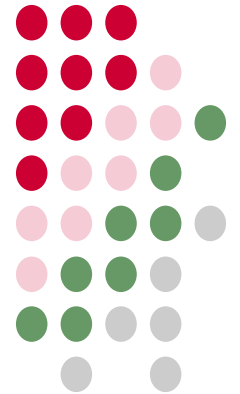


DIABETES CLINIC MODEL 2008



This booklet is designed to offer an example of a 'Diabetes Clinic Model' for use in General practice.

This *model* is a flexible working model which can be adapted to suit the requirements of individual practices.

The first clinic model developed in August 2007, was in the development phase with limited GP input. This reviewed version incorporates GP input and a working Diabetes Clinic Model of six months. This document is NOT a complete document but a work in progress.

Collaboration for the development and review phases of this clinic model has existed between Alicia Bonomo, Practice Nurse, Dr Daniel Diebold, Peel Health Care and Tanja McLeish, Program Development Manager, North West Slopes Division of General Practice.

The development of this model has also been guided by information within existing models including; Diabetes Co-management in General Practice, activities within the Australian Primary Care Collaboratives, information within guidelines and evidence recognised by the medical profession including NH&MRC and the Australian Diabetes Society, with various national publications sourced and referenced.

Photocopying and use of the information for this clinic model is permitted with acknowledgement to the North West Slopes Division of General Practice.

Whilst every reasonable effort has been made to ensure that the information given in this resource is accurate, Peel Health Care and The North West Slopes Division of General Practice will not accept liability for any injury, loss or damage arising directly or indirectly from any use of or reliance on this information.

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Introduction

Peel Health Care aims to improve the quality of diabetes care in their general practice and the health outcomes of their patients who are diagnosed with diabetes by having a structured process in place—a 'Diabetes Clinic' within the Peel Health Care practice.

A proposed outcome of this *clinic* would also be to improve the early detection of Type II diabetes and the prevention of diabetes.

This would be reflected in improvements within the population health data collected within Peel Health Care and ultimately has an impact on the community population health.

Setting up a *clinic* has also formed part of the process undertaken within the participation of Peel Health Care in the 'Teamwork Research Study—enhancing the role of non-GP staff in chronic disease management in general practice' conducted by the University of New South Wales Research Centre for Primary Health Care and Equity.

