Service Development, Modernisation & Reform Measures, and Eligibility

Extract from the Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development

Service Development

- 1.1 Developing GP Services as Part of an Integrated Structured Chronic Disease Prevention and Management
- 1.2 Enhanced Special Items of Service

1. Service Development

1.1 Developing GP Services as Part of an Integrated Structured Chronic Disease Prevention and Management

A Chronic Disease Management Programme for over 430,000 General Medical Services and GP Visit Card patients will commence in 2020 and will be rolled out to adult patients over a 4-year period. The Programme is comprised of three components:

- Opportunistic Case Finding Programme – involving opportunistic assessment in order to detect and diagnose diseases at an early stage so that they can be appropriately managed.
- CDM Structured Programme – with two GP visits and two Practice Nurse visits a year.
- High Risk Preventive Programme – with one annual review.

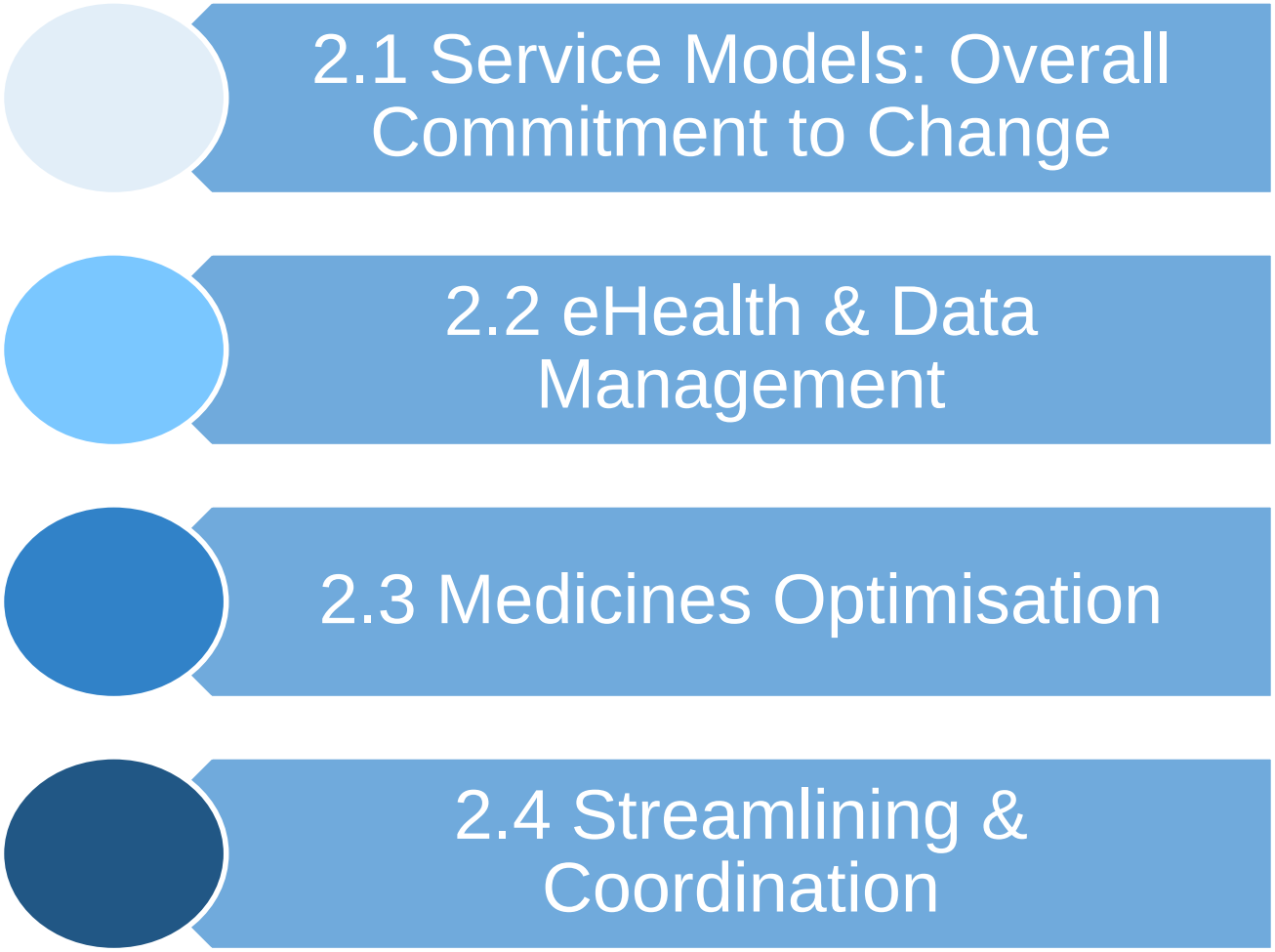
The first phase of the Programme will target patients over 75 years with the Opportunistic Case Finding and Preventive components of the Programme commencing in Year 2. The chronic diseases which will be included are:

