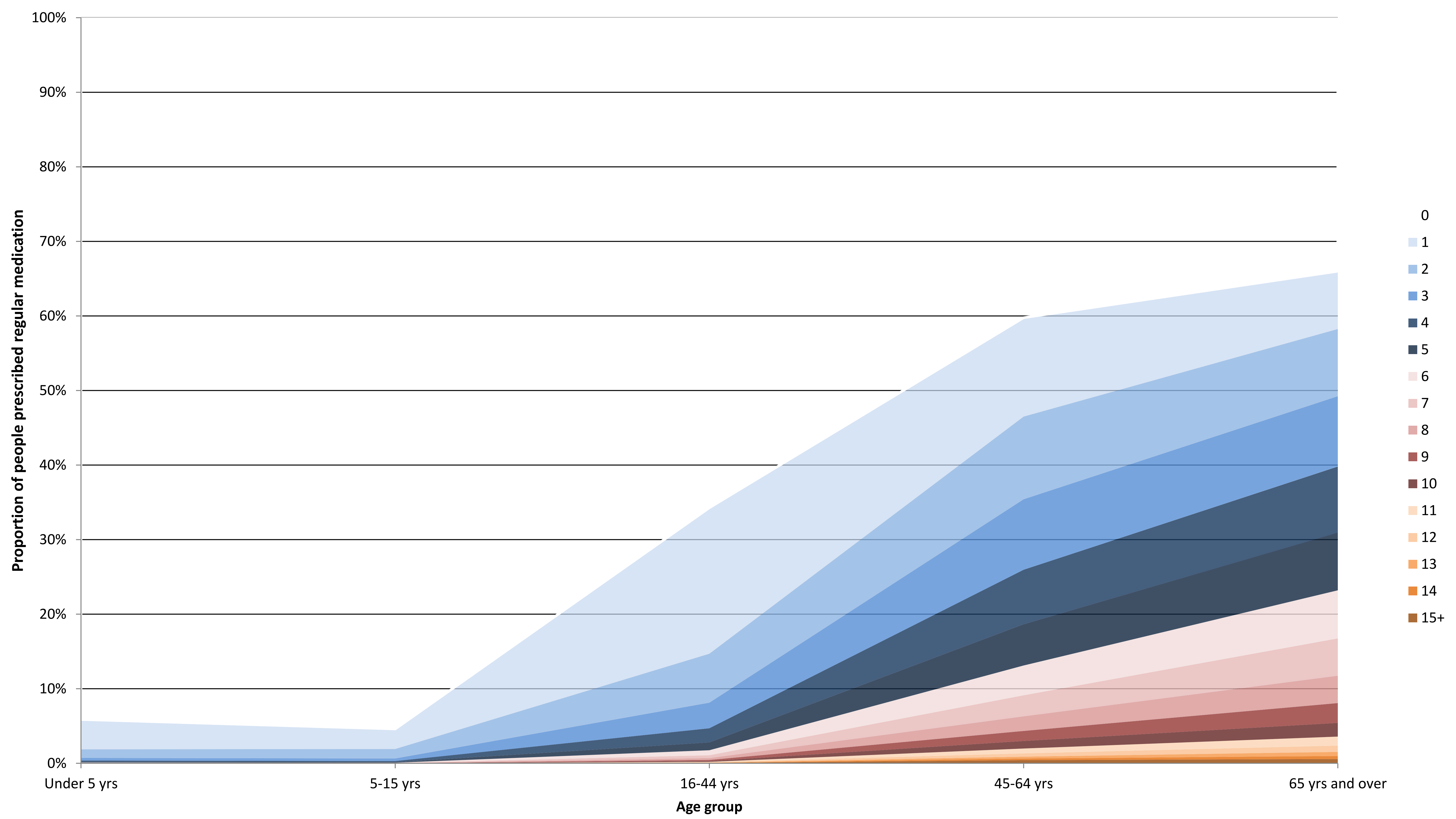

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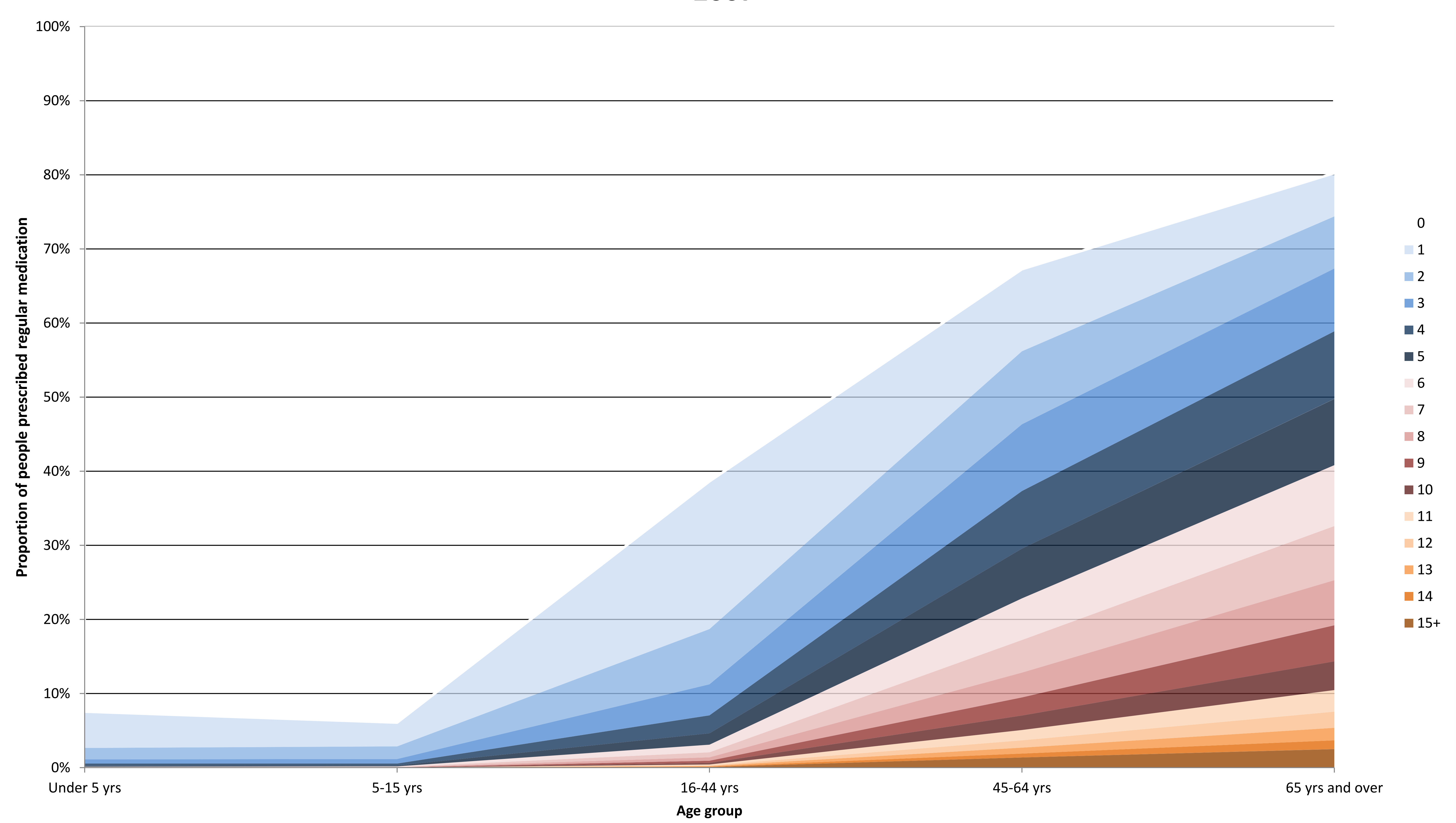
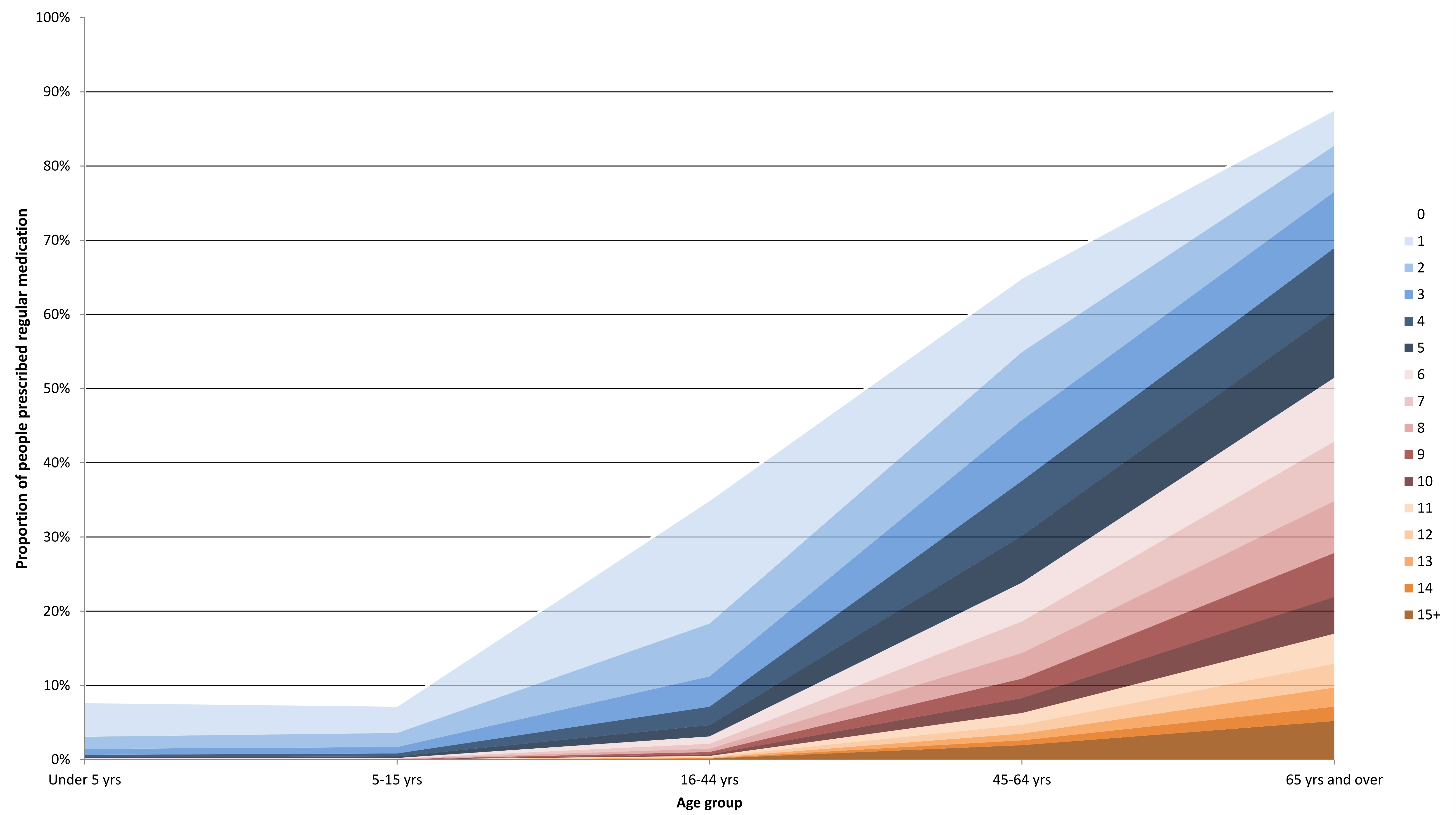


Proportion of GMS population by number of regular medicines



Patients with multimorbidity and polypharmacy: Scottish 7 Steps

Case 2: Multimorbidity without frailty | Right Decisions

Helga

- 58 yrs old female
- Works part time; carer for infirm husband and mother
- Diabetes; CVD (non-STEMI last year); High BP; A Fib; COPD; Chronic back pain; Depression and hypothyroidism
- Smoking 10/ day; alcohol 20 units/ week

- BP 150/85; BMI 35; HbA1c 86; eGFR 55

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Helga: Medications

- Aspirin 75 mg daily
- Metformin 1g tds; Gliclazide 80mg bd
- Pioglitazone 30mg od
- Salbutamol prn; becotide 100bd
- Levothyroxine 75 mcg daily; Citalopram 20mg od
- Amlodipine 10mg od; Atenolol 50mg od; Lisinopril 30mg od; Furosemide 40mg od
- Gabapentin 400mg tds; Diclofenac 50mg tds
- Omeprazole 40mg od

Any medication suggestions?