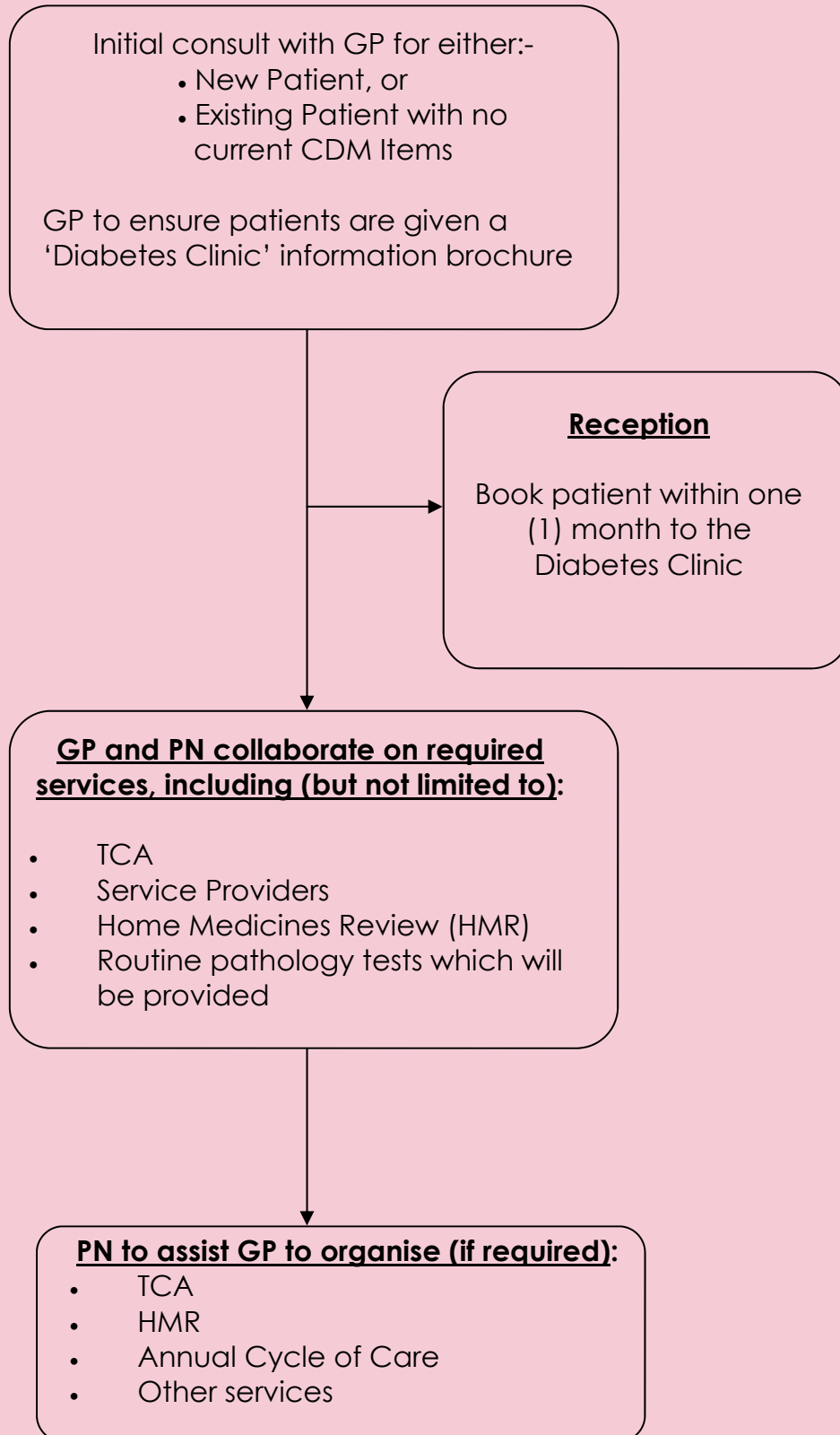


Proposed Care Pathway

When	Practice Activity
Initial GP Appt (opportunistic)	<ol style="list-style-type: none"> 1. Refer Patient to Diabetes Clinic 2. Order relevant pathology (Patient to complete prior to next visit) 3. Tell PN if TCA required and service providers to collaborate with 4. If required, GP Refers for Home Medicines Review and patient booked for 5/6 weeks for return to complete the medication management plan (item 900)
1st Month (PN/GP)	<ol style="list-style-type: none"> 1. GPMP and/or TCA & Diabetes Template MedTech 32 2. Commence Annual Cycle of Care 3. Review of pathology 4. Separate long GP consultation for patient return for Medication Management Plan (Item 900)
6th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 7th month appointment—reception staff b) or at time of GP consult
7th Month (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Review of GPMP and/or TCA 3. Review of pathology
12th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 13th month appointment—reception staff b) or at time of GP consult
13th Month (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Annual Cycle of Care 3. If required, GP Refers for Home Medicines Review and patient booked for 5/6 weeks for return to complete the medication management plan (Item 900) 4. Allied Health Medicare Referral Form if required 5. Review of pathology
18th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 19th month appointment—reception staff b) or at time of GP consult
19th Month (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Review of GPMP and/or TCA 3. Review of pathology
24th Month	<ol style="list-style-type: none"> 1. a) Letter and pathology form sent to patient for completion prior to 25th month appointment—reception staff b) or at time of GP consult
25th Month (2 years) (PN/GP)	<ol style="list-style-type: none"> 1. Diabetes Template Medtech 32 2. Annual Cycle of Care 3. New GPMP and/or TCA 4. Review of pathology 5. Allied Health Medicare Referral Form if required

NB: The Practice Nurse conducts **Item 10997** (support and monitoring) for patients between the structured GPMP and TCA reviews.

Activity Prior to FIRST Diabetes Clinic Attendance



Clinic Appointments Schedule

9.00 am—12.00 pm—15 min time slots

1.30 pm —3.30 pm—15 min time slots

Appointment Times	Practice Nurse	GP
9.00	Joe Bloggs	
9.15	Betty Cool	Joe Bloggs
9.30	Simone Andrews	Betty Cool
9.45	Jacqui Picker	Simone Andrews
10.00	Tom Jones	Jacqui Picker
10.15	Dean Martin	Tom Jones
10.30	John Doe	Dean Martin
10.45	Andrew Smith	John Doe
11.00	Alicia Stewart	Andrew Smith
11.15	Bridgette Jones	Alicia Stewart
11.30	Tanja Walters	Bridgette Jones
11.45	Daniel Burns	Tanja Walters
12.00		Daniel Burns

NB: The appointment duration may vary for a patient who is a newly diagnosed diabetic or for a patient who is commencing insulin where more time is required.