- Diabetes Type 2.
- Asthma.
- Chronic Obstructive Pulmonary Disease (COPD).
- Cardiovascular Disease (Heart Failure, Ischaemic Heart Disease, Cerebrovascular Disease (Stroke/Transient Ischemic Attack [TIA]) & Atrial Fibrillation)

1.2 Enhanced Special Items of Service

- Haemochromatosis – Shift of activity from acute settings to general practice through provision of Therapeutic Phlebotomy for GMS / GPVC Patients est. 24,000 sessions benefiting 8,000 people in a full year.
- Involuntary Admissions Mental Health - securing GP participation in involuntary admissions est. 2,000 admissions in a full year.
- Virtual Clinics - Consultation between Consultant Cardiologists and GPs regarding patients with heart failure, who would otherwise be attending OPDs – 95% reduction on referrals for admission found in demonstrator site - 17,500 virtual clinic slots by 2022.

Service Modernisation & Reform Measures



2.1 Service Models: Overall Commitment to Change

2.1.1 Implementing Community Healthcare Networks (CHNs) And Associated Operating Model For Community Services (CHO)

GP Community Healthcare Network Lead will provide leadership in the following areas to:

- Clinical Leadership.
- Planning, performance & quality assurance.
- Service delivery and improvement.
- Communications.

GPs in Community Healthcare Networks will actively support the implementation of the CHNs and the GP Lead Role including:

Participation in Planning of services
The GP Lead will participate in the planning and prioritising of CHN services in line with the population needs. The establishment of CHNs will facilitate and support the local identification of needs, and service planning and decision making.
In order to facilitate local planning, area needs and decision making a bi -annual planning workshop led by the GP lead and attended by the local management team will be held. A GP from each practice in the CHN should attend this meeting at a minimum, building relationships with the HSE professionals on the Network Management Team. Such meetings shall be scheduled by the GP Lead being cognisant of the working commitments of local GPs.

Participation in Planning of Services - 2 workshops per year for 2 hours per workshop

Multidisciplinary Working & Care Planning
The Network Manager will lead multi-disciplinary team management and ways of working. The Network Manager, in conjunction with the GP Lead will support this care planning process as required including providing advice and guidance, re: prioritising resource to meet the determined needs, analysing trends in such cases and responding directly or seeking support of other services to do so.

GP Involvement will involve:

1. Referring any patients designated as a complex case and requiring discussion at a clinical team meeting (see Criteria for Referral to Clinical Meeting-agreement document) to the appropriate Clinical Coordinator.
2. Attending clinical team meetings and discussing their relevant cases, approximately one hour a month per GP or GP Practice. In exceptional cases where the GP is unable to attend for any reason the GP should discuss with the case manager.
3. Giving clinical input where required.
4. Ensuring that their own clinical notes are updated in accordance with the care plan.
5. Where the GP sees it as necessary given his/her relationship/knowledge of the patient the GP may agree to act as a Key Worker.
6. Ensuring that the Clinical Coordinator is aware of any relevant updates in the patient's case note discussed at a clinical team meeting.

