Inner North West Melbourne Health Collaborative Coordinated Community Care for Diabetes (CCC4D) Project

Final report: October 2015

Acknowledgements

Melbourne Primary Care Network (MPCN) would like to acknowledge the Inner North West Melbourne Health Collaborative (the Collaborative) partners and other participating organisations for their contribution to this project.

Collaborative partners

The Royal Melbourne Hospital

Merri Community Health Services

cohealth (formally Doutta Galla Community Health Service)

Melbourne Primary Care Network (formally Inner North West Melbourne Medicare Local)

Other participating organisations

Victoria University

La Trobe University

University of Melbourne

Australian College of Optometry

Diabetes Australia Victoria

Essendon district diabetes support group

For further information see www.mpcn.org.au

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Executive summary

The coordinated community care for diabetes (CCC4D) project was established in late 2012 as one of four flag ship projects within the Inner North West Melbourne Health Collaborative (the Collaborative). Led by Melbourne Primary Care Network, the project aimed to improve the journey and outcome for patients with type 2 diabetes (T2D) across acute and primary care.

Key project achievements:

- Development of a needs assessment to inform project activities
- Implementation of a Diabetes Quality Improvement Project (DQIP) in eight general practices
- Education and training events for health care professionals and consumers
- Development of consumer resources to support self-management in the community
- Development of a suite of diabetes pathways to improve access to clinical and referral guidelines and support coordination of care across settings.

Key project findings

- Establishment of strong partnerships and clear project governance structures ensures key stakeholders are engaged in an effective and meaningful way.
- Undertaking a needs assessment is essential to clearly identify the case for change, establish project objectives and inform project activities.
- Clinical leadership in quality and service improvement projects is essential to ensure activities are relevant, clinically appropriate and can be realised in practice.
- There is varied primary care capacity and systems in place to provide best-practice comprehensive chronic disease management care for patients with T2D.
- There is limited access to secondary consultation for primary care clinicians to support delivery of care in the community. In addition, existing funding mechanisms do not readily enable the provision of specialist support to increase primary care capacity.
- There was limited access to readily available clinical and local referral guidelines.
- There is limited use of eHealth technologies to support delivery of secure and timely communication between providers and with patients.
- There is limited access to performance data on the provision of best-practice care and service waiting times.

Key recommendations:

The following key recommendations have been endorsed by the project steering committee to address the identified findings. It is recommended that there be an ongoing focus within each of the organisations and through the Collaborative on:

- Increasing workforce capacity across the sector to manage chronic conditions
- Strengthening systems to support chronic disease prevention and management
- Providing patient information, education and self-management support

Background

MPCN, cohealth, Merri Community Health Services (MCHS) and The Royal Melbourne Hospital (RMH) established a collaborative framework to support a partnership approach to improving patient outcomes in the Inner North West region of Melbourne. Population health statistics from 2013 indicated that 3.6 per cent of residents were living with diabetes and more than a quarter of residents were not leading a healthy lifestyle, with high levels of physical inactivity and smoking above the state average. In addition, chronic disease related conditions were present in four of the top six reasons for preventable admission to hospitals for residents, which includes diabetes complications.

Based on the considerable burden of disease in the region, the Collaborative identified T2D as a key priority for service system improvement, with an agreed view that patients could be better managed in the community. The CCC4D project was therefore established to improve service access and delivery of care for patients with T2D in the cities of Moonee Valley and Moreland. In October 2012, MPCN was nominated as the lead agency responsible for development and implementation of the project within the Collaborative partnership.

Project development (January – October 2013)

The project was implemented in five phases.

1. Phase one – needs assessment and governance structure establishment
2. Phase two – development of agreed cross-sector patient pathways (HealthPathways)
3. Phase three – development of service improvement strategies and new models of care to maximise care delivered in the community
4. Phase four – implementation
5. Phase five – report evaluation findings and implement sustainable model of care.\

Needs assessment and governance structure established

The needs assessment was undertaken to identify service system issues and opportunities for improvement. This was achieved through service and referral mapping and qualitative data collection, targeting health professionals across acute and primary care settings. In addition, focus groups were held with local consumers to ensure a patient centred approach. An overview of the needs assessment activities is provided in Appendix 1.

The project steering committee was established in February 2013, comprising representatives from across the Collaborative partner agencies and other key stakeholder organisations, including clinicians, managers, and general practice representatives. This committee met bi-monthly to inform and govern the activities of the project. Project activities, risks and issues were reported to the Senior Manager's group monthly and CEO group quarterly. Members of the various governance groups were responsible for disseminating information and engaging colleagues within their organisations.

The final needs assessment report was compiled by the Australian Institute of Health and Ageing in November 2013. The report, along with an options paper on potential strategies to address the issues identified through the needs assessment process, was distributed to the steering committee in December 2013. The recommendations were to:

- Improve local service coordination and increase knowledge of available resources to health care providers and people with diabetes
- Develop cross system care coordination strategies to improve communication and data sharing between GP's and health services/health care providers
- Enhance service quality by increasing the use of guidelines, service directories and accurate service wait lists
- Increase access and awareness of lifestyle modification programs for primary and secondary prevention
- Improve access to support groups, self-management/peer support programs for consumers
- Create and maintain local service provider networks through education, training and networking opportunities
- Utilise quality improvement methodology to implement project activities.

A planning workshop with steering committee members was held in December 2013 to review the findings, determine which strategies to progress and prioritise activity for action by the project. Based on the needs assessment and workshop, the following objectives were developed for the project:

- Improve general practice management of patients with T2D through a practice level quality improvement project.
- Improve health professional access to patient information through the implementation of care coordination and communication activities.
- Increase patient self-management in the community through improved access to consumer information, education, peer support opportunities and lifestyle modification programs.
- Improve local health professional knowledge and confidence in managing patients with T2D through the delivery of education and training.

The 2014-15 project activity was allocated to the following six work streams:

1. Diabetes HealthPathways
2. Insulin Initiation in general practice (Stepping Up Study)
3. Service coordination and communication
4. Health professional training and education
5. Patient education and self-management
6. Diabetes primary care quality improvement project

Steering committee members were assigned to each work-stream (Appendix 2) to enable input from all four partner organisations and to support implementation of outcomes at an organisational level. An annual joint meeting of the work-streams was held to ensure engagement across the project and to share learning. Progress against planned work-stream activity continued to be reported to the senior managers and CEOs groups to ensure ongoing accountability. Other key stakeholders were also nominated to work streams as required.

