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Date 21 November 2023

Circular No: NCO- 49-2023

**Re: Structured Chronic Disease Management (CDM) Programme – Phase 3**

**Dear Doctor,**

I wish to refer to Circular NCO-02-2023 dated 31st January 2023 and previous Circulars relating to the Structured CDM Programme which should be read in conjunction with this Circular. The purpose of this Circular is to inform you of the new CDM service enhancements which have been agreed by the relevant stakeholders to the GP Agreement 2023 effective from the 30th November, 2023 as part of the rollout of Phase 3 of the Structured CDM Programme.

**1. Structured CDM Programme**

Detailed information regarding the Structured CDM scheduled reviews, Modified CDM (MCDM) continuing as a delivery option, the timing and submission of data returns, completion of Care Plans, Prevention Programme and Opportunistic Case Finding is contained in Circular NCO-02-2023 for your attention.

**2. Structured CDM Programme – Phase 3**

The Structured CDM Programme Phase 3 being implemented from the 30th November, 2023 includes enhancement of the Prevention Programme to include all GMS/DVC card holders with hypertension over 18 years, and all women (cardholders and private patients) over 18 years who had Gestational Diabetes Mellitus or Pre-Eclampsia in a pregnancy since January 2023. Women diagnosed with Gestational Diabetes Mellitus or Pre-Eclampsia since January 2023 who develop Diabetes will be eligible for registration on the Treatment Programme. In addition, Phase 3 includes the inclusion of HAA cardholders as eligible for registration on the CDM Programme and a number of other enhancements as listed in Appendix 1 below. Items 1 to 6 in Appendix 1 will be implemented initially from 30th November with the remaining enhancements, streamlining/consolidation and additional software functionality being implemented in 2024.

**3. Nursing Support - 2024**

In line with the objectives of the GP Agreement 2019, to augment Practice Nursing capacity, it has been agreed the following grant payment rates will apply:-

- **CDM Treatment Programme** - a grant of €28.75 per registered eligible patient for CDM will be paid in 2024 provided that all Treatment Programme data returns for registered eligible patients during 2022 and 2023 have been submitted within the 12 month window which commences on the anniversary of the initial Chronic Disease Treatment Registration visit. For new Treatment Programme registrations occurring during 2024, 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 2024 at 23:59:00.
- **Prevention Programme -** a grant of €14.35 per registered eligible patient on the Prevention Programme will be paid in 2024 provided that the Prevention Programme data return for registered eligible patients during 2023 has been submitted within 12 months of the first Prevention Programme review undertaken in 2023. For new Prevention Programme registrations occurring during 2024, the grant payment will be made provided that the data return has been received by the HSE in respect of the registered eligible patient on or before the 1st of July 2024 at 23:59:00.

- **Opportunistic Case Finding (OCF) –** a rate of €3.20 will be paid in 2024 per patient assessed under the OCF Programme provided that the data return has been received by the HSE on or before the 1st July, 2024 at 23:59:00.

**4. Modifications to IT Systems**

In line with the GP Agreement 2019 and the implementation of Phase 1 & Phase 2 of the Structured CDM Programme the GP Practice systems will be modified to facilitate the service enhancements as part of the rollout of Phase 3 of the Structured CDM Programme being implemented from the 30th November, 2023. The Clinical Data Repository (CDR) will also be modified accordingly. The initial enhancements noted above will be live from 30th November, 2023 with the remaining items being implemented in 2024. 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 2 Tables 1 ,2 3 & 4 to this Circular. A CDM Phase 3 Workflow Diagram is attached in Appendix 3 for reference purposes.

**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 "Opt in" Confirmation Form (available at https://www.hse.ie/eng/about/who/gmscontracts/2019agreement) and return, by email, to your local Primary Care Unit. The "Opt in" Forms will only be accepted by email. Your local Primary Care Unit will issue an acknowledgement following receipt of each "Opt In" Form. You must receive an acknowledgement from your local Primary Care Unit 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 2019 and the new 2023 GP Agreements in your practice and I look forward to your continued cooperation in 2024.