GP Diabetes Clinic Roster

Monday	Tuesday	Wednesday	Thursday	Friday
GP 1 1.30—3.30	GP 2 9.00-12.00	No bookings— 'Well Women's Clinic'	GP 4 1.30-3.30	GP 5 1.30-3.30
	GP 3 1.30-3.30			

PIP & SIP Payments

For a practice to claim the PIP and SIP for diabetes it is necessary for all the patients with diabetes to be registered as having diabetes and placed on the recall/reminder register.

The register may be either paper or computer based. The names of the patients with diabetes may be obtained from pathology by requesting the names of all patients who have had a HbA1c recorded.

PIP practices that use a diabetes register and recall will receive a one-off 'sign on' payment of \$1.00 per Standardised Whole Patient Equivalent (SWPE) or around \$1000 per Full Time Equivalent (FTE) GP.

The SIP-diabetes of \$40.00 is payable once a year after completing an annual diabetes program cycle of care. The minimum requirements are:

- HbA1c—at least once a year
- Comprehensive eye examination—at least once every two years
- Calculate BMI, height & weight—every six months
- Blood Pressure—every six months
- Examine feet—every six months
- Lipid profile—at least once a year
- Microalbuminuria—at least once a year
- Provide self-care education—Patient education regarding diabetes management
- Review diet
- Review physical activity
- Review medication (?Home Medicines Review)
- Encourage smoking cessation



MBS Items

- Level B consult **2517** during which requirements for annual diabetes cycle of care are completed Item 23 will generate payment.
- Level C consult **2521** during which requirements for annual diabetes cycle of care are completed, Item 36 will generate payment.
- Level D consult **2525** during which requirements for annual Diabetes cycle of care are completed Item 44 will generate payment.

These item numbers will trigger the SIP to GPs via the PIP system.

Additional levels of care will be needed by insulin dependant patients and those with abnormal findings, complications and/or co-morbidities.

Outcomes Payment:

To qualify practices must have 20% or more of patients with diabetes receiving the annual SIP cycle of care. A payment of \$5.00 will be paid each quarter per standard whole patient equivalent for each patient with diabetes.

Management Plans (Items 721 & 723):

People with diabetes will qualify for a GPMP (721) and a large proportion also for a TCA (723). For those patients who are disadvantaged and require allied health appointments eg. podiatrist, dietitian, exercise physiologist, the allied health referral in conjunction with the GPMP and TCA will provide 5 free appointments a year. The Practice Nurse (Item 10997) or registered Aboriginal Health Worker could also provide a service to a maximum of 5 services per patient in a calendar year in conjunction to the CDM items. A Home Medicines Review (HMR) will ensure improved medication management.

Economic Modelling for Diabetes Patient

(for one patient over a 24 month period)

Item	Amount	Recommended Frequency (unless clinically indicated)	TOTAL
GPMP— 721	\$127.70	1	\$127.70
GPMP Review – 725	\$63.85	3	\$191.55
TCA—723	\$101.15	1	\$101.15
TCA Review—727	\$63.85	3	\$191.55
Diabetes Annual Cycle of Care (for practices registered for PIP) 2517—2521—2525	\$40 plus Consultation Fee (B/C/D)	1	\$40 Plus Consultation Fee (B/C/D)
Home Medicines Review (HMR) - 900	\$137.05	1	\$137.05
EPC Item for Practice Nurses—10997	\$10.85	10	\$108.50
Item 10991 (see entire criteria in MBS book) • Concession cards • Under 16 • Bulk Billed	\$8.20 PN/GP Item 10991 MBS Fee is \$9.60 - 85% is rebated to general practices.	Per eligible item— in this instance X 20	\$164.00
TOTAL			\$1061.50

NB: The above is an example only and does not include extra consultations over the 12 month period. This example also does not include the practice's current SIP payment per Standard Whole Patient Equivalent (SWPE) or rural loading for each RRMA. (MBS Fees July 2008)

Outcomes After Six Months

Prior to *Clinic* patients were being missed and annual cycles of care were not being completed.

GP Outcomes:

- Frees up GP time to be involved with clinical management and other issues
- Time is taken to establish what items occurred
- Enables a focused effort on data entry with the aim to have reminder system established within 12 months

Patient Outcomes:

- Patient satisfaction and diabetes education including nutrition and exercise
- Expands access to health provider
- Builds on compliance
- Increases self-management skills
- Instills confidence to expand the service eg: initiating insulin

Evidence for Models of Care Delivery to Improve the Management of Diabetes in Primary Care

From the reviews¹ of the evidence for interventions to improve the management of diabetes in primary care, important conclusions can be drawn.