2.1 Service Models: Overall Commitment to Change

2.1.1 Implementing Community Healthcare Networks (CHNs) And Associated Operating Model For Community Services (CHO)

Multidisciplinary Working & Care Planning - Attendance at equivalent of 1 clinical meeting per month for 1 hour (per GP or per GP practice)

Protocol for GPs practicing across different CHNs
While GPs may attend any of the bi-annual CHN planning workshops relevant to their patient's geographic location, they should attend two planning workshops per annum of the CHN in which their main practice premises is located.

- Recognising the professional duty of GPs to care for all their patients regardless of CHN location, GPs will attend 12 clinical meeting of 1 hour duration per annum.
- Where a GP Practice has patients in multiple CHN areas, the relevant CHN clinical coordinators will liaise with each other to run meetings at an agreed time within the scope of the 12 meetings.
- Where there are competing meetings which cannot be coordinated the GP shall not be obliged to attend more than their obligation but will continue to liaise with clinical coordinator as per current professional practice.

Referrals and prioritisation
GPs will participate in the use of standardised integrated care referral pathways across CHNs and/or with acute hospital services particularly those focused on clients with complex needs and/or chronic disease. This will be underpinned by the development of waiting list management processes.

Population Risk Stratification
HSE Public Health & Clinical Programmes will provide guidance and support in relation to appropriate methodology of population risk stratification. GPs will be required to support the identification of clients either from a medical condition perspective or from indicators of levels of dependency e.g. frailty. This will be achieved in a number of ways:

- Opportunistically as clients access services of GPs and have agreed medical conditions or other characteristics.
- Clients who emerge through the multidisciplinary team meetings and where it is deemed appropriate.

Anticipated out comes of GP involvement in CHN

- Coordinated multidisciplinary care approach to care provision.
- Improved service user and Contractor experiences.
- Improved integration of community healthcare services and integration between community Healthcare and acute hospital services.
- GP involvement in the management process within the CHO Operating Model.

2.1 Service Models: Overall Commitment to Change

2.1.1 Implementing Community Healthcare Networks (CHNs) And Associated Operating Model For Community Services (CHO)

Community Healthcare Networks:

GP Lead Role:

- Clinical Leadership.
- Planning, performance & quality assurance.
- Service delivery and improvement.
- Communications.

Network GPs:

- Participation in Planning of Services - 2 workshops per year for 2 hours per workshop.
- Multidisciplinary Working & Care Planning - Attendance at equivalent of 1 clinical meeting per month for 1 hour (per GP or per GP practice).
- Referrals and prioritisation / linked to ICT e-referrals.
- Population Risk Stratification - in line with the nationally accepted population health "pyramid" used in identifying high risk approx. 4 % high risk and 1% very high risk which includes client groups such as chronic disease and also frail elderly**.**

2.1 Service Models: Overall Commitment to Change

2.1.2 Support for and cooperation with hospital waiting-list validation exercises and the National Centralised Validation Unit

- Following up in a timely fashion with the HSE/ National Centralised Validation Unit on those patients who have either been removed from a waiting list because of non-response to the validation letter or who have requested removal themselves as set out below:
    - When a patient receives a validation correspondence (while not advised to) some patients may contact their GP for advice. On completion of a hospital validation cycle; there are a number of potential patient outcomes:

1. Patient responds and requests to remain on the waiting list – no action required by the GP.
2. Patient responds and indicates that they no longer require hospital care – these patients are reviewed by the hospital and where appropriate removed in line with the National Inpatient, Day Case, Planned Procedure Protocol (the "IDPP Protocol 2017"). The patient and the source of referral must be notified of this in writing by the hospital.
3. Patient fails to respond to the validation correspondence - these patients are reviewed by the hospital and where appropriate removed in line with the National Inpatient, Day Case, Planned Procedure Protocol (the "IDPP Protocol 2017").

