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Circular Number: NCO-01-2022

Re: Phase 2 of the Structured Chronic Disease Management Programme in 2022

Dear Doctor,

1. Introduction

As you will be aware the joint HSE, Department of Health and IMO GP Agreement of May, 2019 provides for a significant multi-annual investment in General Practice in terms of increases in fee rates under the GMS Capitation Contract(s) (i.e. Medical Card and GP Visit Card Capitation Contracts), the introduction of new services such as Structured Chronic Disease Management in General Practice, implementation of service modernisation and reform measures in General Practice and the introduction of measures aimed at sustaining General Practice in the years ahead.

The purpose of this circular is to inform you of the new/enhanced services coming on stream in 2022 pertaining to Structured Chronic Disease Management, Modified Chronic Disease Management, Opportunistic Case Finding and the Prevention Programme.

2. Chronic Disease Management (CDM) Programme with the Modified Chronic Disease Management (MCDM) as a delivery option in 2022.

Circular NCO-04-2020 dated 13th of January 2020 outlined arrangements for the introduction in General Practice of the first phase of a Structured Chronic Disease Management (CDM) (Treatment) Programme for eligible patients aged 75 and over. Circular NCO-09-2020, issued 30th of June 2020, outlined details of a Modified Chronic Disease (MCDM) delivery option for eligible patients aged 70 years and over in response to the current public health crisis.

Phase 2 of the Structured Chronic Disease Management Programme will be introduced from January, 2022 and will allow participating GPs who have signed up to the new GP Agreement and also opted in for the Structured CDM Programme to provide the Structured Chronic Disease Treatment Programme to their eligible patients aged 18 years and over who have a diagnosis of one or more of the following conditions as set out in the GP Agreement 2019;

- Asthma,
- Type 2 Diabetes,
- Chronic Obstructive Pulmonary Disease (COPD),
- Cardiovascular Disease including:
    - Stable Heart Failure,
    - Ischaemic Heart Disease,
    - Cerebrovascular Disease (Stroke / TIA) and/ or
    - Atrial Fibrillation

To support eligible patients in managing their chronic condition(s) throughout 2022 it has also been agreed that the Modified CDM (MCDM) reviews will continue to operate until 31st December 2022 as a delivery option under the Chronic Disease Treatment Programme and will apply to eligible patients aged 18 years and over with one or more of the aforementioned conditions.

By reviewing the eligible patient's medical background, using clinical judgement in consultation with the patient and with due regard to public health advice in the context of an evolving situation in relation to Covid-19 during 2022, participating GPs will determine which of the Chronic Disease Treatment Programme delivery options is appropriate i.e. a CDM in surgery review or a remote MCDM review.

To support patients in managing their chronic condition(s) there are two scheduled reviews in a 12 month period (Annual Review & Interim Review) as set out in the GP Agreement with an interval of at least four months between each scheduled review. Each 12 month period is a 12 month window which commences on the anniversary of the initial Chronic Disease Treatment Registration visit. Following the first Treatment Programme review, the next review (Interim Review) should take place no earlier than 4 months after. If an Interim Review does not take place within the 12 month window the next review will be an Annual Review. The rules as set out above apply to the MCDM reviews also.

It is envisaged that each of the scheduled reviews will require a visit to the GP and to the Practice Nurse. The scheduled reviews should be planned so they are of optimal value to the patients and the practice team; for example, if the patient is due to have a consultation with their GP, any planned investigations should be carried out by the Practice Nurse prior to the GP consultation thereby ensuring that results of such investigations are available to the eligible patient's GP for each scheduled review. Where blood tests are less than three months old at the date of the in surgery CD Treatment Programme Review the blood results can be populated from the existing patient chart or record, otherwise the bloods will need to be repeated and results available prior to the GP consultation.

The MCDM reviews should take place over a scheduled phone / video call with the eligible patient. Once a modified review is submitted, it is not possible to add to it later to transform it into a full review. During the course of this remote review, the participating GP may determine, using his/her clinical judgement with due regard to the public health situation and in consultation with the eligible patient, that the eligible patient requires an in surgery attendance for a full chronic disease review including phlebotomy. Participating GPs may request that the patient attends in person and following completion of the physical exam, the participating GP can make the full data return to the HSE. Only one data return can be made in respect of a CDM Treatment Programme scheduled review, i.e., either a modified review data return or a full CDM data return.

A written Care Plan must be issued by the participating GP to the eligible patient following the completion of the CDM/MCDM review regardless of whether the review is a remote review or an in surgery review.

Eligible patients aged 18 years and over who are registered under the Diabetes Cycle of Care and / or the Heartwatch Programme will need to be transitioned onto the Structured Chronic Disease Management Programme. Payments under the Diabetes Cycle of Care and Heartwatch Programme will cease for such patients from the month that the first data return following either the in surgery or MCDM review under the Structured Chronic Disease Treatment Programme is received from the GP by the HSE's Primary Care Eligibility Reimbursement Services (PCERS). The data return must be received by the HSE during the calendar month following the first scheduled review under the Structured Chronic Disease Programme. Otherwise payments under the pre-existing Programmes will be deemed to have ceased on the calendar month that the first scheduled visit occurred.