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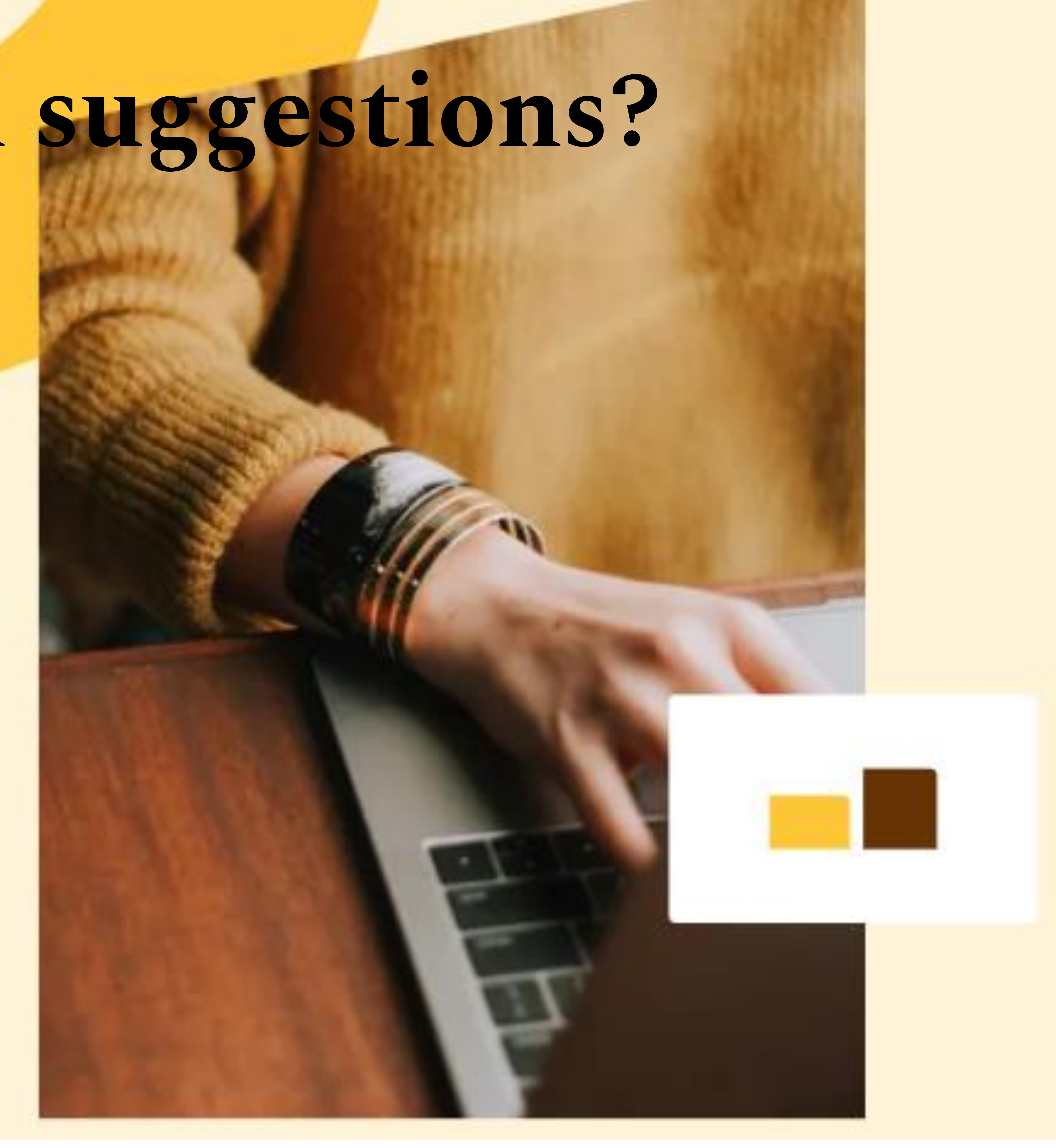