Project implementation (August 2013 – June 2015)

Work stream 1: HealthPathways

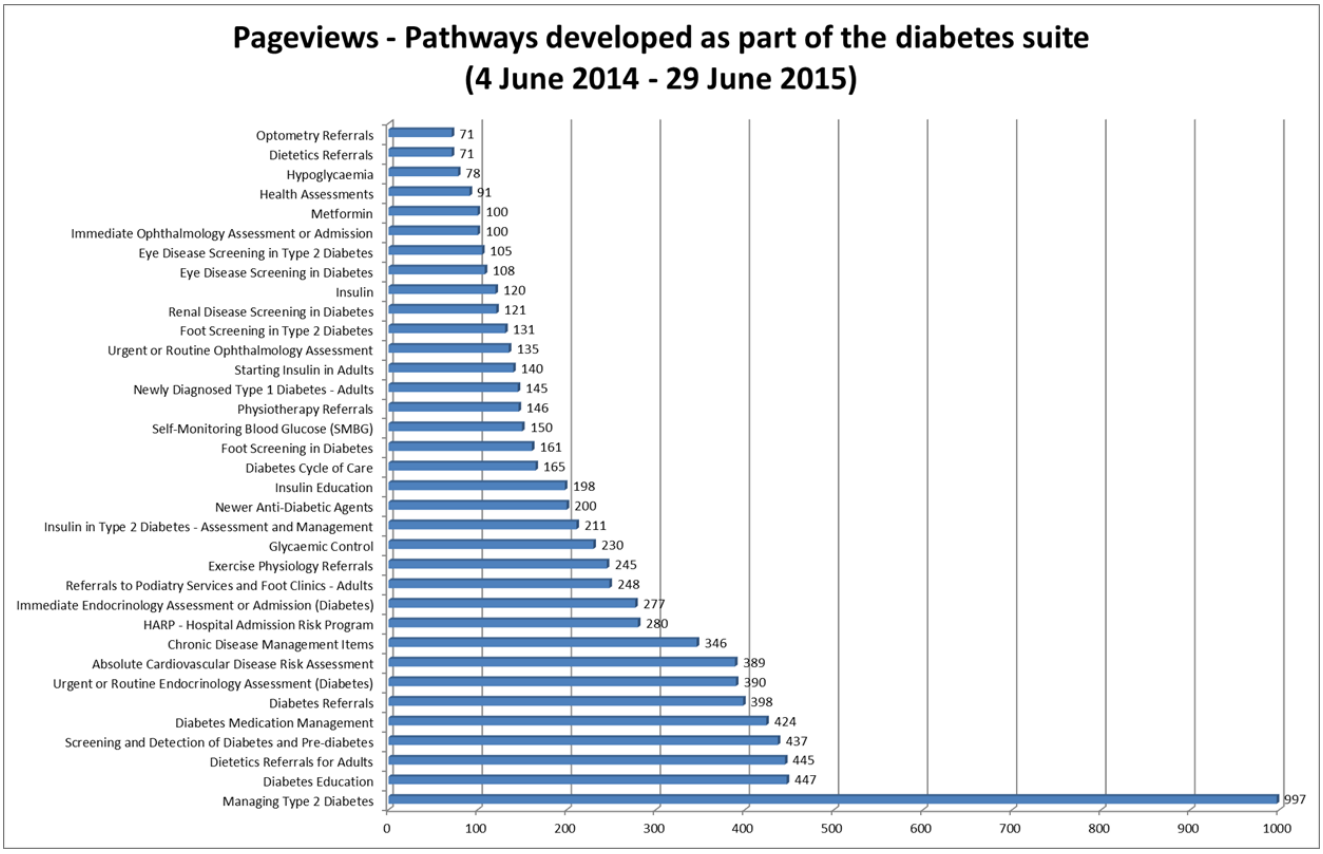
Current health system demands necessitate a collaborative cross sector approach to delineate care more effectively. This is particularly so for the management of chronic and complex conditions such as T2D. HealthPathways was therefore identified as a key strategy to strengthen relationships between primary care and hospital-based clinicians and to improve access to well-coordinated care.

HealthPathways brings together GPs, specialists, nurses and allied health professionals to discuss optimal assessment and management practices, including when, where and how to refer patients to supporting services. The result is a single, web-based portal with readily available clinical and referral guidelines, and patient information, designed to be used by general practice teams at the point of care.

Pathway development commenced with a multi-disciplinary clinical working group in September 2013. By the time HealthPathways Melbourne was launched in June 2014, a total of 11 clinical pathways and 16 supporting referral and resources pages were developed for the website. These can be viewed at this link (Username ***connected*** Password ***healthcare***).

The suite of diabetes pathways are constantly being updated based on updates to clinical guidelines, changes to the service system and user feedback. In addition, a formal review has been set at two years from initial publication.

Since launch, the pathways have been used to support consistent delivery of health professional education and training to increase capacity and promote best-practice care in the inner North West and inner East regions of Melbourne.



Lessons learned and recommendations

Full implementation of HealthPathways across the acute and primary care interface is crucial to ensure that potential benefits are maximised. It is therefore recommended that:

- MPCN continue to maintain the suite of diabetes pathways to ensure their currency and quality, and promote their use by local health professionals;
- All Collaborative partners ensure service information is accurate in both HealthPathways Melbourne and the National Health Services Directory;
- The RMH embed HealthPathways in its management of specialist clinics to improve waiting times, new to review rates and communication with general practice; and
- HealthPathways Melbourne is evaluated.

Work stream 2: Insulin Initiation in General Practice – the Stepping Up Study

The Stepping Up model of care for insulin initiation in general practice was tested in a NHMRC funded cluster randomised controlled trial. 74 general practices across Victoria participated, recruiting 266 patients with T2D. The trial showed that this new model of care, which features an enhanced role for the practice nurse supported by a Registered Nurse-Credentialed Diabetes Educator (RN-CDE), resulted in both a statistically and clinically significant improvement in HbA1c. These findings have important implications for the organisation of health services to support optimal management of T2D in the community.