A patient can only be registered in one element of the overall Structured CDM Programme (OCF, PP or Treatment Programme) at any one time. While a patient can be registered on the PP or Treatment Programme on the same day an OCF Assessment takes place, the OCF assessment must be completed and submitted prior to registration on PP or Treatment programme being commenced.

3. Opportunistic Case Finding (Surgery based assessment only)

Opportunistic Case Finding (OCF) will commence from January 2022 for eligible people aged 65 years and over and involves a process whereby, on an opportunistic basis (i.e. when a patient attends for another issue and the patient is not already registered on the Structured CDM Programme) they are offered an OCF assessment which is undertaken in accordance with a set of risk criteria and appropriate tests/assessments are carried out to identify those with an undiagnosed chronic disease or those at high risk of developing a chronic disease.

OCF assessments will be carried out in line with the 2019 GP Agreement.

The three likely outcomes from the OCF assessment are as follows:

i. Diagnosis of a Chronic Disease covered by the CDM Programme – such eligible patients may then be registered by their GP on the Structured Chronic Disease Management Treatment Programme.
ii. Patient deemed to be at High Risk of developing a Cardiovascular Disease and/or Diabetes. Such eligible patients may then be registered by their GP on the Prevention Programme.
iii. Patient deemed to be Low Risk - stage 1 hypertension and with no target organ damage will be excluded in the current Structured CDM Programme. **Repeat OCF assessments will take place no earlier than 5 years after the previous OCF assessment.**

Rules for entry on to the CDM Treatment Programme post OCF assessment

- Patient diagnosed with one or more of the Chronic Diseases outlined in the Structured CDM Programme should be registered and their first Annual CDM Treatment review to occur ideally within 4 months from the OCF assessment date.
- The patient can be registered on the CDM Treatment Programme on the same day as the OCF Assessment.
- If blood tests are less than 3 months old at the date of the Treatment Programme review the blood tests do **not** need to be repeated and can be populated from the patient chart.
- If blood tests are more than 3 months old at the date of the Treatment Programme review the blood tests will need to be repeated.
- Once the eligible patient is registered on the CDM Treatment Programme all subsequent CDM Treatment reviews should then follow the normal rules set out for the CDM Treatment Programme.

4. Prevention Programme (Surgery based review only).

The Prevention Programme will commence from January 2022 for eligible people aged 65 years and over who following an OCF Assessment are deemed a high risk of developing:

- Cardiovascular Disease and / or,
- Diabetes.

Eligible patients who are found to be High Risk may be registered in the Prevention Programme and will receive one scheduled review in a 12 month period. It is envisaged that this scheduled review will require two visits, one to the GP and one to the Practice Nurse. An annual review of risk factors in line with the 2019 GP Agreement will be carried out where medications and the self-management care plan will be reviewed and additional supports provided and/or referrals made. Appropriate medical treatment (e.g. for hypertension, smoking cessation, blood lipids) will be prescribed and appropriate blood tests carried out. A written Care Plan must be issued by the participating GP to the eligible patient following the completion of the Prevention Programme review.

Rules for entry onto the Prevention Programme post OCF assessment;

- The eligible Patient should be registered on the Prevention Programme and their first Annual review to occur ideally within 4 months from the OCF assessment date.
- The patient can be registered on the Prevention Programme on the same day as the OCF assessment.
- If blood tests are less than 3 months old at the date of the Prevention Programme review the blood tests do **not** need to be repeated and can be populated from the patient chart.
- If blood tests are more than 3 months old at the date of the Prevention Programme review the blood tests will need to be repeated.
- Annual Prevention Programme reviews should take place no earlier than 9 months from the date of the previous Prevention Programme review.

5. Nursing Support

In line with the objectives of the original Agreement, to augment Practice Nursing capacity, the following grant payment rates will apply:-

- **CDM Treatment Programme & Modified CDM (MCDM)** - a grant of €28.75 per registered eligible patient for CDM or Modified CDM (MCDM) will be paid in 2022 provided that all Treatment Programme / MCDM data returns for registered eligible patients during 2020 and 2021, have been submitted within 12 months of the first review undertaken in 2020 & 2021. For new Treatment Programme registrations occurring during 2022, the grant payment will be made provided that one data return has been received by the HSE in respect of the registered eligible patient on or before the 1st of July 2022 at 23:59:00.
- **Prevention Programme -** a grant of €14.35 per registered eligible patient will be paid in 2022 provided that the Prevention Programme data return has been received by the HSE on or before the 1st of July, 2022 at 23:59:00
- **Opportunistic Case Finding (OCF) –** a rate of €3.20 will be paid in 2022 per patient assessed under the OCF Programme provided that the data return has been received by the HSE on or before the 1st July, 2022 at 23:59:00.

