Barriers & Enablers to the uptake of NIDP Diabetes Service Incentive Payments in General Practice

Report

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1. Executive summary

Aim and method

The purpose of this study was to identify the barriers & enablers impacting on the continued uptake of the Diabetes Service Incentive Payment (SIP) within Australian General Practice and the potential role of Divisions in supporting practices to complete their annual cycle of care and claims. Semi-structured interviews were conducted with Chief Executive Officers (CEO), chronic disease program managers and practice support staff from 22 Divisions of General Practice across Australia. Participants were stratified within states on the basis of urban / rural location and by level of Diabetes SIP claims (high / low).

Findings

The findings indicated that all participating Divisions were concerned by the administrative burden and complexity of the Diabetes SIP imposed on practices, especially in comparison with other comparable items in the Schedule. This could be overcome to some extent by involving other practice staff, such as practice nurses, however this required effective communication and teamwork within the practices. Information Technology (IT) systems were found to be important enablers but current practice IT systems failed to proactively identify patients who were at risk of not completing the elements of the annual cycle of care for targeted attention by the practice.

Effective Division support activities included structured practice visits and information management support. High claiming Divisions were active in this regard and more aware of the internal organisational issues within practices compared to low claiming Divisions.

Contributing factors for the successful uptake and maintenance of the Diabetes SIP incentive within general practice:

1. An improved structure to the Diabetes SIP that is integrated with other incentives.
2. Standardised systematic approach.
3. Involvement of other practice support staff.
4. Effective communication and teamwork within the practices.
5. Effective IT systems, hardware & software.
6. Effective Division support activities.

Implications

Key implications arising from the study relate to the:

- Structure of the National Integrated Diabetes Program (especially the complexity of the annual cycle of care) and the integration between it and other initiatives and incentives for general practice.
- Role and activities of Divisions in supporting practices to improve their Diabetes care and monitor process and outcomes.
- Capacity of practices to achieve the annual cycle care for their patients with diabetes.

Further research is needed to clarify the barriers and enablers at the practice level and the effectiveness of Division support activities.

2. Introduction

SIPs are a major feature of the National Integrated Diabetes Program (NIDP), which focuses on improving the quality of care and management of Diabetes in general practice.[1] [2] The incentive payment represents completion of an annual cycle of evidence based care and a means of measuring GP management. Practices with patient register/recall systems linked to disease register/recall and other support mechanisms provided by Divisions of General Practice, are more likely to participate in structured care and claim the incentive.[3] Despite an initial enthusiastic uptake of Diabetes SIP by general practitioners (Health Insurance Commission data 2002), the response has plateaued recently.[4]

Despite the use of the SIP as a measure of GP management and the identification of enablers for the provision of structured care, there is a paucity of literature which explains the leveling off in continued GP uptake of Diabetes SIP. Building on previous data from the National Divisions Diabetes and Diabetes & CVD Quality Improvement Program, this qualitative study has a national focus and seeks to explore and identify facilitators and barriers to the uptake of the National Integrated Diabetes Program SIPs and the implementation and use of registers in general practice(5). The study has three specific objectives:

1) To identifying specific barriers influencing NIDP uptake, SIPs claims and implementation of registers in general practice.
2) To document the characteristics of practices with / without registers and those claiming / not claiming SIPS.
3) To explore the utilization and application of practice registers to assist clinical management (systems/infrastructure).

For the purpose of this report, the findings relating to Objective 1 above will be discussed.

1 Australian Government. Department of Health and Ageing. National Integrated Diabetes Program. Available at::
http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pq-diabetes-nidp.htm

2 For Health Professionals>Conditions &Diseases>Other Health Issues>Diabetes>National Integrated Diabetes Program

3 Guide for General Practitioners. Guide for the Diagnosis, Detection and Prevention of Diabetes.: Produced by National Divisions Diabetes Program (NDDP) Centre for GP Integration Studies, School Public Health & Community Medicine University New South Wales Funded by Department of Health & Aging, Australian Government 2001.

4 Harris MF, Georgiou A, Powell Davies PG, Diabetes Service Incentive Payments by Division 2001/2 to 2003/4. National Division Diabetes Program. Divisions Diabetes & CVD Quality Improvement Program. Centre for GP Integration Studies, School Public Health & Community Medicine University New South Wales, Report November 2004.

3. Methods

A qualitative semi structured interview process was used to explore participants attitudes and opinions about the barriers and enablers related to the uptake of Diabetes SIP. The method is described in more detail below.

Phase 1 – Development of the Interview Protocol

The protocol was based on a review of other similar instruments and was composed of a series of predominantly open-ended questions. The protocol was piloted with one Division of General Practice with expertise in longitudinal registers. The protocol was then refined and finalized based on the results from the pilot.

