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Practice level barriers and enablers to the uptake of the Chronic Disease Management Items and Service Incentive Payment for Diabetes

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July 2006

http://www.cphce.unsw.edu.au

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1 Executive Summary

1.1 Introduction

The purpose of this study was to identify the barriers and enablers at practice level impacting on the uptake of the Diabetes Service Incentive Payment (SIP) and the Chronic Disease Management Items for diabetes care within Australian General Practice. Semi-structured interviews were conducted with General Practitioners (GPs), Practice Nurses (PNs) and Practice Managers (PMs) from 10 practices located in four states. Practices were chosen on the basis of urban or rural location, the size of the practice and by the level of Diabetes SIP claims (high / low). Three case studies were drafted to illustrate barriers and enablers to using the items in a range of practices; two that make modest claims and one that makes more extensive claims.

1.2 Findings

There is a great deal of variation between general practices and sometimes between clinicians within practices. Some practices showed a reluctance to change the way in which they cared for diabetes patients while others welcomed the new MBS items as an appropriate reward for providing planned care. Informants spoke of providing planned care which did not meet the pattern and restrictions of the Diabetes SIP item but which they regarded as appropriate and planned care. Practices reported that it was difficult to find the time needed to invest in efficient systems that would enable them to identify and call patients so that they received elements of the cycle of care in an appropriate timescale, cycles of care were completed and a Diabetes SIP claim made. Many reported that they were making good use of the GP Management Plans which were simpler to organise and provide. A summary of barriers and enablers is provided below in Table 1.

Table 1: Barriers and enablers to the use of the Diabetes SIP and CDM items

Factor	Barrier	Enabler
Items	- More paperwork - Complexity – cycle/ timing / order - GP initiation – nurses can't claim	-PNs can do some tasks -Fits with some GPs way of working
Time	- Lack of GP/PN time - Needs investment time	-Finding dedicated time to do SIP -Dedicated time setting up systems

Factor	Barrier	Enabler
	- Needs maintenance time -Opportunity costs	-PN protected time to do CDM
Personal Preferences	-Bad past experiences -Desire for clinical autonomy	-GPs value financial remuneration -GPs willing to use items
Fit with GP patterns of working	-Poor fit with some GPs way of working -GPs forget to use or claim the items	-Good fit with some GPs way of working -More systematic approach to care by GP includes reminders
Practice	-Care systems that are not linked -Lack of PN or administrative staff in appropriate roles -Variation in GP styles in large practices -Poor communication in the practice	-Good systems that are linked -Appropriate numbers and roles of staff (protected time for CDM, investment time) -Good practice culture and leadership
Patient	-Non compliance -Multiple conditions that need prioritising	-Established fee for service practice with longstanding loyal patients
External	-No clear answers from Medicare	-Part of National Primary Care Collaboratives -Pharmaceutical company sessions -Good advice from Medicare

The Diabetes SIP was thought to be a complex item and for some represented a new way of working. Practices reported that it would take time to change and that many would require external support to set up electronic systems that provided timely reminders to GPs and PNs which fitted the working pattern of particular practices and the GPs within them.

Practice Nurses were thought to be vital to the process of planned care and there was a particular preference among the higher claimers for full time nurses with protected time to focus on updating and maintaining systems. Practice managers and reception staff were seen to be responsible for calling patients and billing for items when asked to do so. Practice Nurses reported heavy workloads and often found it difficult to pay

attention to planned care since they were caught up in the clinical workload of the practice.

The higher claiming practices reported that the items fitted closely with their approach to planned care and that they were pleased to be rewarded for what they regarded as good quality care. Particularly important was the attitudes of the GPs in supporting planned care and providing the resources, particularly PNs with protected time and good electronic information management systems.

Both high and lower claiming practices reported that completing cycles of care depended on patient compliance and that this involved patients attending when they might feel they are well and perhaps incurring a co-payment. In some cases patients had a number of symptoms or co-morbid conditions and completing an element of the cycle of care might not be the first priority. The patient might have consulted for a different reason or the clinician may determine that treating another condition has a higher priority.

Interviewees reported different experience with external support including Divisions and Medicare Australia although there appeared to be a positive response from participants in the National Primary Care Collaboratives programme which emphasises practical quality improvement and the management of change.

1.3 Conclusion

There is a wide variation in the approaches and capacity of general practices to provide planned care for patients with Diabetes. Key to successful uptake is the attitude of GPs, the availability of full time PNs with protected time for chronic disease care and system development, and the skills or external support to invest in supporting computer systems. Even where practices have a positive approach allied with good resources and systems, there are important instances where completing cycles of care is not the most important objective for doctors or patients.