The patient and the source of referral must be notified of this in writing by the hospital.

- In relation to outcomes 2 and 3 where a GP is notified by letter that the patient has been removed from the waiting list there is an option for reinstatement (at the original date) should the GP deem this appropriate.
- In order to establish whether or not reinstatement is required it may be necessary for the GP to communicate with both the patient and the hospital in a timely manner.

2.1.3 Making Every Contact Count (MECC)

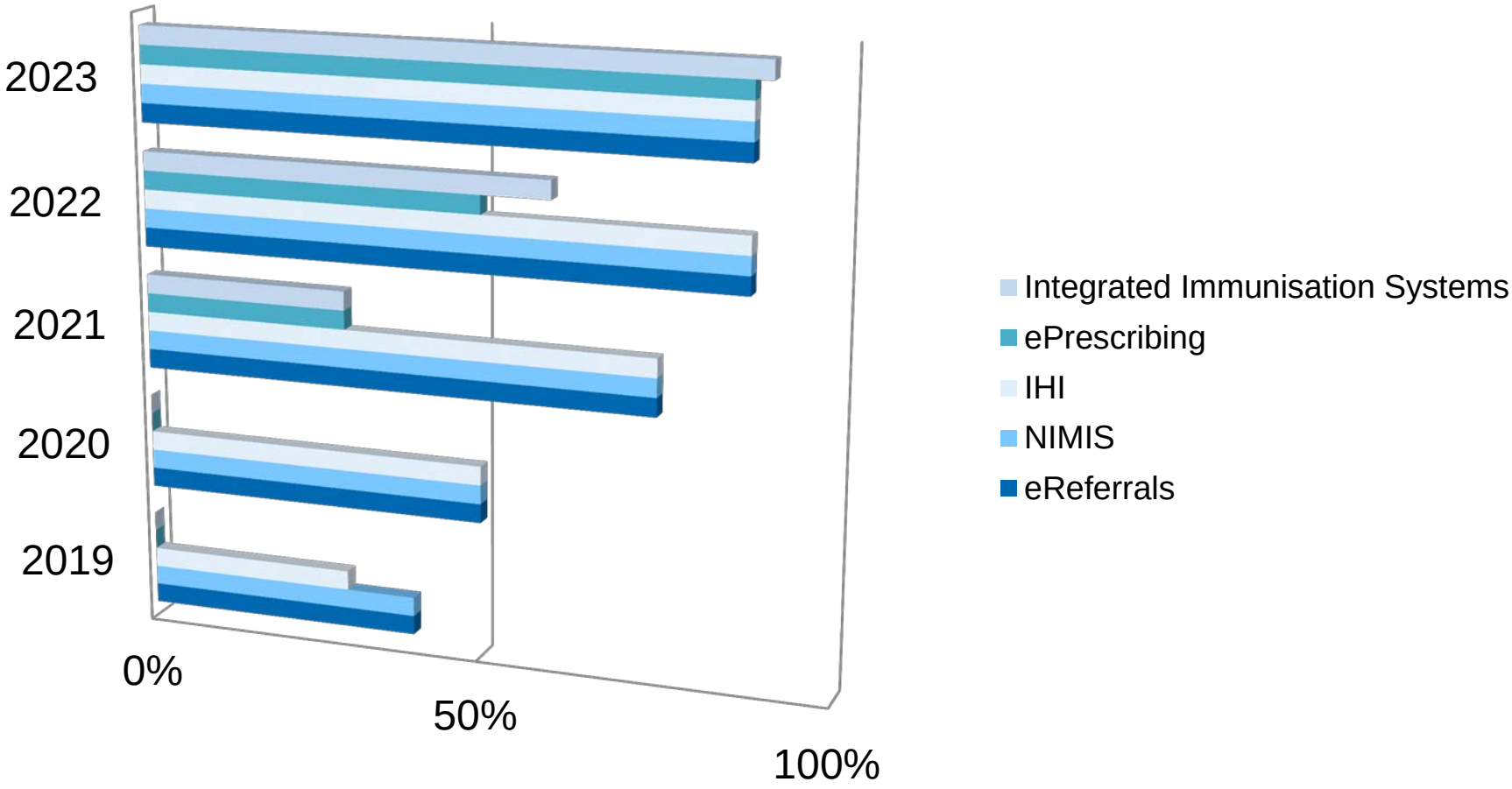
- Ensure that MECC is applied to all patients who come to the GP surgery, as appropriate**.**