Phase 2 – Sample selection

Purposive sampling was used to identify a total of 22 participating Divisions of General Practice. To ensure an adequate range of responses participants were selected on the basis level of SIP claims (high / low) and location (urban / rural and state / territory). Given variable numbers of Divisions across states / territories, these were collapsed into the following groupings: NSW and ACT; VIC and TAS; SA and NT; WA: QLD. These were then stratified within states according to location (urban / rural). From each of the 6 strata (state grouping /urban/rural) a sample of Divisions with the highest and lowest SIP claiming rates for eligible providers for the February to April 2004 payment quarter were selected.[9]

Phase 3 – Implementation

Information about the project and an invitation letter was sent to the Division Chief Executive Officer, with participation confirmed by follow-up telephone contact. All interviews were conducted over the telephone and recorded for transcription purposes. Participant consent to record was obtained at the beginning of each interview. A copy of the interview protocol was sent to the interviewee prior to the interview.

Data collection and analysis

Responses were gathered by digitally recorded telephone interviews. Each interview was transcribed by an independent provider and electronically returned to interviewees for verification. Recordings were then destroyed. Thematic analysis was conducted by coding individual responses for emergent themes and issues.

[9] Australian Government Department of Health and Ageing PIP claims spreadsheet February 2004 quarter.

4. Findings

Of the 22 Divisions invited to participate all took part in the study. Interviews were carried out with six CEO's, four program/practice support staff accompanied by their CEO, twelve program/practice support staff and one external Diabetes consultant. There was variation in the length of time participants had been with the Divisions. CEOs ranged from one to twelve years, program/practice support staff ranged from as little as three & six months to eleven years, and one and a half years for the external Diabetes consultant.

Barriers to the Diabetes SIP Uptake

Administration

Most of the barriers to the Diabetes SIP uptake identified related to the SIP process. This included administrative concerns such as too much paperwork, red tape and time to complete the Diabetes SIP claim. As one respondent pointed out, GPs would *"rather spend time with the patient than filling in paperwork."*

Some Divisions indicated that while GPs were providing the care they were not claiming due to the "laborious" nature of the paperwork.

Respondents also stated that GPs opted to use other incentive payments instead of the Diabetes SIP. Care plans were particularly highlighted as popular as GPs tended to have a better understanding of how to claim in this context and felt they were better remunerated for the amount of work required.

There was also some confusion and a lack of knowledge by GPs concerning which incentive they should claim. Participants indicated that while some GPs thought they were claiming the Diabetes SIP, they were in fact using the wrong item numbers.

Another barrier in completing the SIP was the separate visit required to finalise the SIP procedure. It was either difficult to get patients to comply with this visit or GPs were reluctant to get patients back for the final visit as it was not necessary.

These issues were generally reflected across all participants. Additional concerns for one rural high claiming Division focused on overseas trained doctors with wives as practice managers who *"do not have the concept of how it all works'*.

Practice staff

Participating Divisions also mentioned barriers relating to human resources in the practice. Insufficient support staff within practices and practice nurses to assist with the completion of the annual cycle of care and claiming was highlighted here. This

was a concern expressed by rural high claiming Divisions for solo practices who do not have the capacity to employ additional staff, particularly *"practice nurses to assist with the SIPs"*.

Of particular concern for some rural low claiming Divisions, including those in remote rural areas, were GP shortages, high rates of part-time employment, high patient GP ratios, GP turnover and recruitment, GPs working in more than one practice, the ability of GPs to access Allied Health staff and the absence of IT and Enhanced Primary Care personnel at the Division to assist practices. Solo practices within urban areas shared similar staffing and capacity issues as their rural counterparts.

Communication pathways within practices were felt to be important. Divisions expressed concerns about in-house communication between the consultation room and the front desk. As a result of this, SIP payment claims may incorrectly use the wrong item numbers. The ability of practices to engage and manage change was also identified as a barrier in moving practices forward.

Comments received from one urban high claiming Division summed up what they saw to be the differences between solo GP practices and medical centres in claiming SIPs:

> *"It's easier for the solo GP, there's one system in place and only one doctor to deal with. Whereas in the bigger systems, it's probably a bit more difficult for the receptionist to keep track of how different doctors do it. So that is when it's more important to have protocols and processes and the practice to be working as a team to claim the items".*

Information management

Barriers around information management and technology were also commonly reported. Similar concerns were expressed by both rural and urban Divisions, however low claiming rural Divisions particularly identified the issue of a lack of disease registers in practices, a high level of solo practices and low accreditation rates.