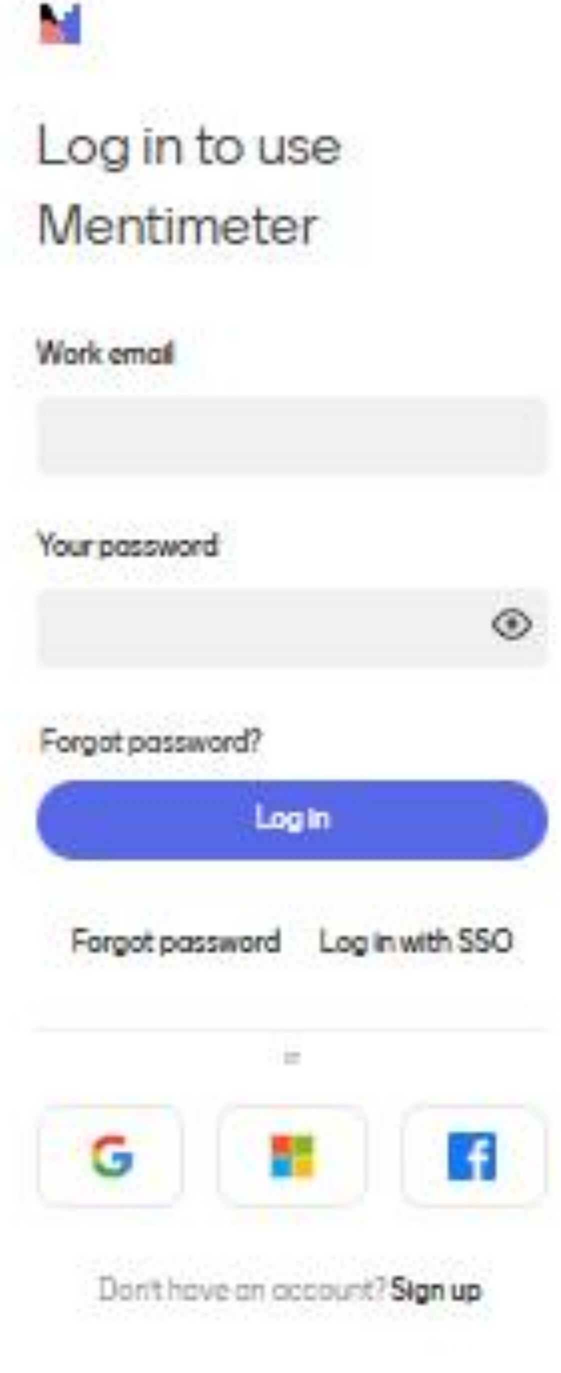

Patients with multimorbidity and polypharmacy: Scottish 7 Steps

Case 2: Multimorbidity without frailty | Right Decisions

(Possible) Registrar Learning Po

- Complexity of patient care:
  - Scottish 7 Steps
- GP Scholarship ....
  - Susan Smith, Emma Wallace, Frances Mair etc
- Consideration of practice / Pharmacist relationship

BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (Published 3 September 2012) Page 1 of 10

RESEARCH

Managing patients with multimorbidity: systematic review of interventions in primary care and community settings

OPEN ACCESS

https://doi.org/10.1136/bmj.e520

BMJ 2015;350:h176 doi: 10.1136/bmj.h176 (Published 20 January 2015) Page 1 of 6

CLINICAL REVIEW

Managing patients with multimorbidity in primary care

Emma Wallace *general practice lecturer*[1], Chris Salisbury *professor in primary health care*[2], Bruce Guthrie *professor of primary care medicine*[3], Cliona Lewis *general practice lecturer*[1], Tom Fahey *professor of general practice*[1], Susan M Smith *associate professor of general practice*[1]

https://doi.org/10.1136/bmj.h176

BMJ 2014;349:g6680 doi: 10.1136/bmj.g6680 (Published 10 November 2014) Page 1 of 2

EDITORIALS

https://doi.org/10.1136/bmj.g6680

Thinking about the burden of treatment

Should it be regarded as an indicator of the quality of care?

Frances S Mair *professor of primary care research*[1], Carl R May *professor of healthcare innovation*[2]

Patient profile: Mrs MN

86 years, widower, **DrVisitCard**

PMed Hx:
AFib, Heart failure, Parkinsons,
Mitral and tricuspid surgeries, Bilateral hip replacements

Medications (14):
Apixaban, bisoprolol, sinemet plus, digoxin, pantoprazole, ezetimibe/simvastatin, folic acid, midon, zopiclone, metolazone, prolia, quinine, bumetanide, nortriptyline

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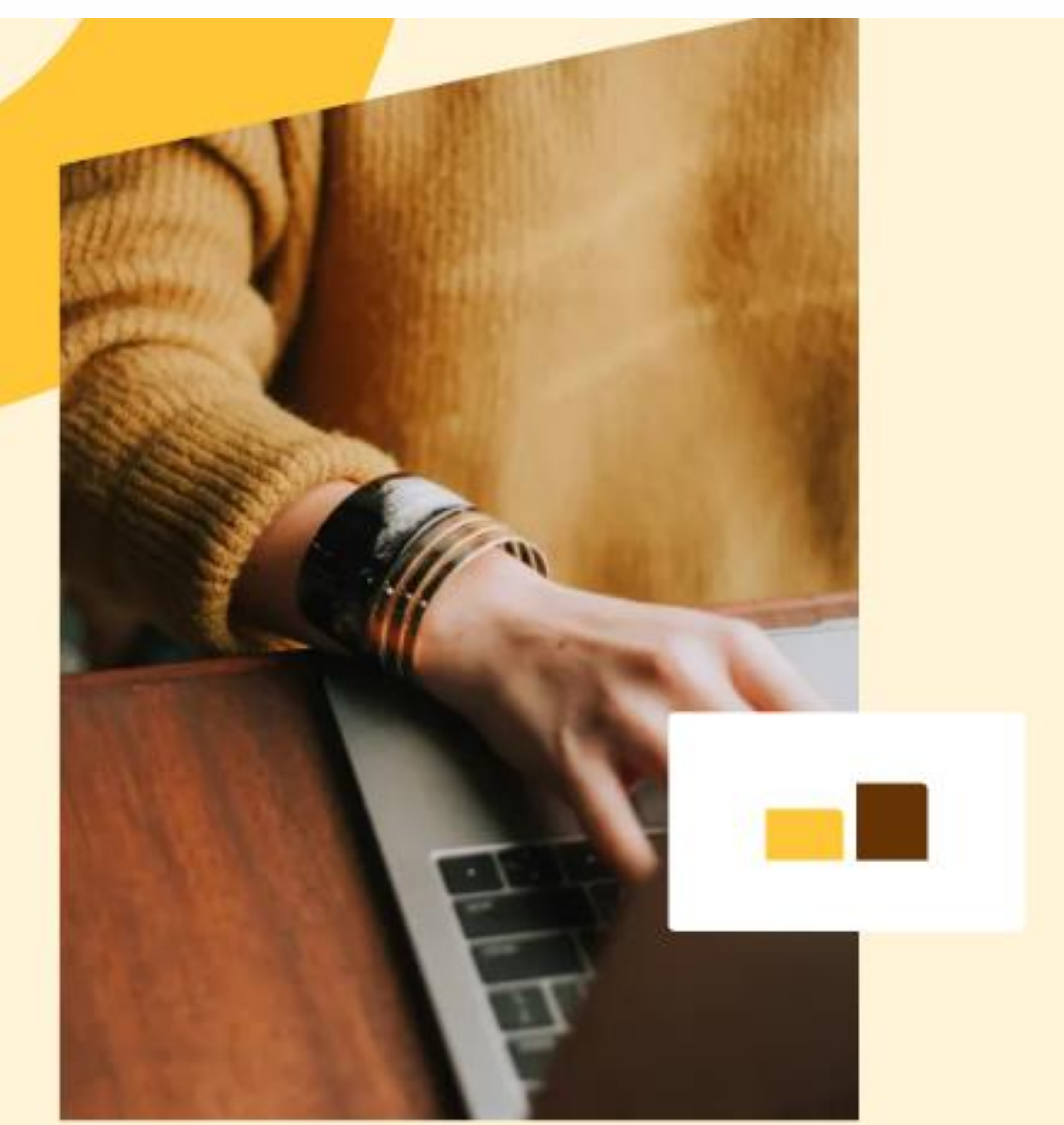