2.1.4 Children First National Guidance for the Protection and Welfare of Children

- Ensure that all practice staff undertake and complete the relevant training as set out and any updated modules as they become available. The free online Children First training support is e-learning module is available on http://childrenfirst.hseland.ie/**.**

2.2 eHealth & Data Management

eHealth Sign-Up, Usage & Adoption Rates



2.2 eHealth & Data Management

2.2.1 IHI

- Comply with the national IHI programme and incorporate IHI numbers for all patients on practice systems on a phased basis over the next 4 years.

2.2.2 eReferrals

- GPs to utilise eReferral system and agree to uptake usage over a phased basis.

2.2.3 ePrescribing

- GP cooperation and participation in the design and development of the IT solution for ePrescribing over 18 to 24 months.
- Once fully integrated, there will be a phased approach to uptake by GPs, with ePrescribing to commence in 2021 with continued uptake from GPs through to 2023 in line with the phasing outlined below.

2.2.4 NIMIS

- GPs to fully uptake the usage of NIMIS once fully rolled out nationwide.

	2019	2020	2021	2022	2023
IHI Patient Sign Up Rates	30%	50%	75%	85-90%	
eReferrals Usage	40%	50%	75%	85-90%	
ePrescribing Adoption			30%	50%	85-90%
NIMIS Usage	40%	50%	75%	85-90%	
Integrated Immunisation Systems			30%	60%	90%

2.2 eHealth & Data Management

2.2.5 Summary and Shared Care Records

- Summary and Shared Care Records will be populated for GMS/GPVC and private patients.
- The IMO agree to support the development and deployment of the Summary and Shared care records within the lifetime of the Agreement.
- GPs will maintain the patient data required to populate the Summary and Shared Care Records on their accredited GP Practice System.
- The data set required for the Summary Care Record has been defined in the Terms of the Agreement.
- If informed consent is required, the HSE will engage with the IMO on the details of how this will be implemented in practice.
- The HSE will promote the adoption of Summary and Shared Care Records.

Whilst the GP will have the facility to sign up patients for the Summary and Shared Care records on their Practice System, the HSE will not be solely reliant on the GPs to sign up patients.

2.2.6 Integrated Immunisation Systems

- GPs will cooperate with the development and deployment of an integrated solution for immunisations (to include a reimbursement module) to go live in 2021.

2.2.7 Healthlink

- Continued adoption of Healthlink by GPs as the primary mechanism to facilitate other eHealth related services e.g. IHI, e-referrals, ePrescribing, NIMIS ordering and other relevant data returns, etc.

2.2.8 Healthmail

- Continued adoption of Healthmail as the primary mechanism for secure communication of unstructured health related messages
- Adoption of Healthmail as a mechanism to reduce our reliance on unsecure and non GDPR compliant solutions such as fax machines
- Protocol agreed and adopted in relation to the use of Healthmail between GPs and the wider health care service.

2.2.9 Use of PCRS Application Suite

- GPs to continue to submit reimbursement claims electronically.
- GPs will operate the online choice of doctor functionality to facilitate electronic registration of all approved medical card, GP visit card and Under-6 applications.