- Complex professional interventions often improve the process of care.
- Process improvements were seen in studies that included structured and regular review. A small beneficial effect in glycaemic control was seen in studies in which a nurse² or pharmacist³ assumed part of the physician's role.
- Recall and reminder systems in combination with professional interventions demonstrated improvement in process measures⁴.
- Involvement of nurses and the inclusion of patient education were associated with positive effects on patient outcomes⁵.

To make a positive difference in the process and outcome of care, the emerging evidence base for multidisciplinary care supports the benefits of the combination of professional interventions, organisational interventions, nurse involvement and patient education⁶. The provision of information, education and psychological support that facilitates self-management is therefore the basis of diabetes care.

One of the key ways to provide this multidisciplinary care is by means of a 'Diabetes Clinic' provided in the primary care setting.

The Practice Nurse can often spend more time than the GP has available to strengthen the patient's knowledge and skills regarding self-monitoring, physical activity, nutrition, foot care etc. The PN can also identify any gaps in their knowledge or skills.

The Pharmacist can support this professional intervention by empowering the patient with knowledge and skills around their own medication management.

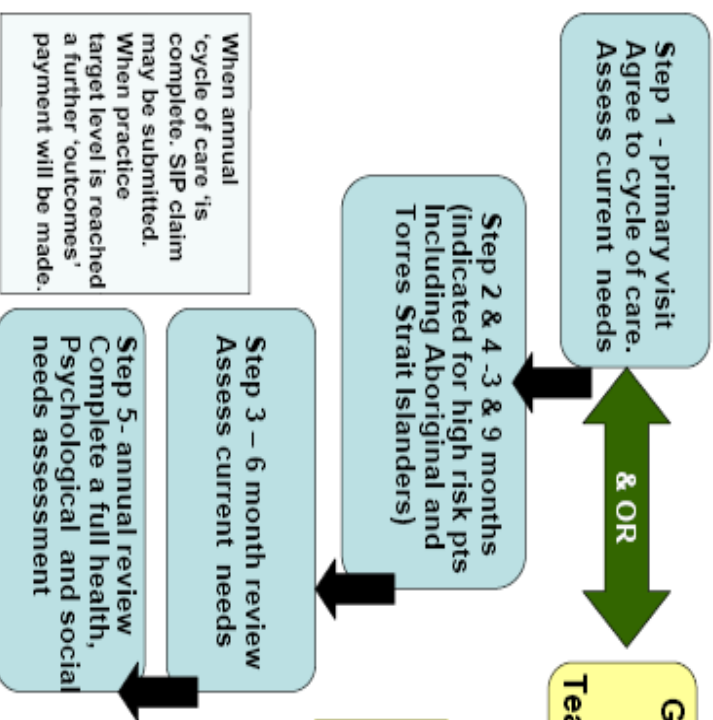
This support can also be echoed in the provision of other services in a team approach to diabetes care, including members such as exercise professionals and podiatrists etc. However, it is *essential* that good communication between team members exists so that advice is consistent and not confusing for the patient, this concretises the importance of two-way collaboration in a Team Care Arrangement (*Item 723*).

1. Ross S, Gadsby R. Diabetes & Related Disorders. 2004;**19**:19-21
2. Day JL, Metacalfe J, Johnson P. Benefits provided by an integrated education and clinical diabetes centre: a follow up study. *Diabetic Medicine* 1992;**9**:855-859
3. Jaber LA, Halapy H, Fernet M *et al*. Evaluation of a pharmaceutical care model on diabetes management. *Ann Pharmacother* 1996;**30**
4. Peters AL, Davidson MB. Application of a diabetes managed care program. The feasibility of using nurses and a computer system to provide effective care. *Diabetes Care* 1998;**21**:1037-1043
5. Aubert RE, Herman WH, Waters J *et al*. Nurse case management to improve glycaemic control in diabetic patients in a health maintenance organisation. *Ann Intern Medi* 1998; **129**:605-612
6. Griffen S, Williams R. Delivering care to the population. In: Williams R, Herman JW, Kinmonth A-L *et al*, editors. *The Evidence Base for Diabetes Care*. Chichester:Wiley, 2002;chapter 32.