Computer literacy remains an issue. Divisions reported a lack of knowledge by GPs to make full use of clinical software to assist with the annual cycle of care.

Divisions also reported that the clinical software used by the majority of practices was not user friendly and that *"tracking through Medical Director is difficult and time consuming"*. Divisions indicated that some practices were not good at setting up and maintaining register/recall systems and that systems differ between practices. The poor use and maintenance of these systems led to what Divisions described as creating "dirty data": data that is not complete and up-to-date.

Also, one high claiming urban Division stated that whilst some practices did use reminder systems in their patient records, reminders for completion of an annual cycle of care were often not triggered.

One rural Division expressed difficulties getting information to assist practices out to GPs who were not electronic. We received no comments about this from urban high claiming Divisions. However, the remaining groups shared similar views with a greater emphasis on clinical software issues in the urban low claiming Divisions.

Practice priorities

GP and practice values were also important. Rural high claiming and urban low claiming Divisions reported that the uptake of the Diabetes SIP and other Commonwealth priorities do not match the priorities of some practices. Uptake of Commonwealth priorities was dependent on the views and values of the GPs in the practice. Divisions also commented on variability of participation among practices. Comments from one urban high claiming Division stated that GPs don't do it because:

> *"they feel they are being forced to jump through hoops, although that is probably less for diabetes than it is for some of the other PIP items."*

Financial

There were mixed views regarding the monetary value of the SIP payment. Both rural and urban Divisions with high and low SIP coverage felt the level of remuneration for the Diabetes SIP was a barrier. It was suggested that care planning was better remunerated. Divisions also indicated that corporate medical centres did not view the Diabetes SIP as being time or cost effective and did not see any benefit in the bonus payment as many of their urban practices charged full fee patient fees.

Enablers to the Diabetes SIP Uptake

Business Practices

All Divisions identified good business practices as important enablers of SIP uptake. Good business practices included taking a systematic approach to diabetes care and having protocols and systems in place. Improved in-house practice communication, particularly between the GP and the front desk was also important. As one urban high claiming Division pointed out:

> *"it seems to be if they change their systems so they can track patients better, where they are using teamwork and using the practice nurse and practice staff. Just having protocols in place so everyone knows what they have to do that seems to help, as well as having guides and so on for staff as well."*

Divisions reported that progressive practices with good practice staff and GPs who are practice principals are the ones that tend to claim the Diabetes SIP. Leadership was seen as an important enabler. Practices with someone to take the lead engage with the Division and patients and facilitate the systems needed to complete the cycle of care and make the claims:

> *"A lead person, who says, Let's do something because the thing that facilitates it is to have a systematic approach to it and people who will own that systematic approach and that system doesn't have to be the GP. In fact, it is preferable that it is not the GP. They can just get on and do the clinical work."*

One rural Division sighted their own business practices, in addressing practice needs around customer relations and management as another enabling factor.

Human Resources

Overwhelmingly, practice support staff, especially practice nurses were considered by all participants as having a major role in supporting GPs to claim SIPs. This role may include anything from the actual billing process to registering and recalling patients:

> *"Practice nurses often do the billing and organise the actual program for the GPs."*

Of concern however, was the absence of an incentive:

> *"no PIP for employing a nurse".*

However, greater capacity for Practice nurses with the new chronic disease item numbers was acknowledged. One rural low claiming Division indicated that they had just completed an audit:

> *"It is only the ones that don't have a practice nurse that are probably not claiming…it made a significant difference if they had a practice nurse."*

Information Management / Technology

Rural high claiming Divisions made many comments, compared with other groups about information management and technology being an important enabler. This was described in terms of access to computers, the internet, clinical software and IT support. As one respondent reported, ideally practices should be *"fully computerized and using clinical desktop software."* Further it was reported that there should be a *"shift to electronic systems including systems that deal with claims"* prompting reminders that there is a certain item number they have to claim at the end of a 12 month cycle.

Division Supports

All Divisions provided support to practices in one form or another. Support specific to SIP included:

- Practice Nurses employed by the Division to assist practices claim SIPs, initiate or facilitate the claiming process.
- Rural Divisions provide allied health services, information technology assistance, practice visits by Division program staff (eg. EPC, Chronic Disease Management, Diabetes Educators).
- Information technology and management support.

From the interviews it was apparent that approaches vary between Divisions. However, practice visits where the Division was working with the practice, were seen as the most successful strategies.

Most commonly practice visits would involve project staff visiting and setting up follow-up visits either themselves or with other specialist staff such as aged care or information management and technology staff.