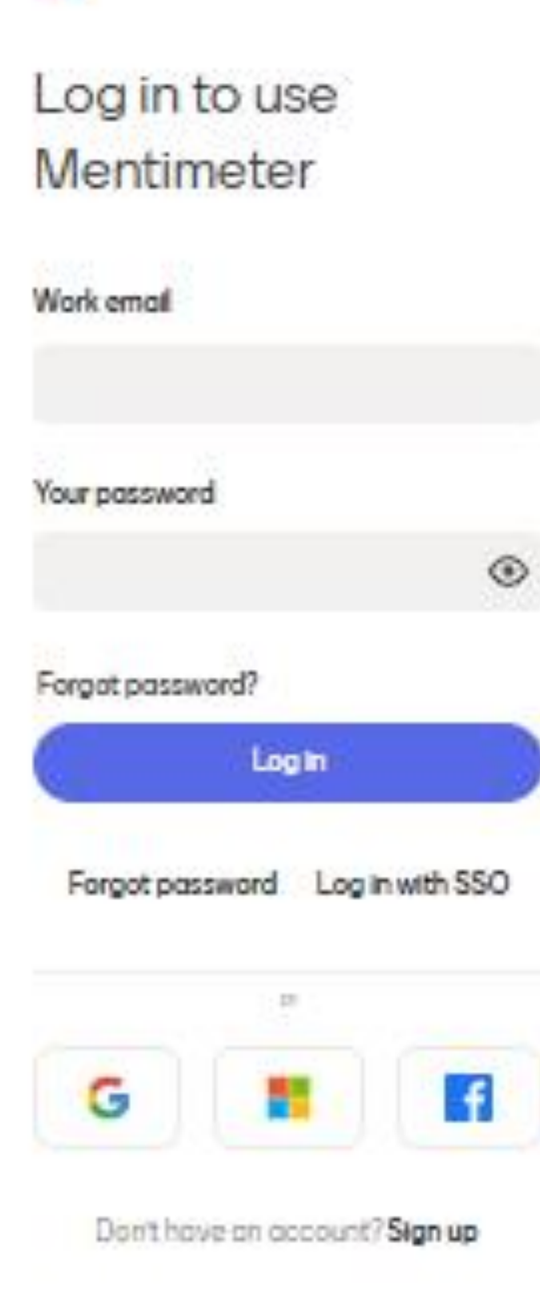

Consultation charges in Ireland deter a large proportion of patients from seeing the GP: Results of a cross-sectional survey

Dermot O'Reilly, Tom O'Dowd, Karen J. Galway, Andrew W. Murphy, Ciaran O'Neill, Ethna Shryane, Keith Steele, Gerry Bury, Andrew Gilliland & Alan Kelly