DIABETES ANNUAL CYCLE OF CARE (PIP)

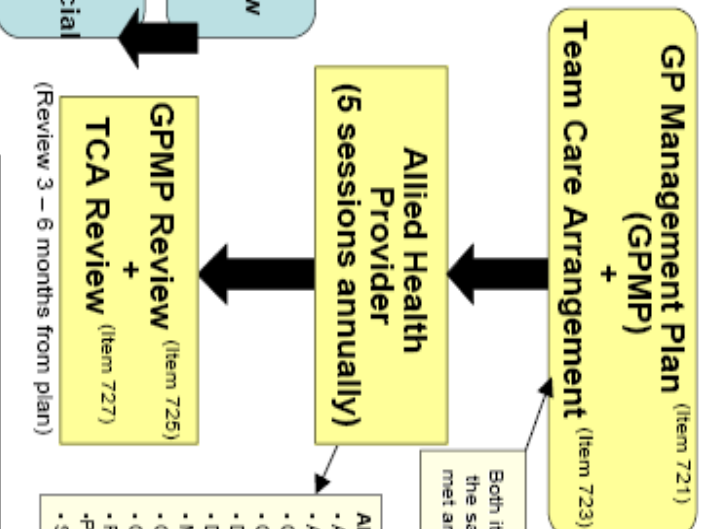
Accessing MBS items for PIP incentive



When annual 'cycle of care' is complete, SIP claim may be submitted. When practice target level is reached a further 'outcomes' payment will be made.

GENERAL PRACTICE SOUTH AUSTRALIA

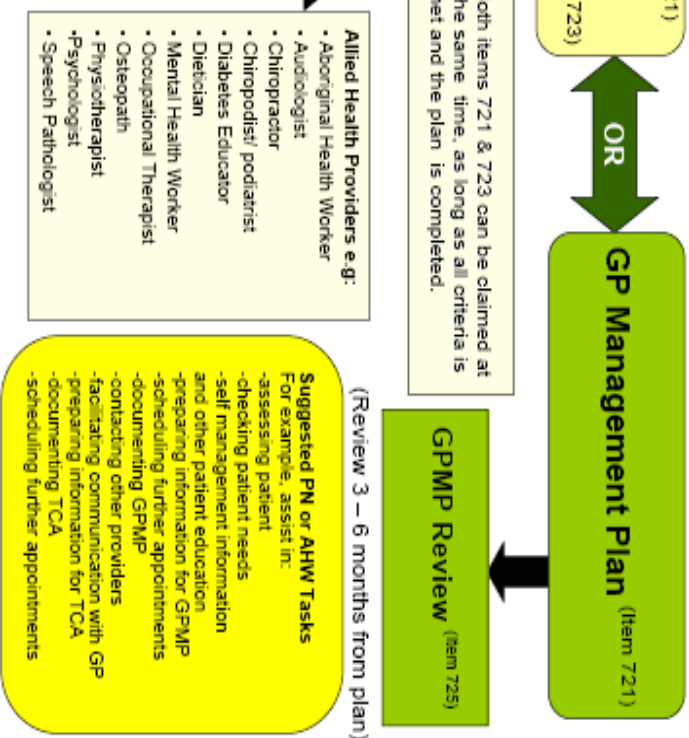
Patients with chronic & complex conditions



Both items 721 & 723 can be claimed at the same time, as long as all criteria is met and the plan is completed.

GP MANAGEMENT PLAN (CDM)

Patients with a chronic condition



(Review 3 – 6 months from plan)

Suggested PN or AHW Tasks
For example, assist in:
-assessing patient
-checking patient needs
-self management information and other patient education
-preparing information for GPMP
-scheduling further appointments
-documenting GPMP
-contacting other providers
-facilitating communication with GP
-preparing information for TCA
-documenting TCA
-scheduling further appointments

3, 6 &/or 9 month visit - claim	3 rd or 4 th visit (completion of annual cycle of care) claim consult fee	& SIP + Outcome %	Minimum Claiming Period
VR Normal consult	2517 -2526	\$40 + \$20 pp	12 months

Name	Item number	Medicare Fee (100%)	Recommended frequency	Minimum Claiming Period
Preparation of GPMP	721	\$124.95	2 yearly	12 months
Preparation of TCA	723	\$98.95	2 yearly	12 months
Review of GPMP	725	\$62.50	6 monthly	3 months
Coordination of Review of TCA	727	\$62.50	6 monthly	3 months

Modified from Knox Division of General Practice Aug 2005 – Last updated February 2007 (Approved by Medicare Australia)