<table>
<tr><td colspan="2">Project aim: To evaluate a model of care for initiation and titration of insulin, focused on the GP/PN team in a ‘real world’ setting.</td></tr>
<tr><td>Outputs:
Seven general practices in the region were recruited to the study.
A post-intervention Insulin Initiation Masterclass was held in October 2014, at which 54 local health professionals attended, including 22 GPs.</td><td>Outcomes
74 general practices across Victoria participated
266 patients were recruited to the study.
12 month follow up data collection was completed on 241 patients in May 2015.
Study findings are pending, final publication will be published and located in late 2015 here</td></tr>
</table>

Lessons learned and recommendations

This pragmatic translational study has important implications for the organisation of care for people with T2D in primary care.

A sustainable funding model is required to support ongoing access to specialist support in the community and embed the model of care with practices in the region. This is consistent with the findings of the DQIP work stream and could include utilisation of existing MBS item numbers.

To further understand how MBS items could be used to fund access to specialist support in the community a briefing document was commissioned by MPCN to Larter consulting. This document "Medicare business model(s) to support specialist outreach in the community" outlined the requirements for each CDM MBS item number to be claimed, and three models of care options that could be support specialist outreach to clinicians, (Appendix 3).

Work stream 3: Service coordination and communication

The service communication and coordination work stream aimed to improve health professional access to patient information, communication between providers and coordination of care across the system.

It was identified that there was varied eHealth capacity across the partner organisations and general practice, and a lack of interplay between providers' IT/IM systems. There was also a lack of agreement about which electronic care planning/care coordination tool to trial, therefore a number of the planned activities were unable to be executed. Consequently, activity focused on assessing the quality and timeliness of communication between health services and general practice through a file audit against the Department of Health and Human Services (DHS) "Guidelines on feedback to general practitioners for community health services"

An audit tool was developed for use across multiple agencies, including community health, HARP and the RMH, based on the guidelines DHS. A total of 167 case files were audited by five agencies across acute and primary care in March 2014.

Results:

All referrals	Response	Comments
Total audits completed	156	MCHS (75), cohealth (52) RMH DNE/OPTs (12) HARP DCM (9) DNC(19)
Referral source: General Practice	49	
Referral source: Self-Referral	29	
Referral source: RMH HARP	9	
Referral source: Hospital	16	
Referral source: Community Health	18	
Other?	37	Council, Internal referral, referral source unknown
Total audits with GP details not included	77	No (45) NA (20)
Total audits with no evidence of GP communication	63	
Total audits with evidence of GP communication	106	
Primary method of communication?	Mail (71)	Fax (35) Other (9) Verbal (6) Secure message (5)
General practice referrals	**Response**	**Comments**
Referral source: General Practice	49	
GP details included in referral?	43	No (1) NA (1)
Total audits with no evidence of GP communication	7	
Total audits with evidence of GP communication	42	
Primary method of communication?	Mail (26)	Fax (15) Secure message (5) DNC (6)

Lessons learned and recommendations

- Consistent communication builds trust and relationships between general practice and other healthcare services.

- Services should seek feedback from general practice and use the ‘Guidelines for feedback to General Practice for Community Health Services’ to inform best practice communication.
- A generic audit tool for use across multiple health services was not sufficiently effective at a service level, due to different systems, patient intake protocols and referral sources. Each service should monitor their performance against the guidelines and develop an audit tool that meets their needs to drive ongoing quality improvement activity.
- Services should use HealthPathways Melbourne as a tool to assist with improving referral quality.
- Secure, accessible and timely electronic communication mechanisms to support coordination of safe and effective care between providers should be a priority for all service providers.

Work stream 4: Health professional education and training

Continuing professional development is crucial for building primary care capacity and delivering best-practice care to the community. It also provides the opportunity to build and maintain relationships through networking with local service providers.

An education and training event was therefore held to provide independent continuing professional development and networking opportunities with local providers, including GPs, nurses, and allied health professionals. In addition, HealthPathways was used to reinforce key clinical messages and provide an accessible reference tool for health professionals to use in practice. The aim was to enhance service delivery by increasing the use of best-practice guidelines and local service directories.

A total of 73 local health professionals participated in the ‘Dealing with Diabetes Education Symposium’ on Saturday, 6 September 2014, including 29 local GPs. Feedback on the symposium was very positive, with the following elements highlighted in the evaluation:

- quality of the speakers;
- provision of information and networking opportunities with community service providers;
- case study session by the clinical panel;
- interactive sessions on injectable therapies, foot checks, and blood glucose monitoring;
- patient experience of transitioning to insulin;
- MBS utilisation; and
- HealthPathways Melbourne

Lessons learned and recommendations

MPCN will continue to play an important coordination role in the delivery of workforce development and networking opportunities in the region. In doing so, it should:

- Conduct learning needs assessments to inform planning and engagement

- Ensure content developed by local network(s) of clinical advisors
- Ensure the inclusion of practical sessions, e.g. blood glucose monitoring and foot checks
- Use HealthPathways to provide consistency of messaging and promote use as a reference tool
- Utilise a range of delivery mechanisms and technology to maximise health professional engagement, such as webinars
- Establish local learning networks
- Ensure activities are aligned and accredited with the Royal Australian College of General Practitioners (RACGP) continuing professional development program
- Create mentor programs to support peer led education and training opportunities.

Work stream 5: Patient education and self-management support

Consumer focus groups informed the needs assessment and identified that “diabetes distress” (stress of self-managing their diabetes) was high among consumers. Although many had predominantly positive health care experiences, managing diet and lifestyle choices were reported to present a significant challenge. One consumer remarked, ‘We know what to do, just not HOW to do it’.

A paper was published in the journal of clinical nursing “Experiences of diabetes self-management: a focus group study among Australians with T2D”, as a result of the focus groups that were held as part of the CCC4D needs assessment.

Service navigation and awareness of local support services, in addition to lifestyle modification programs was identified as a key issue for patients living with T2D in the region. As such, work stream activity focused on the development and dissemination of information for consumers about the prevention and management of T2D, including where and how to access local services.