Some Divisions have registers and databases with reminder/recall capability to assist practices. Effectiveness of these registers was not explored in detail, however a few Divisions commented that these systems were sometimes difficult to use and not as useful as they potentially could be.

A barrier highlighted relating to Division supports in general terms centred on rural high claiming Divisions describing major difficulties in servicing those four hours or more away from the Division and given our *"geographical boundaries do not have the ability to bring everyone together."*

Information to assist Divisions Support Practices

Divisions expressed difficulties with access to information to enable them to provide support to GPs. Both rural and urban Divisions expressed concerns about the quality and usefulness of reports that could be extracted from the HIC databases. They complained that insufficient information was available on the PIP practices, how many and which PIP practices were claiming and that HIC feedback was not in a useful form for practices.

Knowledge

Increasing knowledge and understanding of the SIP process, the roles practice staff play, and could potentially play, and educating GPs around clinical software capabilities are considered enabling factors. One Division reported that *"GPs have mastered care planning and are more confident with new payments*" and they were now *"promoting SIP claims as a result."* Others indicated that increased awareness by GPs of practice staff roles, program manager awareness of provider numbers and an understanding of the cycles and care plans are also enabling factors. Most practice nurses in one Division had completed the 3 day diabetes generalist care course and were able to give education and preventative information.

Financial

For some practices, remuneration was an enabler. Divisions indicated that some GPs were really keen on the SIP payment and would fulfil the criteria to receive the extra funds. Some have a "*need for the dollars*" while others are less motivated by an incentive payment and will fulfil the criteria regardless. Even among the self motivated, it was important that they were rewarded adequately for the extra time involved.

Advertising & Marketing

One urban low claiming Division suggested advertising and marketing through government departments, to encourage SIP uptake among practices and GPs.

> *"I know the College doesn't do any but certainly it is promoted in one way or another – if they believe it's the right thing to do"*

5. Discussion

Divisions of General Practice are well placed to provide the information we were seeking given their knowledge of the National Integrated Diabetes Program process and insight into the operational characteristics of how practices function. What we gained is a snapshot of what Divisions see as the key barriers and enablers to the uptake of the Diabetes SIP. Of course this represents only the views of the Divisions not of GPs themselves. It provides some insight into the level and type of support Divisions offer practices in their Diabetes care and management.

The administrative burden and complexity of the Diabetes SIP was clearly felt to be an issue especially in relation to the level of remuneration in comparison with other items. While this was reported by all Divisions, Divisions with major workforce shortages and those with many solo practices felt that this was a major barrier.

The involvement of other staff such as practice nurses was clearly one way to deal with this but this was not possible in all practices or Divisions. Teamwork and formal protocols for communication within the practice (especially between GPs and reception staff) were important requirements even where other staff were available. This was because, as the size of the practice increased the complexity of communication and the possibility of error increased.

Information technology systems were an important potential enabler. However, many current practice systems made identifying, if patients had completed a cycle of care, for diabetes difficult. Also, even where there were reminder systems in place these did not trigger when patients had not completed the cycle.

Leadership and the priorities set by practice principles were seen to be very important. If GPs felt that completing the cycle of care was important then the remuneration helped to compensate for the extra time involved. If they did not, then the level of remuneration may not be enough to overcome their resistance.

Key Division support activities centred around practice visits and information management support. On-site education about claims and the roles which staff can play was also important. Other approaches included the provision of nursing or allied health staff to practices. It was difficult to determine the relative effectiveness of the various strategies from the interviews. Further practice level research is needed to determine the relative effectiveness of current strategies. We have previously shown that larger practice size and the provision of information technology support by Divisions was associated with higher SIP coverage by Division[7].

Generally high claiming Divisions were more aware of the internal organisational issues within practices (such as the importance of teamwork, internal procedures and

systems and information management) than low claiming Divisions. This was often related to a more active program of practice visits by Division staff. Low claiming Divisions were likely to have more solo practices, have low accreditation rates and poor levels of information technology uptake, especially registers. Problems in communication between Division and practices were suggested by the fact that some low claiming Divisions felt that marketing to practices was more a responsibility of the government and RACGP.

6. Implications

National policy

A major challenge facing policy makers is how to maintain and enhance the National Integrated Diabetes Program given current and changing incentive claiming options for General Practice. This study suggests that there is a balance between comprehensively addressing all the quality indicators and the administrative complexity of the program at practice level that affects the likely uptake, especially in practices without nursing and other staff who can identify patients who need to be targeted in order to achieve the cycle of care. There is also a need to ensure there is sufficient clarity and complementarity between programs especially the NIDP, EPC, nursing and allied health initiatives. There needs to be a way to identify when items other than the SIP are claimed for patients with diabetes.