2.2.10 MedLIS

- GPs located in the areas of hospital roll out (Beaumont, Cavan, The Mater and St James) to use MedLIS functionality (Powerchart) to order online for the four hospitals as it is rolled out.
- A review will be undertaken and until the review is completed and further discussions are held with the IMO, no further roll out of GP ordering will proceed beyond these four sites.

2.3 Medicines Optimisation

2.3.1 Medicines Usage Review
2.3.2 New Medicinal Products-prior Authorisation/Approval Measures
2.3.3 Systemic Interventions On Existing Medicinal Products
2.3.4 Oral Nutrition Supplements (ONS)
2.3.5 Effective Medicine Management

Medication Reviews

GP reviews the pharmacist's recommendations and can either:

- Discuss with the patient as necessary and make the recommended changes to the prescription.
- Discuss with the patient and make partial changes to the prescription (patient centred preferences and capabilities need to be taken into account).
- Decide that recommendations are not appropriate in certain cases and provide reason for same.
- Cooperate with follow up reviews undertaken by the HSE pharmacist's recommendations.

Cooperation with Clinical Guidelines for ONS

- GPs will cooperate with the HSE's administrative system for ONS, including adherence to preferred list of products and prior authorisation by exception requirements where alternative products are being prescribed.

2.4 Streamlining & Coordination

2.4.1 Contract Suspension, Sanction and Termination and Dispute Resolution Procedures

2.4.2 Complaints Policy and Procedure

2.4.3 Practice Profile

2.4.4 Assurance Arrangements

2.4.5 Premises Standards

2.4.6 Patients With Violent Or Abusive Behaviour

2.4.7 Reduction Of Succession Timeframe for GMS Lists

2.4.8 Setting of Fee Rates

2.4.9 Framework Agreement

2.4.10 Paternity & Maternity Leave

2.4.11 Allocation of Funding to Support General Practice in Areas of Deprivation

2.4.12 Average Weighted Panel Calculations

2.4.13 HSE & IMO On-Going Process of Engagement

2.4.14 Engagement on Agreement

2.4.15 Dispensing Doctors Arrangement

2.4.16 Review of Under 6s Contract

2.4.17 Assessment & Confirmation Process

- Replace the Disciplinary and Dispute Resolution Procedures with relevant procedures from the Under 6 Contract.
- GPs to implement patient centred Complaints Policy and Procedure.
- GPs to assist in compilation of profile of GMS Practices and with the on-going updating of same.
- GPs to implement Annual Compliance Assurance Process.
- Premises standards updated.
- Joint HSE/IMO working group to assess the prevalence of violent or abusive behaviour in General Practice and following same to pilot and evaluate a model of service.
- Joint HSE/DOH/IMO working group to review current circulars pertaining to succession arrangements to GMS panels and arrangements for filling vacant lists, including succession arrangements in the case of registered partnerships. Group to make recommendations aimed at updating and consolidating current circulars.
- Acknowledgement by Parties of statutory basis for setting fee rates under the Public Service Pay and Pensions Act 2017.
- Paternity Leave provisions to be increased from 3 days to 2 weeks.
- Changes to Average Weighted Panel calculations to be introduced in defined circumstances such as where a GP, at HSE's request, amalgamates a vacant panel with his/her own panel. To include situations where, subject to HSE prior approval, a vacant GMS panel is taken over by surviving partner(s) in a registered partnership.
- IMO/HSE Process of engagement to commence in June 2019.
- Dispensing Doctors in receipt of the fee rates alluded to at 2.4.15 shall implement HSE's enhanced quality assurance and accountability requirements.

3. Eligibility

The agreement acknowledges the Minister for Health's intention to bring forward proposals for extension of GP care without fees to children aged 6 -12 on phased from 2020, and that the contractual terms for this will be negotiated with the IMO.