The Diabetes Care Project

Information for Practices

CONTROL GROUP

INTERVENTION GROUP 2

December 2011

An Australian Government Initiative

Diabetes Care Project
Empowering patients. Supporting practices.

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The Diabetes Care Project (DCP) is a three-year pilot which is part of the Australian Government's response to the growing incidence of chronic disease in Australia. The pilot will test new ways of providing more flexible, better coordinated care, to improve the management of care for people with diabetes. Approximately 150 general practices and over 10,000 patients across three states will be participating in the pilot.

Overview

What does the project involve?

The project is piloting four key changes in how care is delivered to people with diabetes:

- A **new IT tool** will be used by the care team to support care planning, share information with the patient and the team, and support a streamlined referrals process
- A **new funding model** will make more funding available for the care of those with the greatest need, and will reward practices for improving patient health outcomes, improving patient experience, and delivering best-practice standards of care. This funding model will only replace care planning MBS items and those items associated with diabetes-related PIPs/SIPs—typical GP consults continue to be claimed through Medicare
- A new **Care Facilitator** role will be created. Care Facilitators, in collaboration with the general practice team and other members of the care team, will support the patient in finding the best available care options
- An **education and training program** will ensure that people (both practitioners and people with diabetes) can navigate the resources available to them and improve people's understanding of diabetes management. This training will be delivered online, in person, and on paper.

To ensure proper evaluation of the impact of the pilot's new model of care, participants must experience a different mix of arrangements. After enrolling, your practice will be placed into one of the following two groups:

- **Control Group:** This group practices care as usual with no major changes
- **Intervention Group 2:** This group introduces a Care Facilitator role in patient care, support from a new online IT tool, and new funding arrangements for practices and allied health professionals

These groups are explained further in the Supplementary Information section of this document. Your practice will be randomly assigned to one of these groups by the University of South Australia.

Practices located within other Divisions of General Practice or Medicare Local boundaries may be involved in a third pilot group: **Intervention Group 1**. In this group care is funded as usual. Practices will receive support through a new online IT tool and there will be a greater focus on care coordination.

Why should your practice participate in this pilot?

- **Your patients will have a more coordinated care team**—evidence suggests that coordinated care programs improve clinical outcomes. An IT tool will allow care teams to share information and will facilitate rapid interventions and/or modification of care plans*

* Benefits annotated with the asterisk above will only apply to practices in Intervention Group 2. Only these practices will receive the IT tool, new funding arrangements, and a Care Facilitator. Practices in the Control Group will continue to provide care as usual for people with diabetes.

- **Your practice earnings are expected to increase whilst associated administration will decrease**
  - Participating practices will be provided with the kind of care planning software that has consistently increased practices' ability to claim and receive Medicare funds*
  - Most practices and GPs will receive more funding to care for patients with diabetes through front-loaded lump-sum payments and additional incentives—an average practice can expect up to $120 p.a. per average patient more than they currently receive. GPs will also have greater flexibility in how to allocate this funding and will no longer need to claim an MBS item for care planning interactions*
  - Your practice will receive a $50 payment per enrolled patient for pilot related administration (this figure is the same whether your practice is in the intervention group or the control group)
- **Your practice team will get more support to provide high quality care in an efficient manner***
  - The easy-to-use IT tool can be integrated into the GP desktop and reduces the time it takes for general practice team members to do care planning and reviews
  - The administration burden will be taken out of the care planning process through fully flexible care plan templates and the removal of the administration associated with Team Care Arrangements.
  - A Care Facilitator will work with practices to reduce diabetes-related administrative work that is usually undertaken by GPs and will assist practices to coordinate the care of their patients with diabetes.
- **You can improve the management of diabetes in Australia whilst retaining GP autonomy**
  - The pilot is funded for three years by the Australian Government Department of Health and Ageing and involves Divisions of General Practice, Medicare Locals, state bodies, regional organisations, academic experts, and private groups. This provides an opportunity to identify a new model of care for people with diabetes that can be implemented on a national scale
  - Training and support structures for integrated care will be provided, but existing funding structures will remain intact. Lump sum payments only cover funding related to care planning and do not replace fee-for-service consultations*

In addition, GPs and practices will also receive detailed reporting and feedback regarding the performance of the practice and GPs, and of patients' progress relative to peers.*

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Supplementary Information

Who is running the Diabetes Care Project?

This pilot is funded by the Australian Government Department of Health and Ageing and is being managed by a consortium featuring McKinsey & Company, SA Health, Queensland Health, General Practice Queensland (GPQ), Victorian Department of Health, and General Practice Victoria (GPV), with a number of Divisions of General Practice/Medicare Locals participating across Queensland, Victoria and South Australia. The study is supported by the University of SA, Baker IDI Heart and Diabetes Institute, Statewide Diabetes Clinical Network Queensland, Diabetes Australia Queensland and Diabetes Australia.