2 Acronyms

CDM	Chronic Disease Management
GPMP	General Practice Management Plan
MBS	Medical Benefits Scheme
NIDP	National Integrated Diabetes Program
PM	Practice Manager
PN	Practice Nurse
RRMA	Rural, Remote and Metropolitan Area (RRMA) classification system
SIP	Service Incentive Payment
TCA	Team Care Arrangement
IT	Information technology

3 Introduction

This scoping paper was commissioned by the Australian Government Department of Health and Ageing as part of their contract with the Centre for General Practice Integration Studies at the University of New South Wales. It follows on from an earlier paper which addressed barriers to the uptake of the items from the perspective of Divisions of General Practice (De Domenico, 2005).

3.1 Diabetes PIP and Chronic Disease management items

The Diabetes Practice Incentive Payment (PIP) is 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 (Harris 2004). The incentive payments were introduced in November 2001 to enhance prevention, earlier diagnosis and management of people with established diabetes mellitus. The Diabetes PIP has three components. The first is a sign-on payment for practices that establish a patient register and diabetes recall/reminder system. The second is the **Diabetes Service Incentive Payment (SIP).** This is provided for the completion of an annual cycle of care that includes blood pressure, BMI and foot checks every 6 months, HbA1c, lipids, microalbuminuria, risk management and medication review checks yearly and eyes checked every tow years. The SIP can be claimed once a year for each patient. Thirdly, the **Diabetes Service Outcome Payment (SOP)** is provided to practices that have at least 2% of their patients diagnosed with diabetes and at least 20% of those have completed the annual cycle of care.

The new Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items were introduced in July 2005 and replaced the former items for multidisciplinary care planning services (items 720, 722, 724, 726, 728 and 730) which ceased to be available in November 2005. The new items (721, 723, 725, 727, 729 and 731) provide rebates for GPs to manage chronic disease by preparing, coordinating, reviewing or contributing to CDM plans. These new items were developed in consultation with GP groups to improve the operation of the EPC items and reduce red tape.

The new EPC chronic disease management items are:

- preparation of a GP Management Plan (GPMP);
- review of GP Management Plan;

- coordination of Team Care Arrangements (TCA) for patients with complex care needs;
- coordination of review of Team Care Arrangements
- contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for patients who are not residents of aged care facilities); and
- contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for residents of aged care facilities).

The steps for preparing a GPMP are:

- recording patient's agreement for a plan
- assessing the patient;
- agreeing on management goals with the patient;
- identifying the patient's needs, goals and actions to be taken by the patient;;
- identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
- completing the GPMP document.

Steps for coordinating TCA for a patient are:

- agreement with patient on this service, providers to be involved and consent to share relevant information;
- collaborating with providers to agree on treatment and goals; and
- completing the TCA document.

A Practice Nurse or other health professional can assist in preparing or reviewing a GPMP or TCA by completing some of the assessment (diabetes type, risk factors, control and some aspects of complications), identifying the patient's needs and making arrangements for services on behalf of the GP.

3.2 Using the items together

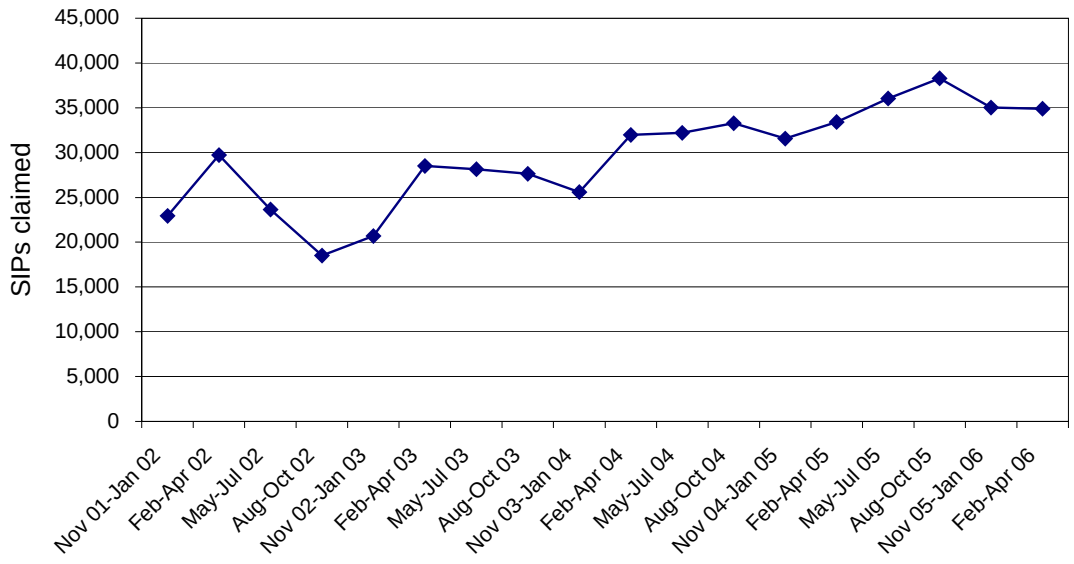
The new CDM items offer an additional and complementary funding mechanism to the Diabetes SIP for providing best practice care of patients with diabetes. Patients are likely to benefit from both the development of a GPMP and the best practice annual

cycle of care. Patients with complex, multidisciplinary needs might benefit from the development of a GPMP and TCA, which can be claimed in addition to the Diabetes SIP (but not within 3 months of the GPMP or TCA).