**Yours sincerely,**

**Pat Healy,**
**National Director**
**Clinical Programme Implementation**
**& Professional Development.**

**Appendix 1 – CDM Programme Phase 3**

**CDM Programme Enhancements – 8 Items**

| | Description |
|---|---|
| 1 | Treatment Programme Annual Review: Add - How many ED attendances related to their chronic disease (not admitted) / Unscheduled Admissions within last 12 months – based on patient recall |
| 2 | Treatment Programme Annual Review: Add – How many COPD / Asthma exacerbations requiring treatment or antibiotics or steroids within last 12 months – based on patient recall |
| 3 | Inclusion of Hypertension Stage 1 in the CDM Prevention Programme |
| 4 | Inclusion of Gestational Diabetes & pre-eclampsia in the CDM Prevention Programme |
| 5 | Inclusion of HAA Cardholders as eligible for registration |
| 6 | Care Plan to be streamlined / updated |
| 7 | Addition of a Data Field to retire a patient from the CDM Programme with associated message to the CDR to update patient records. To include a transfer to nursing home/opt out or death of the patient. |
| 8 | Diabetic patients only - Insert-[Is the patient registered in the RetinaScreen? Yes/no] |

**Streamlining / Consolidation of Current CDM Software – 17 items**

| | Description |
|---|---|
| 9 | Non HDL Cholesterol – auto calculate from the software |
| 10 | Add Hyperlink to relevant CD Clinical Guidelines to the ICGP Landing Page & insert the hyperlink at the top of each review. |
| 11 | Amend the HBA1C Data Field to ensure the value captured from the Lab result is the<br><br>mmol/mol value as opposed to % value. |
| 12 | In the "Outcome from OCF Review" Data Field in the existing OCF Dataset – add Asthma and COPD to the drop down list of Conditions "Diagnosed with a Chronic Disease – Register on Treatment Programme" |
| 13 | Removal of BNP Data Field from existing CDM Programme Datasets and retaining current NTproBNP data field |
| 14 | Remove the foot check for diabetic at an interim review |
| 15 | Implementation of current IHI field included in CDM Datasets |
| 16 | Change the FBC to a non-mandatory field for Asthma |
| 17 | Addition of "New Diagnosis" prompt field at the beginning of each CDM Treatment Programme Review |
| 18 | Remove ECG date – change to [Has there been an ECG since the last review? yes/no] |
| 19 | Remove ECHO date - change to [Has there been an echo since the last review? Yes/no] |

| | |
|---|---|
| 20 | Remove Spirometry date- to be [Has there been a Spirometry since the last review? Yes/no] |
| 21 | Information button on diagnostic criteria for Pre Diabetes |
| 22 | Raised LDL Cholesterol-Ensure that the [Not available] option is available across all the GP Vendor systems. |
| 23 | Pneumococcal vaccine not auto populating at present |
| 24 | CHADSVasc score should save after first visit – currently have to enter details every time |
| 25 | Autopopulation of baseline details in system from CDM for height, weight, BMI, Blood Pressure – working for some fields. From baseline details into CDM is working for height weight BMI but not for BP From CDM into baseline details not working for any system. |

**Additional CDM Software Functionality – 5 Items**

| | Description |
|---|---|
| 26 | Add functionality to enable the CDM notes to be converted to PDF and to enable the export of CDM data. |
| 27 | Development of the Web checker to facilitate Patient Movement between GP's in order to maintain patients on the correct care pathway on the CDM Treatment Programme |
| 28 | Develop a patient recall functionality across all the GP vendor systems to identify a patient is enrolled in the CDM Programme. |
| 29 | Develop a finder type functionality to search for a set list of codes for patients who are not already on the CDM Programme |
| 30 | Develop functionality to enable a GP to amend patient enrolment errors. |

**Appendix 2 – Structured CDM Programme Fee Rates**

**Table 1- Chronic Disease Management Programme**

| **Services rendered under the Agreement of 2019 and the Agreement of 2023– 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**

| **Services rendered under the Agreement of 2019 and the Agreement of 2023 – payments in respect of delivery of Modified Chronic Disease Management Programme.** | | |
|---|---|---|
| 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 |

**Table 3 - Opportunistic Case Finding and Prevention Programme**

| **Services rendered under the Agreement of 2019 and the Agreement of 2023 – 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 45 years and over) meeting the chronic disease risk criteria as set out in the Agreement of 2019 | €60.00 |
| 2. | Chronic Disease Prevention Programme – annual fee for assessment of a patient (aged 45 years and over) identified with high-risk of cardiovascular disease or diabetes as set out in the Agreement of 2019 or for assessment of a patient (aged 18 years and over) identified with high risk of cardiovascular disease or diabetes as set out in the Agreement of 2023 | €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.