The consortium has developed the models of care that will be tested during the pilot through extensive consultation with a number of stakeholder groups. These include the Diabetes Advisory Group consisting of leaders of major stakeholder groups, such as the AMA; Clinical Reference Groups in South Australia and Queensland consisting of a broad cross-section of people with diabetes, GPs, practice nurses, diabetes specialists and allied health professionals; as well as many other clinicians and people with diabetes from across Australia.

Why has the government identified the need for a new model of care for diabetes?

- The number of people diagnosed with diabetes is expected to reach approximately 4.6 million within four years[1]
- Approximately 275 Australian adults develop diabetes every day[2], which equates to approximately one every five minutes
- Diabetes costs Australia more than $3 billion per year[3], with health care costs alone amounting to over $900 million[4]
- Diabetes accounts for nearly a quarter of all avoidable hospitalisations[5]—with approximately 39,000 Australians hospitalised every year for diabetes-related eye complications alone.[6]

The DCP will promote a patient-centred approach to diabetes management as previous studies have shown that placing the patient at the centre of their care and involving them in their treatment choices improves overall health outcomes and care delivery. The pilot aims to empower people with diabetes by putting them at the centre of their own unique care team, and enabling them to build and monitor their own care plans. In doing

1 http://www.australiandiabetescouncil.com/About-Diabetes/Quick-facts.aspx

2 International Diabetes Institute, AusDiab 2005 report

3 DiabCo$t Australia, 2003

4 AIHW, Diabetes: Australian Facts 2008

5 Public Health Information Development Unit

6 AIHW, Diabetes: Australian Facts 2008

so the pilot seeks to improve the overall health of people with diabetes, as well as the satisfaction of people with diabetes and their care providers.

What will be the main roles and responsibilities of the practice?

Your practice's main responsibilities will continue to be providing the best possible care for your patients. During the pilot there will be some additional responsibilities which are outlined below.

- Patient enrolment at your practice will be driven by your practice team, with significant support from your local Division of General Practice or Medicare Local. This will require you to discuss the pilot with your eligible patients and help with the enrolment process
- You will receive training on how to use the IT tool, and information about how other parts of the pilot will work. Most of this training can be done online, with a small portion conducted in person. You will be reimbursed for the time you spend in in-person training
- You will use the IT tool to create care plans for patients enrolled in the pilot and to communicate effectively with allied health professionals and specialists on your patients' care teams
- You will work with the Care Facilitator to establish working rhythms that contribute to achieving the highest possible care for patients
- You will distribute pilot payments made to the practice to practice staff

You have the opportunity to withdraw from participation in the pilot at any time, but we strongly encourage your commitment for the full duration (up to 2.5 years).

Who will be making the final decisions on matters related to patient care?

The GP will remain responsible for the day-to-day decision-making on the best clinical care for the patient. The Divisions of General Practice/Medicare Locals and the pilot consortium will be responsible for supporting practices in patient enrolment and for managing payments to practices.

What is the timeframe for the study?

The pilot will begin in January 2012 and will last for up to 2.5 years.

Who is the Diabetes Care Project for?

Enrolment is voluntary for eligible people with a diagnosis of type 1 or type 2 diabetes. They will not be eligible to participate if they:

- Are under 18 years of age
- Are participating in the Department of Veterans' Affairs Coordinated Veterans' Care (CVC) Program
- Currently have gestational diabetes
- Are currently pregnant
- Currently have dementia

- Currently have a terminal illness with a life expectancy of less than two years
- Have been diagnosed with Type 1 diabetes in the previous 12 months.

Any patient meeting any of these exclusion criteria at any time during the pilot will need to withdraw from the pilot.

Patients who are participating in the Closing the Gap program will be eligible to enrol in the pilot. However, for practices who are part of Intervention Group 2, an enrolled patient who is also participating in the Closing the Gap program will no longer be eligible for the tier 1 PIP Indigenous Health Incentive. This is because these benefits are linked to the Medicare billing for GPMPs, TCAs and their reviews—which are replaced during the pilot.

Practices in the Divisions of General Practice/ Medicare Locals that are working with the consortium are eligible to participate, subject to the following requirements:

- Practice software (GP desktop application) is compatible with the IT tool for data extraction purposes—please ask your Division of General Practice/Medicare Local for exact requirements
- Practice meets the Royal Australian College of General Practitioners (RACGP) definition of 'general practice'
- Practice is accredited (or registered for accreditation) against the current edition of the RACGP 'Standards for general practices'
- Practice has current public liability insurance
- All health professionals at the practice who will be providing care to enrolled patients are appropriately qualified and registered, and have current professional indemnity insurance

How will treatment differ from usual care?

