An Roinn Sláinte
DEPARTMENT OF HEALTH

4th September 2015

Mr. Tony O'Brien
Director General
Health Service Executive
Dr. Steeven's Hospital
Dublin 8

RE: Changes to the Form of Agreement for Provision of Services under Section 58 of the Health Act 1970 (as amended).

Dear Mr. O'Brien

I am directed by Leo Varadkar T.D., Minister for Health to refer to the agreement reached between the Department of Health, the Health Service Executive and the Irish Medical Organisation in the above matter. The effect of this agreement, which has been reached between the parties pursuant to Paragraph 41 of the Form of Agreement with Registered Medical Practitioners under the General Medical Services (GMS) Scheme, is to modify Paragraph 11 of the said Form of Agreement by the inclusion of a Cycle of Care for adult persons with a diagnosis of Type 2 Diabetes who hold a Medical Card or GP Visit Card.

The details of the enhanced service, including the terms and conditions and the specified payment rates, are set out in the attached Schedule at Appendix I. This Schedule is hereby incorporated into the GMS contracts with medical practitioners and the terms of the GMS contracts shall be construed accordingly.

The Cycle of Care, which GMS contract holders may opt to provide or otherwise, will enable qualifying patients who are registered for the service to avail of two annual visits to their GP practice for a structured review of their condition.

Participating medical practitioners should commence the process of registering their adult Medical Card and GP Visit Card patients with a diagnosis of Type 2 Diabetes from 8th September 2015 in advance of the introduction of the Cycle of Care on 1st October 2015.

The HSE should now write to each GMS contract-holding GP advising them of the introduction of the Diabetes Cycle of Care and the operational details pertaining to same.

Yours sincerely

Tommy Wilson
Assistant Principal
Primary Care Division

CC *Mr. Pat O'Dowd, Assistant National Director, HSE National Contract's Office*
Mr. Paddy Burke, Assistant National Director, HSE, PCRS
Ms. Susan Clyne, Chief Operations Officer, Irish Medical Organisation

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APPENDIX I

CYCLE OF CARE FOR PERSONS WITH A DIAGNOSIS OF TYPE 2 DIABETES

1. PREAMBLE

The prevalence of diabetes in Ireland is circa 5.6% of the adult population. Over 85% of adults with diabetes have Type 2 diabetes. It is expected that this number will increase by a further 60% over the next 10 to 15 years, a reflection of a number of factors including changed lifestyle pattern, increased weight gain, sedentary lifestyle and increased life expectancy within the population. The prolonged exposure to hyperglycaemia associated with diabetes results in microvascular (retinopathy, nephropathy and neuropathy) and macrovascular (cardiovascular, cerebrovascular and peripheral arterial disease) complications. Therefore, in addition to being an important public health issue, it is estimated that Type 2 Diabetes care consumes up to 10% of the Irish healthcare budget.

2. INCORPORATION OF CYCLE OF CARE INTO GMS CONTRACTS

The Department of Health, the Health Service Executive (HSE) and the Irish Medical Organisation (IMO) have agreed to the introduction of a Cycle of Care for adult patients with a diagnosis of Type 2 Diabetes under the Framework Agreement of June 2014 and in accordance with the provisions of paragraph 41 of the General Medical Services (GMS) Contracts (i.e. Medical Card and GP Visit Card Contracts). This Schedule is hereby incorporated into the GMS contracts with medical practitioners and the terms of the GMS contracts shall be construed accordingly. The Cycle of Care for adult patients with a diagnosis of Type 2 Diabetes is an enhanced service offering which GMS contract holders may opt to provide or otherwise.

3. DEFINITION OF TYPE 2 DIABETES

The current WHO diagnostic criteria for diabetes: fasting plasma glucose ≥ 7.0mmol/l (126mg/dl) or 2–h plasma glucose ≥ 11.1mmol/l (200mg/dl). In addition, an HbA1c of 48mmol/mol (6.5%) is recommended as the cut off point for diagnosing diabetes. A value of less than 48mmol/mol (6.5%) does not exclude diabetes diagnosed using glucose tests.

3.1 In accordance with the provisions of this Agreement the Medical Practitioner shall:

3.1.1 Establish and maintain a patient register and reminder system for their Patients with a confirmed diagnosis of Type 2 Diabetes, hereafter referred to as Registered Patients.

3.1.2 Implement a defined Cycle of Care for their Registered Patients as set out in this schedule.

4. REGISTER

4.1 The register and reminder system shall:

4.1.1 Include a list of the Participating Medical Practitioner's known Registered Patients.

4.1.2 Include the Registered Patient's name, contact details, date of birth, gender, GMS number, date of diagnosis and clinical measures for diagnosis.

4.1.3 Be kept active and updated.

4.1.4 Be in standard agreed format.

5. THE CYCLE OF CARE

5.1 The Cycle of Care aims to augment the service available to GMS patients with a diagnosis of Type 2 Diabetes in the primary care setting prior to the introduction of a comprehensive structured chronic disease programme.

This Diabetes Cycle of Care provides for two review consultations annually comprising an annual review and follow up visit. While the patient may require more frequent consultations, there should be an interval of at least four months between the annual and follow up visit.

6. REVIEW VISITS UNDER CYCLE OF CARE

6.1 The Participating Medical Practitioner shall review and monitor his/her registered patients in accordance with the Cycle of Care. The Participating Medical Practitioner shall provide two review consultations annually comprising an annual review (first visit) and a follow up review (2nd visit).

6.1.1 **Annual Review Consultation (First Visit)**

During the annual review (1st visit) the Participating Medical Practitioner shall:

1. Review and record Blood results since registration – HBA1C, Lipids (total Cholesterol and LDL), Basic Renal Function to include Creatinine, ACR (or Microalbuminuria where ACR is not available).

2. Review the following Preventative Lifestyle Factors with the Registered Patient:-

   - Smoking
   - Alcohol
   - Exercise
   - Weight control

   Provide brief intervention and refer to support services, if appropriate.

3. Carry out review of medication.

4. Carry out symptomatic foot review and referral, if appropriate.

5. Check continuing participation in eye prevention programme and where appropriate refer to National Retinopathy Screening Programme.

6. Record and assess Registered Patient's Height and Weight (BMI) and refer on for weight control support, as appropriate.

7. Record and assess Registered Patient's Blood Pressure and manage as appropriate.

8. Record immunisation status (influenza and pneumococcal) and arrange for administration of vaccine, if appropriate.

9. Provide to the Registered Patient education about their diabetes and referral of newly diagnosed registered patients to Patient Education Service.

10. Schedule next review.