6. Modifications to IT Systems

In line with the original agreement and as with Phase I of the CDM Programme the GP Practice systems will be modified and upgraded to support Phase II of the CDM programme, which as mentioned includes both the Opportunistic Case Finding and Prevention Programmes. This will involve an expansion of the existing GP Practice systems CDM module with new screens and options for both Programmes. The Clinical Data Repository (CDR) will also be re-configured and expanded to support the new data provided by the new Programmes. All systems will also be upgraded to support the cohort of patients eligible for the CDM and MCDM, i.e., patients 18 years and older. This will be live from January 2022. Such software updates/enhancements to support the needs of the CDM Programme have been fully funded by the HSE, and will not give rise to any related software development, maintenance or support costs for the individual GP.

The fee structure and fee rates for the Structured Chronic Disease Management Programme, which includes the delivery option of the Modified Chronic Disease Management (MCDM), Opportunistic Case Finding (OCF) and Prevention Programme and Practice Nursing Grant are set out in Appendix 1 Tables 1 ,2 3 & 4 to this Circular.

If you have not yet opted in to provide the CDM Programme and wish to do so in accordance with the agreed terms, conditions and standards, as set out in the 2019 Agreement, please complete and sign the attached "Opt in" Confirmation Form (also available at https://www.hse.ie/eng/about/who/gmscontracts/2019agreement) and return, by email, to the HSE using the following email address gp.agreement@hse.ie. The "Opt in" Forms will only be accepted by email. The HSE will issue an acknowledgement following receipt of each "Opt In" Form. You must receive an acknowledgement from gp.agreement@hse.ie before registering any patients on the CDM Programme. If you have already submitted a CDM Opt In Form to the HSE there is no need to do so again.

May I take this opportunity to thank you and your Practice Staff for your efforts in implementing the GP Agreement in your practice in 2021 and I look forward to your continued cooperation in 2022.

Yours sincerely,

Pat Healy,
National Director
Clinical Programme Implementation
& Professional Development

Appendix 1- Fee Rates 2022

Table 1- Chronic Disease Management Programme

Services rendered under the General Medical Services Scheme - Agreement of 2019 – payments in respect of delivery of Chronic Disease Management Programme		
1.	Annual fee payable in respect of eligible patient (aged 18 years and over) with one of the chronic conditions listed in the Agreement of 2019	€210.00
2.	Annual fee payable in respect of eligible patient (aged 18 years and over) with two of the chronic conditions listed in the Agreement of 2019	€250.00
3.	Annual fee payable in respect of eligible patient (aged 18 years and over) with three or more of the chronic conditions listed in the Agreement of 2019	€300.00

Note: You will be required to submit a data return to the HSE, in the required format, following each of the scheduled reviews through your GP Management System. Reimbursement of 50% of the relevant annual fee, as set out in Table 1 above, will issue to you from PCERS following receipt of each data return.

Table 2- Modified Chronic Disease Management 2022

Services rendered under the General Medical Services Scheme - Agreement of 2019 – payments in respect of the delivery of Modified Chronic Disease Management.		
1.	Fee for remote review consultation of an eligible patient (aged 18 years and over) with one of the chronic conditions listed in the Agreement of 2019	€55.00
2.	Fee for remote review consultation of an eligible patient (aged 18 years and over) with two of the chronic conditions listed in the Agreement of 2019	€65.00
3.	Fee for remote review consultation of an eligible patient (aged 18 years and over) with three or more of the chronic conditions listed in the Agreement of 2019	€75.00

Table3 - Opportunistic Case Finding and Prevention Programme 2022.

Services rendered under the General Medical Services Scheme - Agreement of 2019 – payments in respect of delivery of Opportunistic Case Finding and Chronic Disease Prevention Programme.		
1.	Opportunistic Case Finding Programme – fee for assessment of patient (aged 65 years and over) meeting the chronic disease risk criteria as set out in the Agreement of 2019	€60.00
2.	Prevention Programme – annual fee for assessment of patient (aged 65 years and over) identified with high-risk of cardiovascular disease or diabetes as set out in the Agreement of 2019	€82.00

Note: You will be required to submit a data return to the HSE, in the required format, following the OCF Assessment and each of the annual Prevention Programme reviews through your GP Management System. You will then receive payment from PCERS following receipt of each data return as set out in Table 3 above.

Table 4- Practice Nurse Grant

Services rendered under the General Medical Services Scheme - Agreement of 2019 – Practice Nurse Grant		
1.	Practice Nurse Grant per patient registered for Chronic Disease Management Programme or Modified Chronic Disease Management.	€28.75
2.	Practice Nurse Grant per patient registered for Chronic Disease Prevention Programme	€14.35
3.	Practice Nurse Grant per patient assessed under Chronic Disease Opportunistic Case Finding	€3.20

Note: Eligibility for receipt of Practice grant is subject to the conditions as set out in Section 5 in the attached Circular.