Structured Chronic Disease Management Programme Phase 2

Information booklet for General Practitioners

About this booklet

This booklet tells you about the Structured Chronic Disease Management Programme. It includes information about:

- how you can sign up (page 4).
- the three programme components (pages 5-12)
- what patients are eligible under each programme (page 5)

What is the Structured Chronic Disease Management Programme?

The Structured Chronic Disease Management (CDM) Programme aims to prevent and manage patient chronic diseases using a population-approach. It helps you identify and manage GMS and GP visit card patients at risk of chronic disease or who have been diagnosed with one or more specified chronic diseases (listed on page 9).

The programme is being implemented over four years.

As per the 2019 GP Agreement, the introduction of an integrated model of a structured Chronic Disease Management Programme in General Practice is to be introduced in two phases.

Phase 1

This phase began in 2020 with the Structured Chronic Disease Treatment Programme. It started with patients aged 75 years and over who have a diagnosis of one or more specified chronic diseases. In July 2020, it expanded to include patients aged 70 and over, and a modified programme was introduced to facilitate remote reviews during the COVID-19 pandemic.

Phase 2

Phase 2 does two things:

- It extends the age group for the Structured Chronic Disease Treatment Programme.
- It introduces two new components to the programme (more about these on page 5).

The programme will continue to be rolled-out to different age groups over the next few years.

Benefits to you

- You can offer your patients access to a programme that will likely improve how they manage their health.
- You can use the CDM software to monitor your patients' conditions, specific to the relevant chronic diseases listed on page 9.
- You will be paid in line with those payments agreed as part of the GP Agreement (2019).

Benefits to your patients

- Patients will benefit from early detection of risks for developing chronic disease.
- They will also benefit from early detection of complications or new conditions, which reduces the risk of worsening health, hospital admissions or both.

They will be better able to manage chronic disease conditions.

How do I sign up to provide the Structured CDM Programme?

You will need to do two things:

- sign up to the new GP Agreement (2019) and
- opt in to the programme by returning the opt-in form available at the link provided in HSE Circular NCO-01-2022. You can find a copy of this circular on the GP Suite.

Each individual GP must opt in to the programme prior to commencing a CDM review, even if the CDM software is already on the GP practice management system.

Three things then happen:

- The National Contracts Office (NCO) acknowledges receipt of your opt-in form.
- The HSE will notify the vendor of your GP practice management system that you have agreed to take part in the programme.
- Your vendor updates your practice software to include the CDM system.

Every CDM review includes a key date. This key date is the date on which the CDM review is created, not the date you submit it to the HSE. This is important to know because you must opt in to provide the CDM programme prior to commencing the registration of patients and commencing patient reviews to ensure remuneration for such reviews.

What are the components to the Structured CDM Programme?

There are three components within the Structured CDM programme:

- Opportunistic Case Finding Programme (OCF)
- Structured Chronic Disease Treatment Programme
- Annual Chronic Disease Management Prevention Programme (PP)

What patients qualify under each of the programmes?

Different patients, determined by age, qualify for different components of the programme, depending on the year. You can see this in the following table.

CDM Phasing Table

Programme	2020	2021	2022	2023
Structured Chronic Disease Treatment Programme	Age 70 and over	Age 65 and over	All adults age 18 and over	Programme continues
Opportunistic Case Finding Programme (OCF)	-	-	Age 65 and over	Age 45 and over
Annual CDM Prevention Programme (PP)	-	-	Age 65 and over	Age 45 and over

Structured reviews

You can find information about how to schedule patient reviews in HSE Circular NCO-01-2022. Your practice software will guide you through the process. Your system vendor will provide a video and other training materials to explain how to use the CDM software. The Structured Chronic Disease Management reviews should be in the GP surgery, but due to the COVID-19 pandemic, they may be online or over the phone. The CDM Prevention Programme reviews should be in the GP surgery only.

Written care plan

After each review under the Structured Chronic Disease Treatment Programme and CDM Prevention Programme, you must give the patient a written care plan. In it, you should have recorded a list of agreed goals that will help the patient become actively involved in the management of their chronic disease or risk factors.