Divisions of General Practice

For Divisions a major challenge is how to target support to meet individual practice needs within Divisional operational functionalities and limitations. The new performance indicators for Divisions include specific indicators for practice support and the extraction of data on the proportion of patients who are indigenous and capture patient data from practice registers (see Appendix). This will depend on the capacity and strategic direction of the Division, the capacity of practices (in terms of workforce, size and internal organisation), the relationship between Divisions and their members and the focus of the Division's practice support activities. Divisions which accept their responsibility and role in supporting practices to improve their diabetes care and increase the uptake of the SIP rather than relying on government or other organisations to market to GPs are more likely to be successful in achieving better uptake.

General Practice

For each general practice their major challenge is how to demonstrate that a Diabetes Annual Cycle of Care has been achieved given current incentive claiming options. This requires considerable effort. Given the complexity of general practice this is difficult to sustain without more effective information management tools which would allow practices to identify patients who will not meet their annual cycle of care targets. It can certainly be enhanced by involving non GP health care workers but this in turn requires clear procedures and good communication within the practice team. This is consistent with the findings of the Practice Capacity Study conducted in 2004[8].

7. References

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APPENDIX: NATIONAL PERFORMANCE INDICATORS FOR DIVISIONS OF GENERAL PRACTICE

Priority Area: MANAGE CHRONIC DISEASE Domain: DIABETES

Objective: Divisions will support general practices/GPs to provide optimal care and contribute to the achievement of the best possible health outcomes for patients with diabetes.

Rationale: Sustained improvements in health outcomes for people with chronic diseases such as diabetes have been associated with a more systematic approach in general practice including intensive follow up, use of clinical management guidelines integrated with self-management support programs and more effective use of nurse case managers and non-physician care providers. Systematic care includes having a disease register, regular recall and review, protected time, a practice nurse, clear written guidelines and a system for auditing standards of care. Supporting chronic disease care is a core role of Divisions.

Level 1 **Divisions** **(Organisational Structures/Processes - Programs)**	**Level 2** **General Practices/GPs** **(Organisational Structures/Processes - Programs)**	**Level 3** **Processes of Care for Patients, Families, Communities**	**Level 4** **Intermediate Outcomes for Patients, Families, Communities**
N_DIA 1.1 Division collaborates with other organisations, service providers and consumer/carer groups to facilitate patient access to optimal diabetes care. *2 points (compulsory)* **N_DIA 1.2** Division takes a systematic approach to support general practices/GPs to provide optimal diabetes care. *2 points (compulsory)* **N_DIA 1.3** Division facilitates access to effective Continuing Professional Development (CPD) for diabetes care. *2 points* **N_DIA 1.4** Number and proportion of GPs from whom the Division is receiving electronic patient	**N_DIA 2.1** Number and proportion of general practices using a practice register/recall/reminder system to identify patients with diabetes for review and appropriate action. 4 points (compulsory) plus bonus points from 2006-07 >xx% of practices = 2 points >xx% of practices = 4 points	**N_DIA 3.1** Number of service incentive payments (SIPs) made to GPs practicing in the Division's area compared to the estimated population in the Division's area with diabetes. 8 points (compulsory) plus bonus points from 2006-07 >xx% = 4 points	**N_DIA 4.1** Number and proportion of patients with diabetes on practice register/recall/reminder systems whose most recent HbA1c in the past 12 months was: • 7.0% or less; • more than 7% but less than 10.0%; • 10.0% or more; • not measured. 20 points plus bonus points from 2006-07

Level 1 **Divisions** **(Organisational Structures/Processes - Programs)**	**Level 2** **General Practices/GPs** **(Organisational Structures/Processes - Programs)**	**Level 3** **Processes of Care for Patients, Families, Communities**	**Level 4** **Intermediate Outcomes for Patients, Families, Communities**
records to provide feedback for quality improvement in diabetes care. 20 points plus bonus points from 2006-07 >20% of practices = 5 points >40% of practices = 10 points >60% of practices = 15 points >80% of practices = 20 points ***N_DIA 1.5*** Division takes a systematic approach to support general practices/GPs to consistently capture and record Aboriginal and/or Torres Strait Islander origin for patients with diabetes on the practice register/recall/reminder systems. 2 points (compulsory)		>xx% = 8 points	xx = 10 points xx = 20 points **N_DIA 4.2** Number and proportion of patients with diabetes on practice register/recall/reminder systems whose most recent total cholesterol in the past 12 months was: • less than 4.0 mmol/L; • 4.0 mmol/L or more; • not measured.20 points plus bonus points from 2006-07 xx = 10 points xx = 20 points