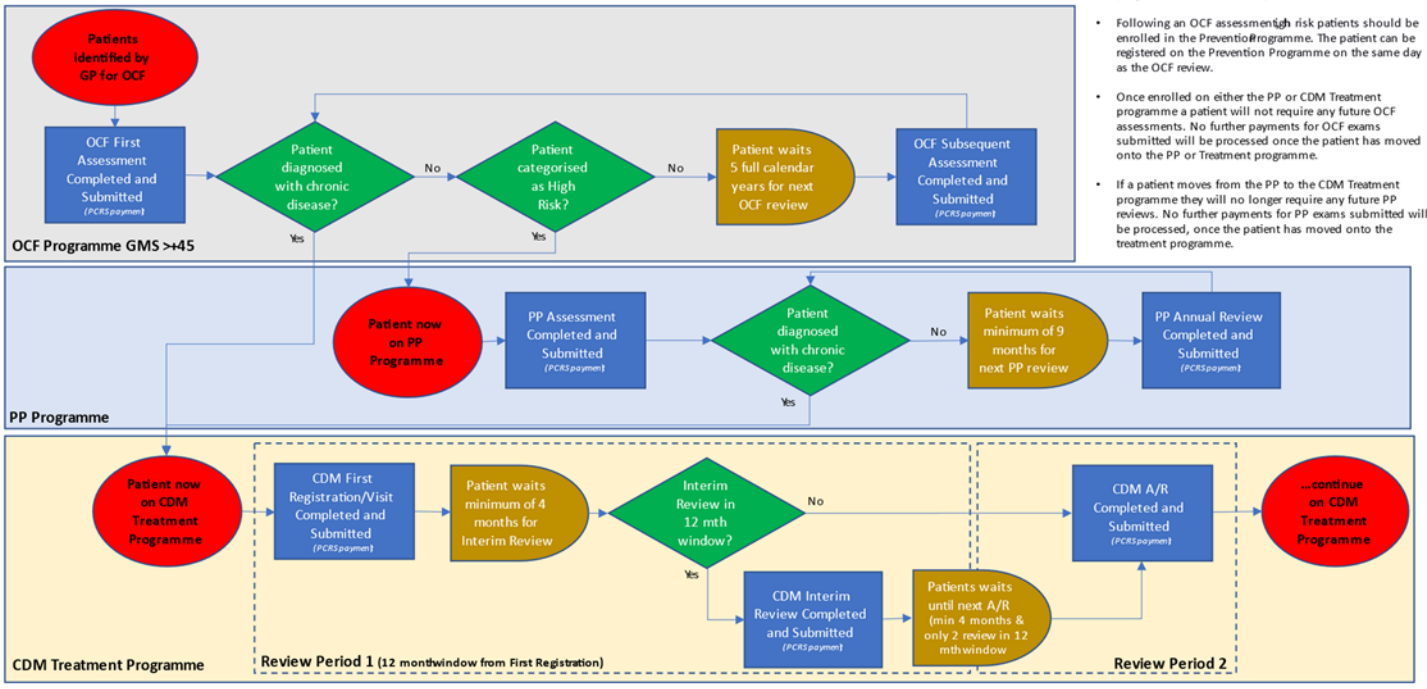
**Table 4 - Practice Nurse Grant**

| **Services rendered under the General Medical Services Scheme - Agreement of 2019 and the Agreement of 2023 – Practice Nurse Grant** | | |
|---|---|---|
| 1. | Practice Nurse Grant per patient registered for Chronic Disease Management Programme or the Modified Chronic Disease Management Programme. | €28.75 |
| 2. | Practice Nurse Grant per patient registered for the Chronic Disease Prevention Programme | €14.35 |
| 3. | Practice Nurse Grant per patient assessed under the Chronic Disease Opportunistic Case Finding | €3.20 |

**Note:** Eligibility for receipt of Practice grant is subject to the conditions as set out in Section 2 in the Circular NCO-02-2023.