The aim of the care plan is to:

- help the patient be more aware of how to recognise if their condition is deteriorating
- provide tips to help the patient respond to deteriorating conditions, helping them develop and use an action plan
- actively support the patient to stay in their community.

Opportunistic Case Finding (OCF) Programme - GP Surgery Based Programme

The OCF programme is for new patients who have not previously been diagnosed as having a chronic disease. The programme is for patients who you suspect may have an undiagnosed chronic disease or those at risk of developing one. Please see the CDM Phasing Table on page 5 for the eligible patient age group per year.

What does the programme involve?

OCF assessments take place on an opportunistic basis; that is, when a patient attends for another issue.

Risk criteria can be applied and appropriate tests or assessments carried out to identify those with an undiagnosed chronic disease or those at risk of developing cardiovascular disease, diabetes or both.

When the patient has one or more of the following indicators, you perform an OCF assessment.

Indicators for an OCF assessment

- Hypertension >= 140/90 mmHG
- Current smoking status
- BMI ≥30kg/m2
- Previous BNP greater or equal to 34 pg/ml or NTproBNP greater or equal to 125pg/ml
- Ethnicity - White Irish, Irish Traveller, Other White, Black Irish, Black African, Other Black, Chinese, Other Asian, Other, Roma
- History of gestational diabetes
- Dyslipidaemia that was previously recorded
- Moderate or severe chronic kidney disease (eGFR <60ml/min 1.73m2) that was previously recorded
- History of severe mental illness
- Other – you must indicate a reason

How do I do an OCF assessment?

Use the template in the GP software system to do an OCF assessment

In an OCF assessment, you carry out tests including:

- blood pressure
- QRISK3 assessment
- blood tests: HbA1c and BNP levels
- renal function tests
- pulse rate and rhythm

What do I do based on OCF assessment outcomes?

(Also Refer to Appendix 1 Flow Chart)

What you do based on the OCF patient assessment outcomes depends on a patient's risk of developing a chronic disease.

Patient's risk:	Then you must:
Low risk of developing a chronic disease	Repeat the OCF assessment in no less than five years
At risk of developing cardiovascular disease, diabetes or both	Register the patient on the Annual CDM Prevention Programme (PP)
Diagnosed with a specific chronic disease	Register the patient on Structured Chronic Disease Treatment Programme

Structured Chronic Disease Treatment Programme

This programme is for patients who have a medical card or GP visit card and have a diagnosis of one or more of the listed conditions below.

- Type 2 diabetes
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Cardiovascular disease including:
  - Stable Heart Failure,
  - Ischaemic Heart Disease,
  - Cerebrovascular Disease (Stroke / TIA) and/or
  - Atrial Fibrillation

What patients should I register on this programme – and when?

Please see the CDM Phasing Table on page 5 for the eligible patient age group per year.

What does the programme involve?

The programme includes two free structured reviews (Annual Review & Interim Review) in every 12 month period that a patient is part of the programme.

The 12-month period starts on the date of the initial CDM Treatment Programme Registration visit.

Each structured review includes one consultation with you and one with the practice nurse. The patient can see both you (their GP) and your practice nurse during the same review or separately at different times. There is no charge to patients for any tests carried out as part of the review. There should be at least four months between reviews.

How do I manage patients referred from an OCF assessment?

The first treatment programme review should be held within four months of the OCF assessment. Blood tests are not required for the first treatment programme review. However, if blood tests are more than 3 months old at the date of this first or any future Treatment Programme reviews they will need to be repeated ahead of the Treatment Programme reviews being undertaken.

When should reviews be scheduled?

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. All Treatment Programme reviews should take place with an interval of at least 4 months between each review.

For all subsequent reviews after year 1, you should follow the normal rules set out in the GP Agreement (2019) for the Structured Chronic Disease Treatment Programme.

Annual CDM Prevention Programme (PP) - GP Surgery Based Programme

This programme is for patients at high risk of cardiovascular disease, type 2 diabetes or both.

The PP programme is for patients who have been referred from an OCF assessment as a result of one or more of the following:

- QRISK3 ≥ 20%
- stage 1 hypertension BP 140/90 to 159/99mmHG with target organ damage
- stage 2 or 3 hypertension BP>160/100mmHG
- pre diabetes or previous BNP greater than 34 pg/ml (if previously recorded) or NT pro BNP ≥ 125 pg/ml (if previously recorded)

What patients do I register on the Structured CDM Programme - and when?