If your practice decides to participate in the pilot, you will be randomly assigned into one of two participant groups outlined below.

- **Control Group:** This group receives patient care as usual with no major changes
- **Intervention Group 2:** This group receives support from a new online IT tool, involvement of a Care Facilitator, and adjusted funding arrangements

  – **Support from a new online IT tool**

  Evidence from trials in the US and UK show that improving clinician access to relevant patient information results in better health outcomes for those patients. An online IT tool will facilitate this improved access in the DCP.

  o The IT tool will be provided free-of-charge for use with enrolled patients and non-enrolled patients with diabetes. It will be provided at a 50% cost reduction for all other patients

  o The IT Tool will be able to extract relevant patient data from the most widely-used GP desktop systems. It will not edit or update any data in the GP desktop system. If a GP has marked a condition as 'Confidential' on their GP desktop it will not be uploaded to the IT tool. GPs can review data in the IT tool to make sure it is appropriate

  o The IT tool will enable each member of the care team (including the patient) to access the patient's relevant information. The level of access to patient information

will be subject to the role of each member of the care team, with GPs provided with full access. Members of the care team will be able to share visitation notes, see the care plan and monitor progress. Patient details will only be available to members of the care team and the GP retains control in determining membership of the care team

- Comprehensive training and support (including a phone/email helpdesk) will be offered to promote best-practice use of the tool
- Reporting on the performance of practices will be available within the tool to facilitate the review of activities and outcomes at both the practice and individual patient level

– **Focus on care coordination**

In addition to the use of the IT tool, there will be a simplified process for setting up and working with a care team (reducing the administration currently associated with Team Care Arrangements), and the practice team will have the opportunity to attend regular care forums

– **Funding based on patient need**

A tailored approach to funding will provide patients with greater needs with greater access to funding. People with diabetes will be placed into different categories based on the complexity of their condition and the extent to which key clinical metrics (HbA1c, blood pressure and cholesterol) are 'Within-range'.

- Complex needs include related complications, such as renal or limb or eye complications, stroke, depression, heart failure, myocardial infarction or chronic heart disease
- People with diabetes will be determined to have their key clinical metrics 'Out-of-range' if any of the following are true: HbA1c >7.5; Blood Pressure >150/80; Cholesterol >5 mmol; or Blood Pressure >140/80 and Cholesterol >4.5 mmol). Note: these are not to replace the recommended targets you currently use (such as the RAGCP guidelines)
- If the patient's clinical metrics are not above the levels set, the patient is considered to have their clinical metrics 'Within-range'

– **Funding to support quality care**

The pilot will provide quality improvement support payments (which will go directly to the practice) based on patient experience, patient health outcomes, and the care team's adherence to best-practice care delivery:

- Patient responses to surveys form the basis of funding tied to patient experience—only completed surveys will be included in the determination of this portion
- Payments linked to best-practice care delivery are based on care plan completeness, the accuracy of data entry, and how well patient care follows the plan that was agreed upon
- Improvement in HbA1c levels (or continued healthy levels for those who have HbA1c levels within-range) form the basis of outcomes-based payments

– **Introduction of a Care Facilitator**

The Care Facilitator is a new role within the care model for Intervention Group 2. Divisions of General Practice/ Medicare Locals will be responsible for the recruitment and management of Care Facilitators. GPs will retain primary responsibility for the care of people with diabetes, but they will be supported by Care Facilitators who will assist them (and their patients with diabetes) to manage care delivery and access required services. In collaboration with the care team, Care Facilitators will:

- o Provide care planning training and coaching support to practice staff
- o Oversee the patient's adherence to their plan (with respect to attendance at planned appointments), including assisting the patient to access logistical support for them to get to/from planned visits
- o Assist practices to understand the provided care plan templates, and where necessary guide the practice team on their use
- o Assist the practice and patient to find appropriate allied health professionals
- o Share best-practice and pilot lessons across practices
- o Work with practices to identify patients who require earlier than planned recall due to changes in their health, such as hospitalisations
- o Coordinate in-person care team activities as required, such as case calls (which replace the existing case conference system)

– **A care plan specific to each individual person with diabetes**

Care plans will be based on evidence-based guidelines and then tailored as needed.