## Appendix 3 –CDM Phase 3 Workflow Diagram

### Phase 3 Overview – How patients can move between programmes
### 1) OCF to PP or CDM
### 2) PP to CDM

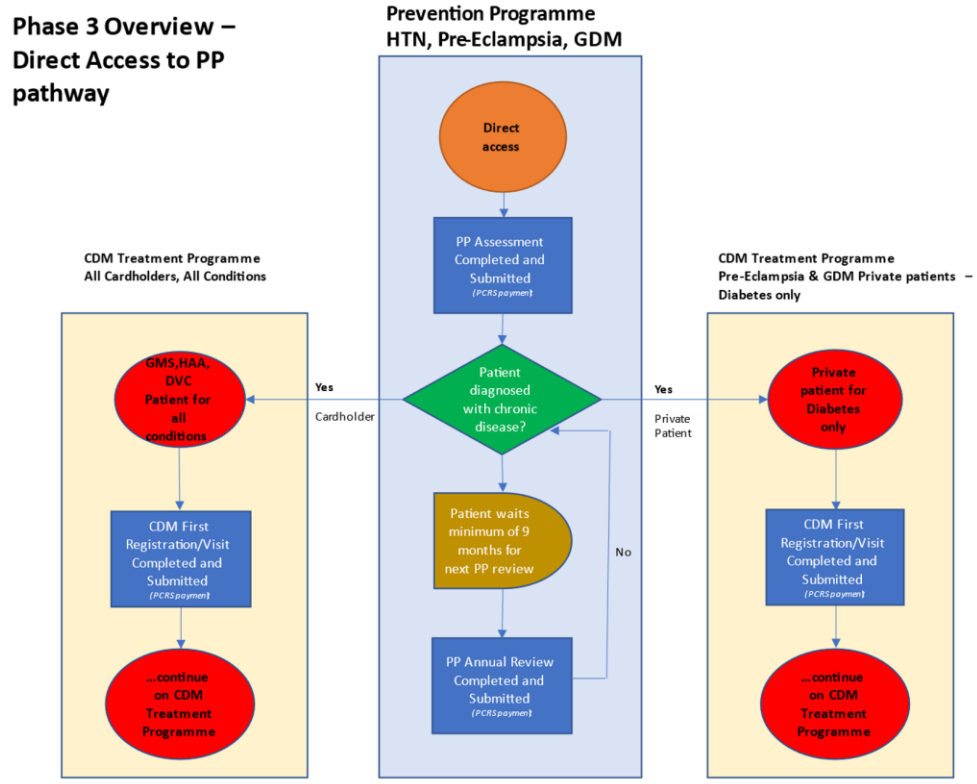



**Key Rules**

**OCF and PP**

- Patients opportunistically diagnosed with a chronic disease should move into the CDM treatment programme. The patient can be registered on the CDM treatment programme on the same day as the OCF review.
- Following an OCF assessment, high risk patients should be enrolled in the Prevention Programme. The patient can be registered on the Prevention Programme on the same day as the OCF review.
- Once enrolled on either the PP or CDM Treatment programme a patient will not require any future OCF assessments. No further payments for OCF exams submitted will be processed once the patient has moved onto the PP or Treatment programme.
- If a patient moves from the PP to the CDM Treatment programme they will no longer require any future PP reviews. No further payments for PP exams submitted will be processed, once the patient has moved onto the treatment programme.

# Phase 3 Overview – Direct Access to PP pathway




PP Programme, >+18 years HTN Pre -Eclampsia, GDM

**Key Rules**

- Patients identified with HTN, GDM or Pre-Eclampsia are permitted direct access onto the PP programme.
  *Note: GMS Patients over 45 years who had Hypertension Stage 1 and a OCF completed previously are eligible for entry on the Prevention Programme regardless of outcome of the previous OCF.*
- If a patient moves from the PP to the CDM Treatment programme they will no longer require any future PP reviews. No further payments for PP exams submitted will be processed, once the patient has moved onto the treatment programme.
- **Eligibility Criteria:** HTN - GMS,HAA, DVC card >+18 years
- **Eligibility Criteria:** GDM and Pre-Eclampsia - GMS, DVC, HAA and Private Patients diagnosed since Jan 2023
- **Eligibility Rules:** GDM and Pre-Eclampsia for GMS, DVC, HAA >+18 years eligible to progress to treatment programme for any condition. Patients whose eligibility under GMS / DVC ceases may remain as Private Patients on the Treatment Programme for Diabetes only.
- GDM and Pre-Eclampsia for Private patients >+18 years eligible to progress to treatment programme for Diabetes only.
- Patients >45yrs with stage 1 HTN and previous normal OCF will be allowed direct access to PP if eligibility criteria met at any point in time.