A “Diabetes and your health” guide was developed listing all relevant services in the region for people at risk of or living with T2D and their carers, with further information on diabetes on the MPCN website. In addition, editorial advertisements were run in the local Leader newspapers for Moreland and Moonee Valley.

An education event for consumers living with T2D in the region was held in partnership with the Essendon District Local diabetes support group in October 2014. Speakers included hospital specialists, a GP with a special interest in diabetes, a dietician, exercise physiologist and a podiatrist. A total of 71 consumers attended the forum, all of whom found the information helpful in assisting them to manage their diabetes.

In addition, 100% of attendees reported that they intended to make lifestyle changes after their attendance at the forum and 12 people became new members of the Essendon District local diabetes support group.

Lessons learned and recommendations

The webpage information and diabetes services guide have only been developed in English and have not yet been evaluated. It is therefore recommended that MPCN understand the needs of the range of CALD populations in the region and evaluate the effectives of these resources to inform any future activity. In addition, the following recommendations should guide future work in this area:

- Relationships and linkages should be developed with community groups, health care organisations and NGOs to minimise duplication, build on existing work in this area and to engage hard to reach groups.
- Links should be strengthened with Diabetes Australia Victoria and other existing support groups to effectively reach the target audience and effect change.
- Consumers/careers should be involved in the design and development of resources and in the provision of education and networking opportunities.
- Targeted approaches should be developed for high risk populations and those that may not be well engaged, e.g. CALD populations, males, or people living with mental health conditions.
- Literacy levels and health literacy must be considered when designing resources, programs, services, education and tools for consumers.
- Move from ‘disease’ focus to ‘wellness’ focus.
- Consider and embrace new technology to assist with self-management and social connection.
- Collect and centralise locally developed patient based resources.

Work stream 6: Diabetes Quality Improvement project (DQIP)

The DQIP was implemented to improve the general practice management of patients with T2D through a tailored quality improvement initiative with eight general practices.

This model tested the assumption that by providing endocrinologist and diabetes nurse educator (DNE) support, health professional confidence to manage patients with diabetes could be increased thereby reducing the need to refer to specialist services.

General practices were recruited through an expression of interest process, advertised through newsletter articles, at general practice visits and by invitation from the RMH. Eight general practices were then selected to participate in the project, which ran for nine months.

The pilot project supported general practice teams through:

- Development of targeted practice improvement plans
- Clinical audit and data cleansing
- Establishment of diabetes registers
- Data collection and benchmarking
- Specialist/diabetes outreach support to discuss selected de-identified cases
- Networking opportunities
- Continuous professional development and local collaborative learning sessions for general practice teams.

General practitioners were asked to select two-four patients with T2D to discuss in a group or one on one setting, with the endocrinologist/DNE within their general practice. Key findings of the de-identified case discussions indicated:

- Low confidence in initiating insulin
- Low confidence on appropriate medication management, including newer medications
- Good access to local allied health providers
- High number of patients with complex care needs

Although PEN CAT data was collected over the nine months of the project, there was very little change and or varying changes in clinical data for patients on the diabetes register. Combined data for those general practices who participated did indicate an increase in completion of diabetes annual cycle of care items, but further analysis of data sets over a longer period of time would need to be undertaken to establish an accurate conclusion.

The DQIP was evaluated through the pre-post data collection which indicated 100% increase in health professional confidence to manage patients with diabetes. Although this is a positive outcome, the resourcing required for the implementation of the project for perceived outcomes is not sustainable across the larger region. Further work needs to be undertaken to develop similar specialist outreach models, which are more efficient in supporting health professionals in the region and are supported through existing funding mechanisms to ensure sustainability.

Project aim: Improve the general practice management of patients with T2D through a regionally tailed quality improvement initiative with General Practices in Moonee Valley and Moreland.

Outputs

- Eight general practices recruited into DQIP
- De-identified patient audit tool developed
- Pre/Post evaluation surveys developed
- Three PEN CAT webinars on improving systems for diabetes care
- Two quality improvement workshops
- 12 practice visits complete with the endocrinologists where 59 de-identified patient cases were discussed
- Monthly data submission from seven general practices
- Pre and post surveys completed by 20 healthcare professionals
- Three general practices installed decision support tools (PEN CAT, Cleansing CAT & PEN TopBar)
- DQIP poster presented at primary health care research conference and the Improvement Foundation conference

Summary impact outcomes

All health professionals strongly agree or agree (100%) that they have an:

- Increased knowledge of managing patients with diabetes
- Improved clinical outcomes for patient cases(s) discussed

Majority of health professionals strongly agree or agree (>75%) that they have an:

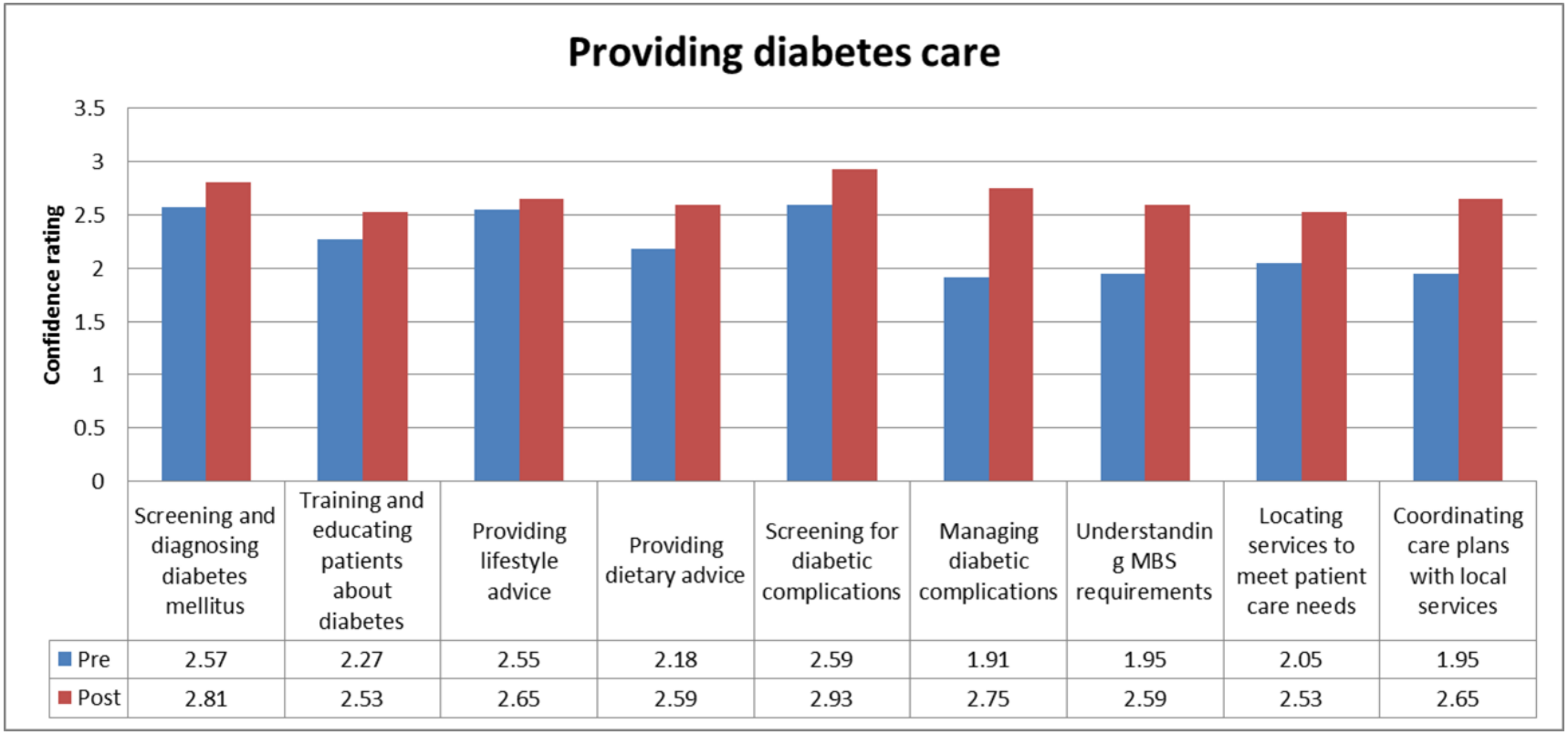
- Increased knowledge of local services and programs for patients with diabetes
- Increased knowledge and or claiming of MBS items/and Diabetes cycle of care
- Increased access to clinical support tools (HealthPathways, PEN CAT, TopBar)
- Increased the quality of diabetes care provided within our general practice

Some health professionals strongly agree or agree (>50%) that participation in the project:

- Reduced the need to refer to hospital outpatient services (for type 2 diabetes)
- Improved the way our practice communicates with other services

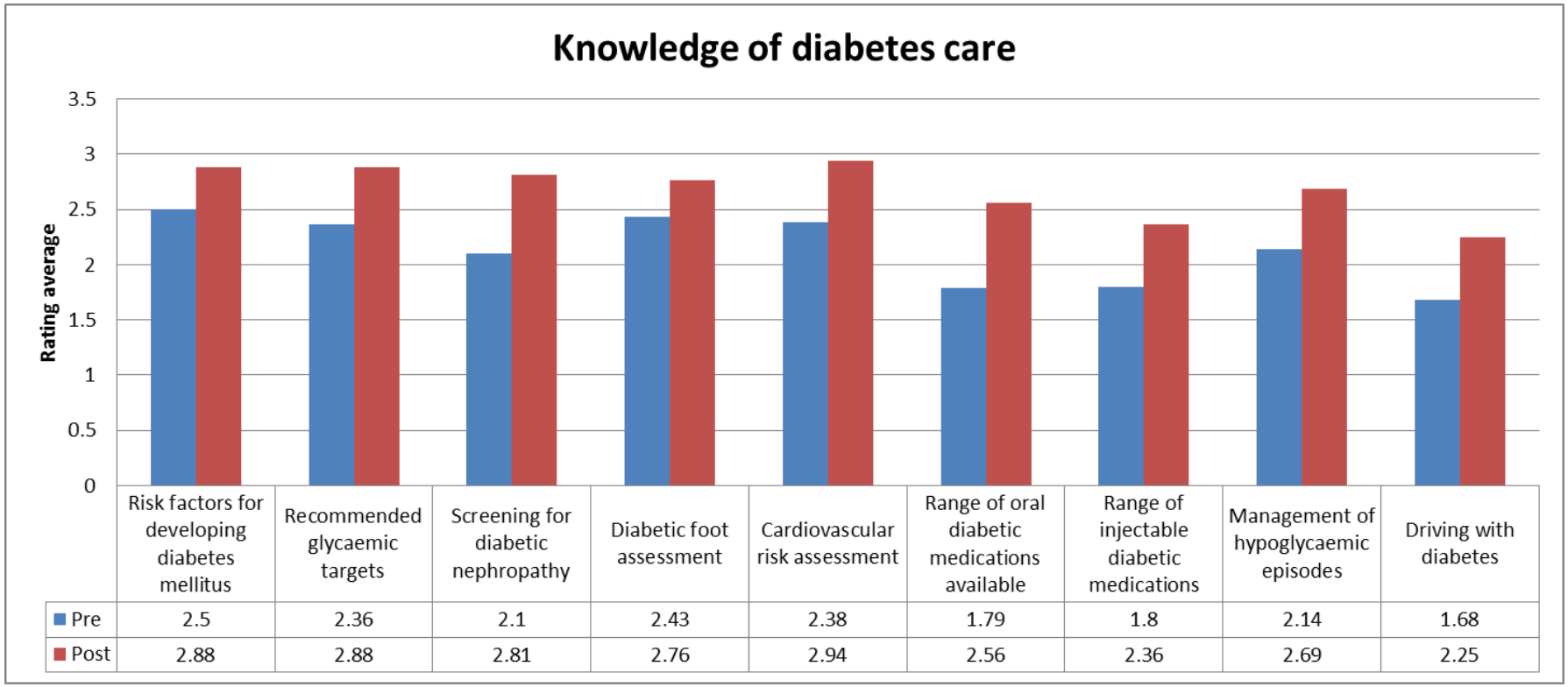
Full version of pre-post evaluation results can be accessed on request