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Heart

https://doi.org/10.1136/hrt.2008.145912

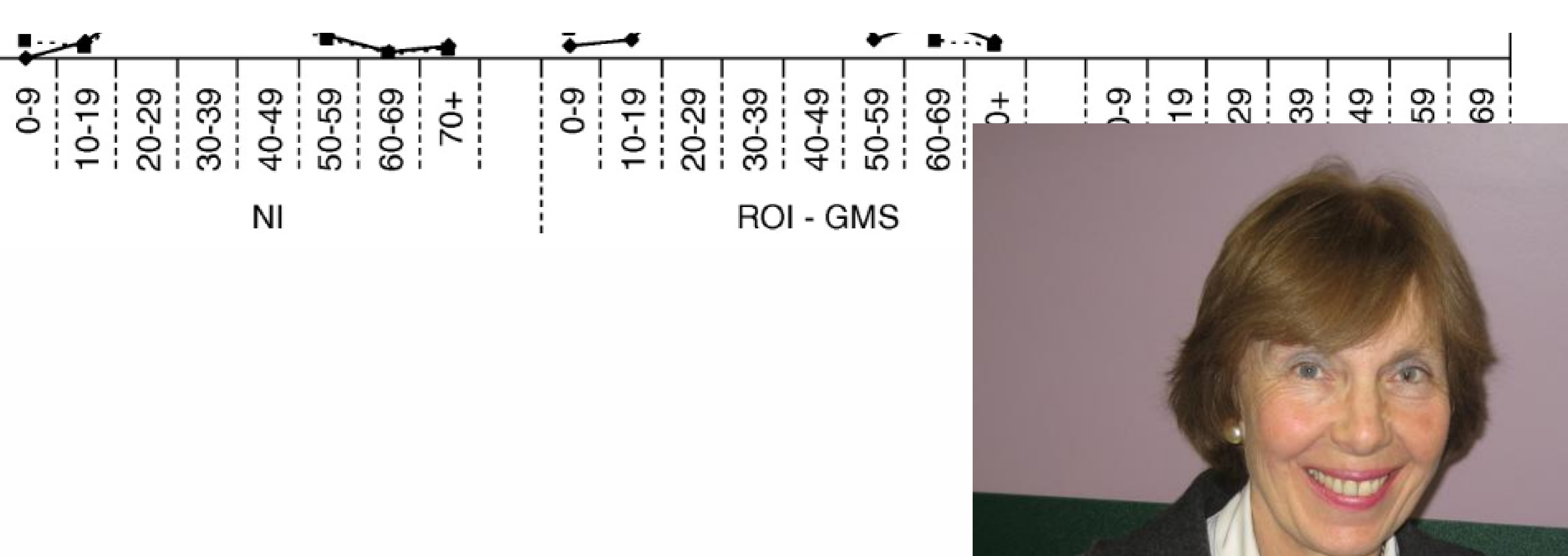
Original article
Epidemiology

Secondary prevention of cardiovascular disease in different primary healthcare systems with and without pay-for-performance

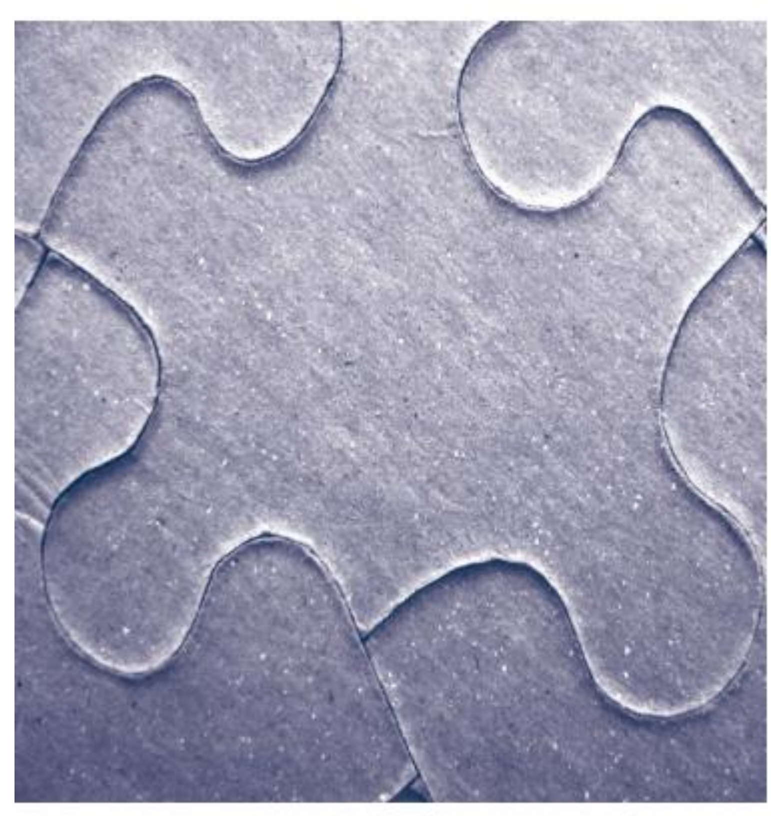
M E Cupples [1], M C Byrne [2], S M Smith [3], C S Leathem [1], A W Murphy [2]

Margaret E Cupples, Department of General Practice and Primary Care, Dunluce Health Centre, 1 Dunluce Avenue, Belfast BT9 7HR, UK; m.cupples@qub.ac.uk

Citation Tools



Policy impact: Access to a GP



Report of the Expert Group on Resource Allocation and Financing in the Health Sector

LATEST UPDATE:

BY JULY 2025, 199,418 PATIENTS OVER 70 YEARS AND 340,609 LESS THAN 8 YEARS, RECEIVING FREE GP CARE

be focused initially on supporting those with high levels of needs for services and should also be more closely related to incomes.

Timeline: A project on the development of a coherent framework and related systems of fees and capitation should be initialled before the end of 2010, with a completion date no later that the end of 2011.

https://www.esri.ie/system/files/publications/BKMNEXT171.pdf

(Possible) Registrar Learning Points

- Health seeking behaviour of patients by category
- Management of ‘assigned’ GMS patients
- Income streams of the practice