Please see the CDM Phasing Table on page 5 for the eligible patient age group per year for this programme. Please also refer to flowchart included in Appendix I of this booklet.

What does the Prevention Programme (PP) involve?

You need to do the first PP review within 4 months of the OCF assessment. You don't need to order new blood tests for the first PP review. However, if blood tests are more than three months old at the date of this first PP review or any future PP reviews they will need to be repeated ahead of the PP reviews being undertaken.

The programme includes one structured review consisting of one consultation with you and one with the practice nurse in every 12-month period. The patient can see both you (their GP) and your practice nurse during the same review or separately at different times.

You must make sure that there is a minimum 9 month gap between each PP review.

Any planned investigations should be carried out during the practice nurse consultation, before the patient has their consultation with you.

In the reviews, you will need to cover:

- patient education
- preventative care
- medication review
- a physical examination
- an individual care plan, which is agreed with the patient.

There is no charge to patients for any tests carried out as part of the review.

You should actively manage patients and record risk factors and interventions, such as for diabetes, hypertension and others. You should provide or refer patients to additional supports, for example smoking cessation or weight management supports.

You should refer patients diagnosed with prediabetes to the Diabetes Prevention Programme for pre-diabetic education.

Can patients be registered on OCF, PP or Treatment programmes at the same time?

No. 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 as an OCF Assessment takes place, the OCF assessment must be completed and subsequently submitted to the HSE prior to registration on PP or Treatment Programme being commenced.

Do I keep patients on existing programmes for certain chronic diseases?

No. You will need to move eligible patients who are registered under the Diabetes Cycle of Care and the Heartwatch Programme onto the Chronic Disease Management Programme.

Payments

How much am I paid – and when?

PCERS will remunerate you the relevant fee following receipt of each valid data return.

You can see the fee rates in HSE Circular NCO-01-2022. The modified CDM is remunerated at an agreed reduced rate by the PCERS.

Will payments for existing programmes for chronic diseases stop?

Yes. Payments for existing chronic disease management programmes will stop from the month that PCERS receives

your first CDM data. Remember to submit your data return as soon as possible after each CDM patient review you do.

For more detailed information, please refer to the HSE Circular NCO-01-2022 and to the GP Agreement (2019)

www.hse.ie/eng/about/who/gmscontracts/2019agreement

Supports available to you

What do I need to know about my software?

Information entered into a CDM form in your software is saved even if it is not complete. You will be able to return to the form and change or add information.

However, after you select 'Submit', you cannot change details or add additional information to the form.

Where do I get technical support for the CDM software?

Your software vendor will be able to give you technical support for the CDM software. This includes upgrades.

Socrates
Tel: 071 919 3600
Email:
support@clanwilliamhealth.com

HPM
Tel: 01 463 3098
Email:
gpsupport@clanwilliamhealth.com

Health One
Tel: 01 463 3098
Email:
gpsupport@clanwilliamhealth.com

CompleteGP
Tel: 01 215 0292
Email:
completegp@inventise.com

Who do I contact for general information about the programme?

NCO
Tel: 044 939 5519
Email: gp.agreement@hse.ie

Who do I contact for payment queries about the programme?

PCERS Doctors Unit
Tel: 01 864 7100
Email: pcrs.doctorsqueries@hse.ie

How do I order leaflets?

1. Register on www.healthpromotion.ie
2. Log in.
3. In Category, select 'General Practice'.
4. In the keyword search box, type 'Chronic Disease' and click 'Go'.

You can then order these leaflets or download them to print.

- **HPC01326** Chronic Disease Management (CDM) Programme – GP Information Booklet
- **HPC01327** Chronic Disease Treatment Programme – Patient Information Leaflet
- **HPC01400** Chronic Disease Prevention Programme – Patient Information Leaflet
- **HPC01328** Chronic Disease Management (CDM) Programme Privacy Statement Poster

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.

Use the key rules for OCF and PP with the flowchart 'Overview: How patients can move between programmes' on page 16.

Appendix 1 - Overview: How patients can move between programmes

1) OCF to PP or CDM 2) PP to CDM