Results 1: Pre VS post DQIP confidence levels for health professionals in providing diabetes care



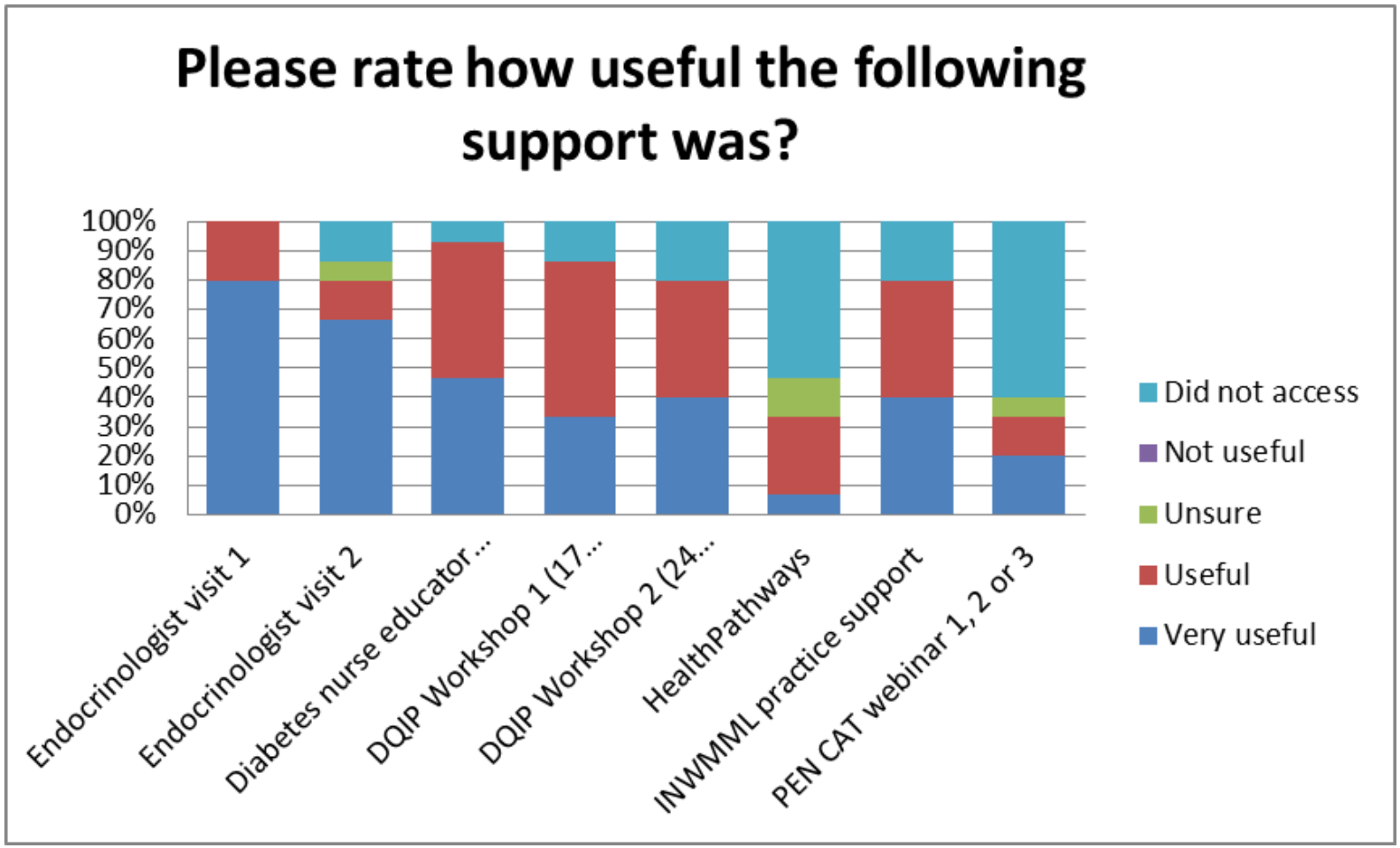
	Screening and diagnosing diabetes mellitus	Training and educating patients about diabetes	Providing lifestyle advice	Providing dietary advice	Screening for diabetic complications	Managing diabetic complications	Understanding MBS requirements	Locating services to meet patient care needs	Coordinating care plans with local services
Pre	2.57	2.27	2.55	2.18	2.59	1.91	1.95	2.05	1.95
Post	2.81	2.53	2.65	2.59	2.93	2.75	2.59	2.53	2.65

Results 2: Pre VS post DQIP Health professional knowledge of diabetes care



	Risk factors for developing diabetes mellitus	Recommended glycaemic targets	Screening for diabetic nephropathy	Diabetic foot assessment	Cardiovascular risk assessment	Range of oral diabetic medications available	Range of injectable diabetic medications	Management of hypoglycaemic episodes	Driving with diabetes
Pre	2.5	2.36	2.1	2.43	2.38	1.79	1.8	2.14	1.68
Post	2.88	2.88	2.81	2.76	2.94	2.56	2.36	2.69	2.25

Results 3: Rating of support elements provided to health professionals during DQIP



Results 4: Key findings of DQIP pre-post survey data analysis

Three key themes emerged from the DQIP pre-post survey analysis. These included:

1. **Improving general practice systems**

   Health professionals expressed the need to participate in the DQIP to improve practice systems including:

   - Data quality and benchmarking
   - Working as a team
   - Improving claiming of CDM MBS item numbers and diabetes cycle of care
   - Post results from the DQIP indicate health professionals
   - Increased knowledge and claiming of MBS items/and Diabetes cycle of care
   - Increased access to clinical support tools (HealthPathways, PEN CAT, TopBar)

2. **Education and upskilling for disease management**

   The majority of the health professionals saw the DQIP as an opportunity to upskill in diabetes management, and provide better care for their patients.