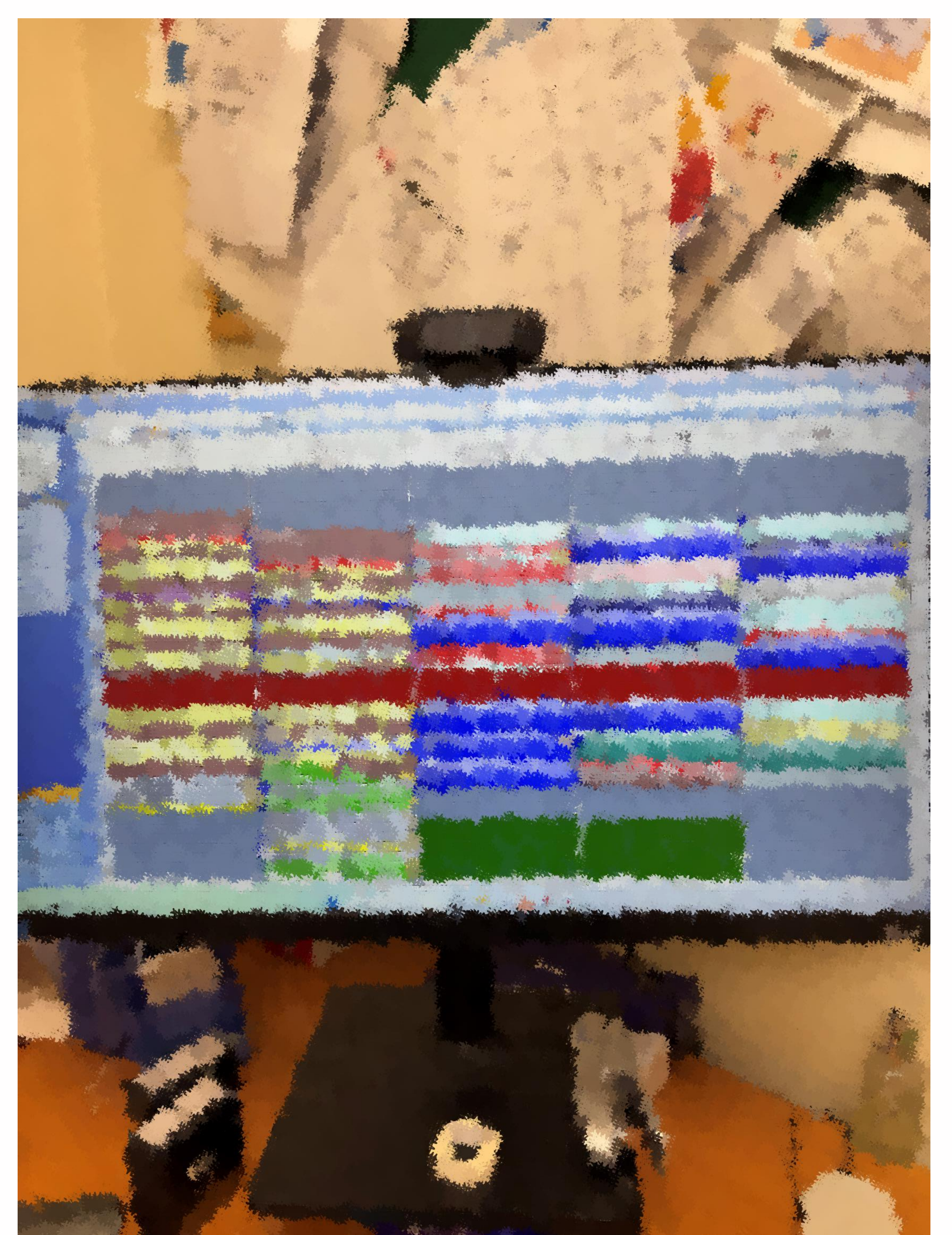
Aims

1. Outline examples of the impact research has had on Irish chronic disease management *(and ?Registrar learning points)*

2. **Discuss current research which emphasises the richness and busyness of current general practice**

3. Suggest future research approaches compatible with busy working GP lives

Current research: *'The hidden work of general practice'*



Social Science & Medicine 350 (2024) 116922

Fig. 1. Example of cartoon illustration of observed scenario.

https://doi.org/10.1016/j.socscimed.2024.116922

“There is never any rest, never enough time and too much to do”: A qualitative study of GP work intensity in an Irish context (*Holly Hanlon, …..Niamh Humphries*)

https://vimeo.com/reviews/42d05c6e-273f-41ad-98c7-ca2287dfc66e/videos/1176233212

(Possible) Registrar Learning Points

- Read the paper??
- Do they wish to have an ‘open or closed’ door?
- What sort of a GP do they wish to be?

Aims

1. Outline examples of the impact research has had on Irish chronic disease management *(and ?Registrar learning points)*

2. Discuss current research which emphasises the richness and busyness of current general practice

3. **Suggest future research approaches compatible with busy working GP lives**

Ollscoil na Gaillimhe
University of Galway

The RiSolve trial of an App for urinary incontinence in adult females: *Ireland's first fully remote and direct to patient regulated Trial*

S Boominathan, C Matthews, L Reddy, L O'Connor, AW Murphy, (University of Galway) & G Cundiff , E Carr, B Staunton, E McLucas (Amara Therapeutics)

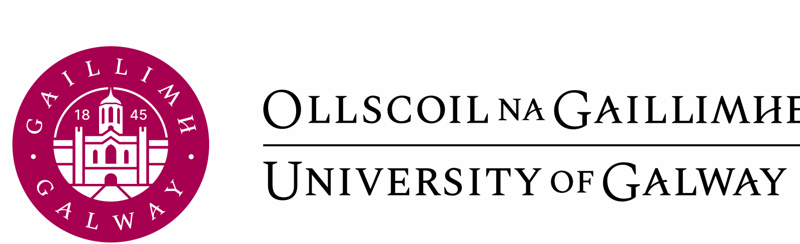
RiSolve *regulated* study outline

- Patients: Adult females with OAB
- Intervention: *CE marked* App with behavioural therapies including:
  - pelvic floor training, education around triggers and best practices, pilates, journaling, urge suppression and breathing techniques
  - focused cognitive-behavioural therapy
  - 1 module a week for eight weeks; c.2 hours per week
- Comparison: None
- Outcomes: Recruitment and retention; standardised questionnaires

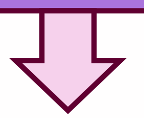
https://primarycaretrials.ie/risolve/

What was asked of GP's?

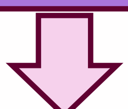
- To simply 'signpost' the study by placing a Poster in the waiting room – contact us and we will post it to you *and / or*
- By drawing attention of patients to the study through the QR code or contact details at risolvestudy@universityofgalway.ie
- ***Plus*** targeted social media



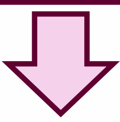
Recruitment (14/10/2025-21/11/2025)



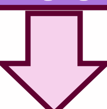
Total Expressions of Interest (n = 208)
204 *(98%)* via Social Media Advertisement
4 via GP Referral & Poster



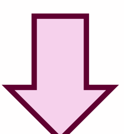
Invitation Emails Sent with Participant Information Leaflet (n = 174)



Participants Responded to Invitation (n =69)*(40%)*



Participants Screened (n = 60)



Participants Enrolled (n = 46)
Completed 8/52 Follow Up 38/46 (83%)
Adherence 71%

Discussion

- Very rapid (waiting list!) and, apparently, appropriate participant recruitment
- May have applicability to other common and impactful conditions; less so to significant conditions requiring medical assessment in recruitment and support
- Alleviates pressure on over extended general practitioners