- o The care plan template is a base set of care plan recommendations, matched to a patient's risk segment, designed to ensure consistency with best-practice clinical guidelines for the management of diabetes from the RACGP and Diabetes Australia
- o People with diabetes and their care teams will then tailor the template care plans to suit their needs and preferences. A 'menu' of more flexible options than are currently available for professionally delivered allied health services will be provided, allowing both people with diabetes and practitioners to make informed care decisions.

We do not expect any risks, inconveniences, or discomfort for people with diabetes participating in the pilot.

How exactly does the pilot's new funding model work?

Only practices in Intervention Group 2 will be piloting these new funding arrangements.

- Flexible funding will provide practices with a lump sum of funds based on the risk stratification of its participating patients, and practices will no longer receive funding on a 'fee-for-service' basis when completing care plans and reviews. The lump sum is designed to provide:
  - – Sufficient compensation for completing a patient's care plan and the recommended reviews. This means that an average practice will be provided with at least as

much compensation as they receive today to manage the care of their population of people with diabetes

– Increased flexibility for the practice team to allocate their time most effectively between their group of enrolled patients. GPs can perform fewer/shorter reviews for some patients and more/longer reviews for others based on need and clinical judgement, without the need to make any claims to Medicare for these services

- Allied health interactions included as part of the care plan will be funded by the pilot consortium, and are separate from the practice based flexible funding. There will be a maximum funding allocation per patient based on their risk stratification. This allocation replaces the current patient entitlement through the MBS that allow a maximum of five individual and eight group allied health appointments, with patients with greater needs receiving access to an increased pool. Within their pool of funds there will be greater flexibility—no rules regarding the number of group or individual sessions, and increased options in terms of length of interaction.
- Quality improvement support payments will reward practices for improving patient health outcomes, improving patient experience, and delivering best-practice standards of care. The payment to the practice will be up to $150 per patient per year, depending on their performance across clinical (HbA1c), process (primarily care plan activity completion), and patient experience criteria. These payments will replace the diabetes-related PIPs and SIPs.
- All practice payments will be made directly to practices, and practices will retain discretion on how those payments will be best distributed to their staff, or used for other reasons. AHP payments will be paid directly to AHPs.

How will practices and care teams learn about the new changes?

The amount of training and education will depend on whether your practice is part of the Control Group or Intervention Group 2. Training will cover three essential training areas:

1. Basic information about the pilot and what it has to offer
2. Technical requirements for making sure everything works
3. Additional diabetes knowledge to assist people with diabetes and their care teams to manage diabetes effectively (only available to Intervention Group 2 practices).

What patient data is to be gathered at patient enrolment?

A core set of data will be gathered during enrolment to provide a clear reference point for the duration of the pilot. Three different types of information will be collected during enrolment:

- Demographic information
- Clinical metrics
- Survey data relating to quality of life, patient health, psychometrics, and experience.

Personal data and clinical metrics will be entered directly into the IT tool upon enrolment, either at the practice or via an online interface. Where a patient completes their registration for the pilot remotely, their information will need to be manually entered and then a practice appointment scheduled so that baseline data/metrics capture can be completed. The surveys for patients will be paper-based and collected centrally by the pilot consortium.

What role will practices play in the enrolment process?

The patient enrolment process will be driven by practices. To ensure that the patient enrolment process is not too burdensome, practices in both the Control Group and Intervention Group 2 will be given:

- Support from their local Division of General Practice or Medicare Local
- The IT tool to simplify data capture and migration of basic information from the GP desktop to the IT tool following patient consent (the control group will have access to this data capture portion of the tool, but not the full functionality)
- Standard GP consults may be billed for any patient consultations required during patient enrolment.

In addition to this support, practices in Intervention Group 2 will have a Care Facilitator who will work with the practice in the longer term, and who will be able to take on much of the workload for enrolment.

How does intervention Group 2 differ from intervention Group 1?

Based on the Division of General Practice/ Medicare Local your practice is located in, your practice will be allocated to either Intervention Group 2 or the Control Group. Other practices may be placed in Intervention Group 1 or the Control Group. Practices in Intervention Group 1 will receive a similar IT tool to practices in Intervention Group 2, but they will not be piloting adjusted funding arrangements, the use of a centrally funded Care Facilitator in patient care, or care plans tailored from base care plans based on the patients' risk stratification.

What information will be collected and where is it going?