   Pre survey results indicated low confidence and knowledge in:

   - Medication management including insulin initiation
   - Screening and managing diabetes complications

   Post results from the DQIP indicate an:

   - Increased knowledge of managing patients with diabetes
   - Improved clinical outcomes for patient cases(s) discussed
   - Improved knowledge and confidence in using medication including insulin
   - Improved knowledge and confidence in screening and managing diabetes complications

3. **Knowledge and navigation of health services and guidelines**

   The pre survey results indicated low confidence levels in locating local and coordinating care plans with services. The DQIP had some influence with an increased knowledge of local services and programs for patients with diabetes and a small majority indicating improved communication with other services. Involving other local health services in DQIP activities, such as case discussions could improve linkages further.

Lessons learned and recommendations

A significant challenge for the DQIP was the coordination of general practice-Endocrinologist/DNE visits. In addition, there was potential for integrating the role of community health within the DQIP project, which was not explored. It is recommended that community health are engaged in the development and implementation of any future general practice based quality improvement projects.

Further recommendations include:

- Development of best-practice chronic disease management systems and clinical audit should be undertaken before an intervention is commenced.

- Clinical input and leadership is integral in the development and implementation of quality improvement projects and clinical interventions.
- A key practice contact is required to ensure adequate practice engagement and leadership throughout project.
- Ensure sustainable funding models are explored, including the role of MBS in the delivery of quality improvement projects
- Explore the use of new technologies to support remote access to specialist input.
- Ensure economic evaluation of any future projects to build an business case for alternative funding models eg cost benefit of endocrinologist time and avoidable bed days.
- Develop mechanisms for linkages to specialist advice, and community health services.
- Further support for general practice and providers on new medications, in particular injectable therapy.
- Engage and use local allied health/community health services to build relationships and HealthPathways to improve knowledge of local services.

Recommendations

A final steering committee meeting was held in July 2015 to review project work stream achievements, lessons learned, and endorse the project recommendations.

The following recommendations are based on project outcomes, feedback from steering committee members and current best practice. Recommendations have been allocated to collaborative agencies, with the aim of embedding these within current program structures.

	Recommendation	Timeframe	Lead agency
Increase workforce capacity to manage chronic conditions	Develop sustainable, in-practice specialist support models to build capacity of primary care to manage chronic conditions	Ongoing	MPCN
	Create local learning networks to encourage ongoing professional development and knowledge exchange for local health professionals	Ongoing	MPCN
	Establish mentoring and exchange programs to encourage practice based learning for health professionals	Ongoing	MPCN
Provide patient education, self-management and support	Hold annual education symposium informed by local consumers living with diabetes	Annual (Date TBA)	MPCN
	Strengthen links with local peer led support programs and Diabetes Australia Victoria	Ongoing	MPCN

	Recommendation	Timeframe	Lead agency
	Implement regional community marketing and awareness campaign for prevention and management of T2D	From January 2016	Collaborative partners / DAV
	Increase engagement with high risk groups including CALD, males, and people living with mental health conditions	Ongoing	MCHS cohealth
Strengthen systems for chronic disease management and prevention	Increase general practice and primary care access to quality improvement programs and clinical decision support tools for systems improvement	Ongoing 2016	MPCN
	Embed annual general practice communication audits and improvement plans within community health and hospital service	Annual	RMH, MCHS, cohealth
	Establish regional knowledge and learning hub health professionals. Knowledge hub will coordinate the storage and distribution of tools, templates and education for a coordinated regional approach.	December 2015 Quarterly updates	MPCN
	Review Diabetes HealthPathways within clinical advisory group	June 2016	MPCN

Appendix 1: CCC4D Phase 1: Needs assessment activities overview

Activity	Outcome
CCC4D Project Plan	• Project plan endorsed and project steering committee established
Community Health Referral Audit and Data Collection	• Referral Audits for all patients with T2D Accessing Service • 4 Weeks of Audits Completed (May-June)
HARP Referral Audit and Data Collection	• Referral Audits for all patients with T2D Accessing Service • 4 Weeks of Audits Completed (May-June)
Consumer Engagement Strategy	• Qualitative Researcher from VU engaged to support strategy • Ethics Application Approved • Promotion Material developed and distributed • 4 Focus Groups Conducted in July 2013 • 24 Consumers participated • Each attendee was provided a 30 minute 'Dealing with Diabetes' health update by a pharmacist or a dietician • Evaluations complied from sessions to date indicate 100% satisfaction with the quality and content of the sessions
Service Mapping Strategy	• Service Mapping Tool Developed and information collected from 6 major health care organisations in the region • Private allied health providers and specialist services mapped across the INWMML catchment area
Stakeholder engagement strategy	• Stakeholder engagement strategy developed • Currently 54 registered stakeholders • Diabetes Demonstration Projects Newsletter Edition 1
Injecting New Life Into Diabetes Active Learning Module CPD Event	• Active Learning Module CPD Event for GPs and PNs
RMH Data Collection	• Inpatient and Outpatient data collect for residents of MV and Moreland in the 2011-2012 and 2012-2013 period
General Practice Interviews	• Interviews conducted with 9 health care professionals at 6 General Practices in the areas of MV and Moreland

Appendix 2: Steering Committee & working group members

Name	Organisation	Role
Prof Peter Colman	Royal Melbourne Hospital	Endocrinologist
Dr Alison Nankervis	Royal Melbourne Hospital	Endocrinologist
Fiona McCormack	Royal Melbourne Hospital	Community Partnerships Coordinator
Katie Marley	Royal Melbourne Hospital	Manager: Diabetes Nurse Education Unit
Danny Liew	Royal Melbourne Hospital	Epidemiologist
Sean Lynch	MPCN (Formally INWMML)	General Manager: Reform & Development
Janelle Devereux	MPCN (Formally INWMML)	Manager: Development & Integration
Jessica Holman	MPCN (Formally INWMML)	Project Manager
Rachel Miller	MPCN (Formally INWMML)	Diabetes Co-Management Service
Jane Gilchrist	Merri Community Health Services	Manager: Partnership in Health (HARP)
Lucien Deane-Johns	Merri Community Health Services	Manager: Primary Health Care Programs
Antoinette Mertins	Merri Community Health Services	General Manager: Primary Care
Dianne Couch	cohealth (Formally Doutta Galla)	General Manager
Claire Conlon	cohealth (Formally Doutta Galla	Acting Practice Manager
Natasha Carlesso	cohealth (Formally Doutta Galla)	Acting Program Manager: Intake
Deborah Mihely	Diabetes Australia Victoria (DAV)	Diabetes Nurse Educator
Dr Jo-anne Manski Nankervis	General Practice	General Practitioner Advisor
Evelyn Boyce	General Practice	Practice Nurse Advisor
Gillian Cass	MPCN (Formally INWMML)	CDM/MBS Program Officer
Lauren Jordan	MPCN (Formally INWMML)	eHealth Program Officer
Rachel Maggiore	MPCN (Formally INWMML)	Service development Program Officer
Vicki Sathasivam	MPCN (Formally INWMML)	Diabetes Nurse Educator
Jane Bostock	cohealth (Formally Doutta Galla)	Team leader: Chronic care team
	Merri Community Health Services	