The Present: MIDAS multi-arm trial *(Smith, S)*

Overarching aim to:

evaluate the clinical and cost-effectiveness of two multimorbidity interventions designed to support

a. GP's managing medicines and
b. Patients through social prescribing

https://bmjopen.bmj.com/content/15/6/e101315

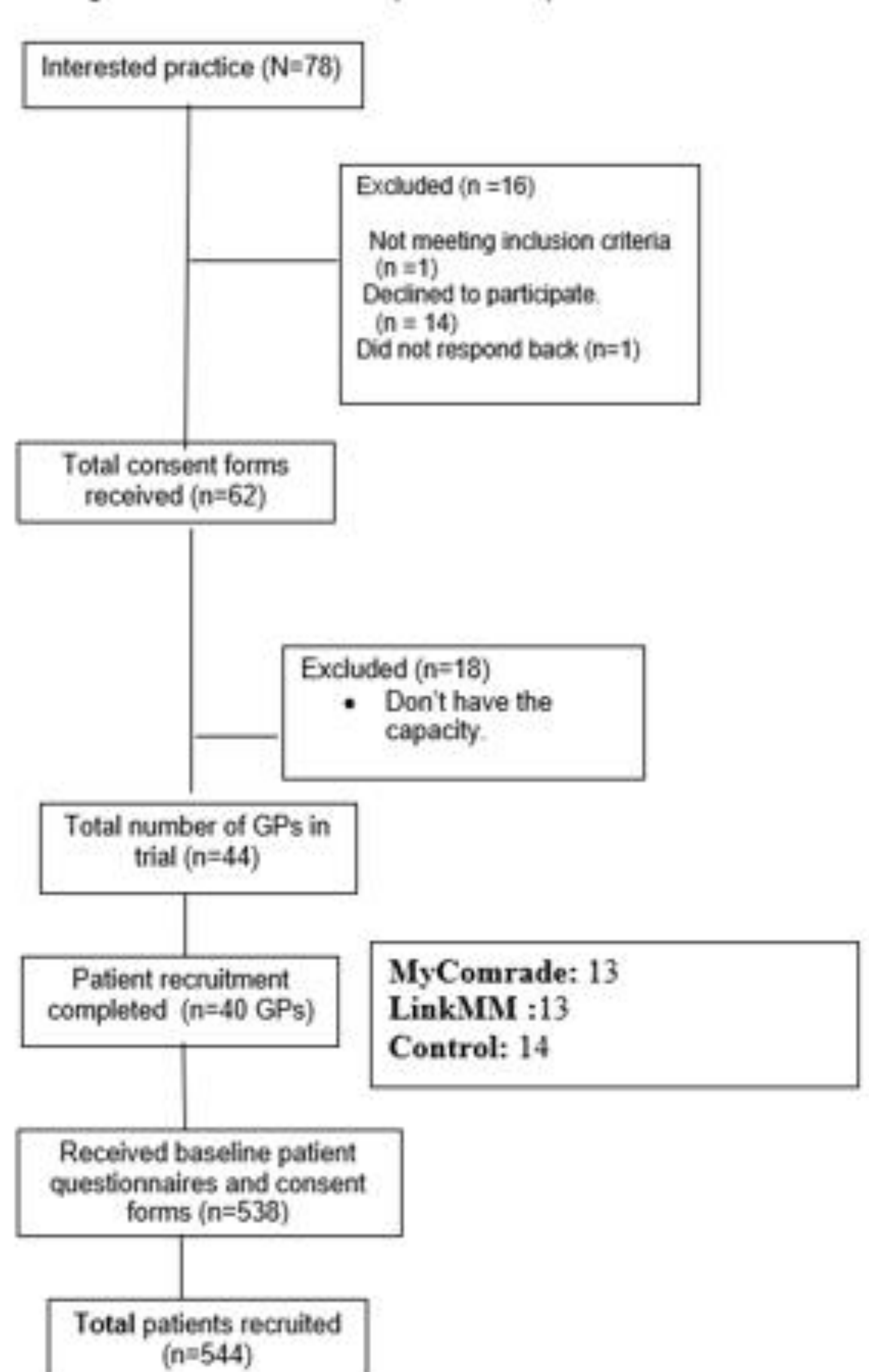


Figure: MIDAS practice recruitment (12.01.2026)
Interested practice (N=78)
Excluded (n =16)
Not meeting inclusion criteria (n =1)
Declined to participate. (n = 14)
Did not respond back (n=1)
Total consent forms received (n=62)
Excluded (n=18)
• Don't have the capacity.
Total number of GPs in trial (n=44)
Patient recruitment completed (n=40 GPs)
MyComrade: 13
LinkMM :13
Control: 14
Received baseline patient questionnaires and consent forms (n=538)
Total patients recruited (n=544)

OLLSCOIL NA GAILLIMHE
UNIVERSITY OF GALWAY

The Future: Trusted Research Environment

Schematic example of a trusted research environment (TRE) for Irish General Practice
(based on UK Health data Research Alliance 2021)

Patient → GP Practices → Data (coded and freetext) → Patient opt-out → Anonymised data

SAFE data

National linkage with other datasets, e,g.
- Cancer registry
- CSO
- HIPE
- PCRS

International linkages e.g. NIHR

Oversight (e.g. NREC)

Project Review requests

Transparency

SAFE projects

TRE

- Information governance framework
- Strategy and oversight
- Data quality
- Data requests

SAFE setting

AIRLOCK

Users:
Researchers
Policy makers
HSE

SAFE people

Summary data outputs

SAFE outputs

Conclusion:
Power of the 3 P's: patients, people and papers

Journal of Psychosomatic Research

Secondary prevention of coronary heart disease: Patient beliefs and health-related behaviour

Latest News | About Walsh Medical Practice | Doctor's Advice | Children's Health

Dr Mark Walsh

Joined Practice 1984

Qualifications: MB MICGP MRCGP MRCPI

Interests: Family Medicine, Sports & Exercise, Diabetes Care, General Practice Training, Medical Education and Travel Medicine.

Thank you

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