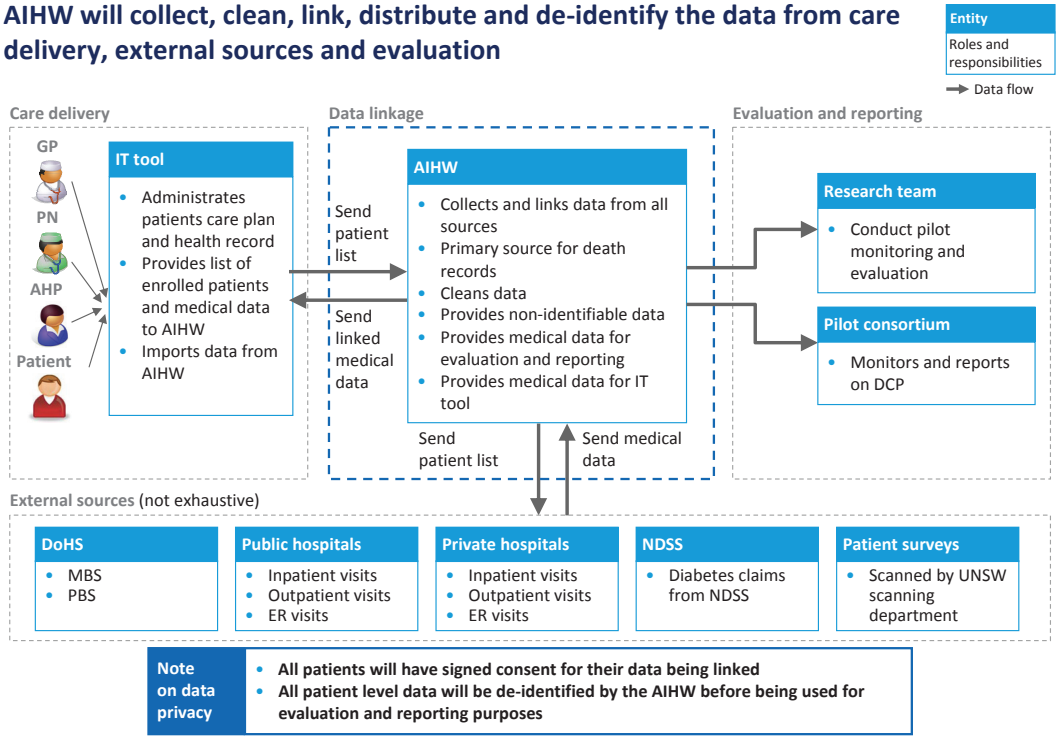
With practice and patient consent, the project consortium will collect patient medical information. We will be collecting this information from Medicare Australia (Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS)), National Diabetes Services Scheme (NDSS), pathology laboratories, and hospitals. We will also collect primary care information from patient interactions with the care team. The primary care data includes clinical metrics, patient notes, and existing medical conditions. The data will be extracted from the GP desktop system (e.g. Medical Director) by the IT tool.

Please see the Exhibit below for details about the flow of the information.

An accredited data-linking organisation, the Australian Institute of Health and Welfare (AIHW), will be responsible for linking information across the different sources. They will match and link health records and will de-identify (i.e. remove any specific personal details such as name, Medicare number, date of birth) before passing the information to the research team for analysis. This is done to protect patient privacy in accordance with the *Privacy Act 1988*. Due to the need to ensure consistency and validity, a small number of research team members may have access to the identifiable information. These members of the research team will sign additional confidentiality statements in alignment with AIHW policy. Analysis will only be conducted on de-identified information.

At the end of the pilot, the identifiable data will be held within AIHW in accordance with their data storage and retention policies. The analysis done by the consortium will be passed to the Department of Health and Ageing, which will own the results.

AIHW will collect, clean, link, distribute and de-identify the data from care delivery, external sources and evaluation



Are there risks involved with using a new IT tool in the practice?

We do not expect that there will be any hardware or software issues from installation/use of the project's software. The standard version of the IT tool is currently in use at a large number of practices with no reported problems. The main part of the IT tool is browser-based, i.e. access to the tool is via a web browser (the connection is encrypted, similar to an online banking system).

Will the model be changed during the pilot?

It is not envisaged that the main components of the operating model will fundamentally change over the course of the pilot, but the consortium reserves the right to implement incremental improvements in the day-to-day operations of the pilot in order to better support participants in achieving target outcomes. Changes will be based on consultation with pilot participants and advisors, including General Practices, and will be aligned with overall pilot objectives and principles. Participating practices will remain subject to the existing standards of professional and legal conduct.

What will the project team do to ensure confidentiality?

Details of participating practices and GPs will remain confidential. Patient data will be sent directly to an accredited data-linking organisation that will de-identify the data before passing it to the pilot consortium. Access to data will be limited to the Principal and Co-Investigators and will only be used for the current project. All data will be stored in locked cabinets in a secure area of the pilot consortium or, in the case of electronic data, on password-protected servers.

If you have any further questions please contact your local Division of General Practice or Medicare Local.