Appendix 3: MBS models of care for specialist support in the community *(Larter Consulting, September 2015)*

Models of care supported by the MBS

There are only two categories of services that attract MBS items but do not require a personal attendance with the patient: multidisciplinary care conferences (medical practitioners) and specialist telehealth consultations whereby the specialist and patient are linked by videoconference. Telehealth consultations are limited to patients residing outside metropolitan Melbourne, or those that are residing in residential aged care facilities or that are patients of Aboriginal Community Controlled Health Services. Within the Melbourne PCN catchment area this would be patients residing north of Craigieburn, north west of Sunbury, west of Melton and south west of Werribee. There are no MBS items that remunerate input from allied health providers, pharmacists or nurse practitioners that do not involve a personal attendance with the patient.

Therefore the following models to attract rebates could be considered:

Model 1: For patients in the community setting, either the specialist organises and coordinates a multidisciplinary case conference (4 attendees) or the GP does (3 attendees)

Advantages

- Both the specialist and the general practitioner would attract Medicare rebates
- Following the audit/review of patient notes at the practice the specialist could be participating in the case conference at either the general practice or any other setting that is convenient

Disadvantages

- To fulfil case conferencing item descriptors, the specialist must
    - Obtain informed patient consent for the case conference including offering the patient an opportunity to withhold any information that the specialist may have about them from other providers – this could be by telephone
    - Offer the patient (and carer if appropriate) a summary of the conference and providing this to other team members – this could be by telephone
    - Discuss the outcomes of the case conference with the patient (and carer if appropriate) – this could be by telephone
- Four providers must be involved if the specialist organises the case conference, including two other providers who are not medical practitioners; or three if the GP organises the case conference, including one other provider who is not a medical practitioner; yet there is no remuneration for this participation (these may be a pharmacist and/or general practice nurse if these providers are providing a specialist service in their own right; allied health providers; or community care providers)

Model 2: For patients being discharged from hospital, either the specialist organises and coordinates a multidisciplinary case conference (4 attendees) or the GP does (3 attendees)

Advantages

- Both the specialist and the general practitioner would attract Medicare rebates

Disadvantages

- Not ideal for DQIP as the patient is already in hospital
- To fulfil case conferencing item descriptors, the specialist must
    - Obtain informed patient consent for the case conference including offering the patient an opportunity to withhold any information that the specialist may have about them from other providers – this could be by telephone
    - Offer the patient (and carer if appropriate) a summary of the conference and providing this to other team members – this could be by telephone
    - Discuss the outcomes of the case conference with the patient (and carer if appropriate) – this could be by telephone
- Four providers must be involved if the specialist organises the case conference, including two other providers who are not medical practitioners; or three if the GP organises the case conference, including one other provider who is not a medical practitioner; yet there is no remuneration for this participation (these may be a pharmacist and/or general practice nurse if these providers are providing a specialist service in their own right; allied health providers; or community care providers)

Model 3: For patients in eligible areas that would benefit from face-to-face offsite specialist input with GP or practice nurse participation, organise a telehealth consultation

Advantages

- Specialist participation can take place anywhere
- GP can participate at the patient-end including taking advice about patient management

Disadvantages

- Not ideal for DQIP as the patient is still having a consultation with a specialist
- Setting up telehealth space and organising telehealth consultations can be difficult as they often disrupt usual general practice and specialist workflow

Concluding comments

At this time, the Medicare Benefits Schedule only provides very limited support for innovative models of medical specialist input that do not involve a patient consultation. Only telehealth fully remunerates care providers for their participation. Case conferencing remunerates GPs and specialists, but not other providers in the multidisciplinary team. Care planning only remunerates general practitioners. There is remuneration for pharmacists conducting medication reviews but these involve a personal attendance with an accredited pharmacist. There are item numbers for nurse practitioners but these also involve a personal attendance and are not financially viable if bulk billed.

Further specific questions about the MBS, and verification of the interpretations in this report, could be checked with Medicare Australia with via their "askMBS Item Enquiry" service[1]. This service aims to provide a written response within ten working days.

[1] http://www.medicareaustralia.gov.au/provider/medicare/mbs-item-interpretation-enquiry.jsp

Appendix 4: Budget

MELBOURNE PRIMARY CARE NETWORK

Statement of Income and Expenditure

Period **October 1, 2013 to June 30, 2015**

Program **Diabetes**

		2013-14	2014-15	Total
INCOME				
	Program Funds (Commonwealth)	$106,410	$247,001	$353,411
	Sponsorship Income (for Events)		$6,400	$6,400
TOTAL INCOME		$106,410	$253,401	$359,811
EXPENDITURE	*Health Professional Payments (includes):*	$97,410	$215,728	$313,138
	Project Manager			
	GP Advisor Payments			
	Practice Nurse Advisor Payments			
	General Practice Payments (DQIP)			
	Phase 1 Needs Assessment			
	Consumer Payments	$1,400		$1,400
	Facilitator Fee	$5,600		$5,600
	Community Health Payments	$2,000		$2,000
	Education Events and Workshops - three events (includes):		$17,673	$17,673
	Venue Hire			
	Catering			
	Speakers Fees			
	Evaluation (La Trobe University)		$20,000	$20,000
TOTAL EXPENDITURE		$106,410	$253,401	$359,811
NET SURPLUS / (DEFICIT)		$0	$0	$0