3.3 Uptake of the items in general practice

Despite an initial enthusiastic uptake of Diabetes SIP by general practitioners (Health Insurance Commission data 2002), the response has plateaued recently (See Fig.1). The following tables were compiled from data collected from the Australian Government Medicare Australia website (www.medicareaustralia.gov.au).

Figure 1: Number of Diabetes SIP items claimed from November 2001 to April 2006



For the most recent payment quarter almost all PIP practices were 'signed on' for the diabetes SIP (See Table 2). Approximately 40% of providers from 70% of 'signed on' practices claimed SIPs during this quarter except for the Northern Territory where 40% of eligible providers claimed SIPs from only 30% of the 'signed on' practices.

Table 2: Percentage of practices and providers with SIPs

May 2006 Payment Quarter		Diabetes Sign On		Diabetes SIPs		
State Divisions	Total number PIP practices	Number PIP practices signed on	Number of eligible providers*	Number of SIPs	% Signed on practices with SIPs	% Eligible providers * receiving SIPs
NSW Divisions	1,655	1,474	4,571	11,774	70%	42%

May 2006 Payment Quarter		Diabetes Sign On		Diabetes SIPs		
State Divisions	Total number PIP practices	Number PIP practices signed on	Number of eligible providers*	Number of SIPs	% Signed on practices with SIPs	% Eligible providers * receiving SIPs
VIC Divisions	1,185	1,087	4,105	9,726	68%	39%
QLD Divisions	919	835	2,566	5,921	62%	40%
SA Divisions	362	331	1,452	3,425	73%	40%
WA Divisions	388	357	1,498	2,778	69%	39%
TAS Divisions	129	119	402	835	64%	45%
NT Divisions	34	30	71	97	30%	39%
ACT Division	78	62	212	352	68%	35%

Table 3 shows that urban areas (RRMA 1 and 2) have similar rates of SIPs per 'signed on' practice to practices located in large rural centres (RRMA 3). Practices in rural remote locations (RRMA 4-7) had fewer SIPs per practice but this is like to be a result of fewer numbers of patients per practice in these areas. In fact, the rate of SIPs per 1,000 SWPE was similar for all locations in the last payment quarter.

Table 3: Number of SIPs for practices classified using the RRMA classification

May 2006 Payment Quarter	RRMA 1	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7
Sign on - practices	2,665	322	281	271	623	49	84
Sign on - SWPE	5,912,568	776,632	751,206	913,702	1,305,559	53,209	38,072
SIP	19,462	3,402	2,697	3,346	5,620	233	148
SIPs per practice	7.3	10.5	9.6	12.3	9	4.7	1.8
SIPs per 1,000 SWPE	3.3	4.4	3.4	3.6	4.3	4.4	3.9

*SWPE = Standardised whole patient equivalent

A national study conducted in 2005 addressed this issue by investigating facilitators and barriers to the uptake of the diabetes SIP in general practice at the Division of General Practice level (De Domenico 2005). The study found that Divisions were concerned about the administrative complexity of the SIP for general practices. However, these could be overcome by:

- an improved structure to the Diabetes SIP that is integrated with other incentives.
- a standardised systematic approach.
- involvement of other practice support staff.
- effective communication and teamwork within the practices.
- effective IT systems, hardware & software.
- effective Division support activities.

A study of the Asthma 3+ Plan pointed to GP concerns about workload and complexity of the items and to patient views about the severity of their disease, their compliance and their attitude towards, asthma care (Zwar 2005).

4 Method

Semi structured interviews were used to explore respondents' attitudes and opinions about the barriers and enablers related to the uptake of Diabetes and chronic disease management items?SIP. Case studies were compiled by conducting in depth interviews with three practices.

It is not possible from a study of this sort to encapsulate the full range and variety of Australian general practices. For instance, it was not possible to persuade a corporate practice to take part. The findings across the practices do point to a number of consistent and common themes which are presented below.

4.1 Phase 1 – Development of the Interview Schedule

The interview schedule was developed with reference to a similar study undertaken with Divisions of General Practice in 2005 (De Domenico 2005) and modified for the general practice setting. The interview schedule used a mixture of closed and open ended questions to facilitate a detailed description of the context, experiences, attitudes and opinions within each practice. (See Appendix)

4.2 Phase 2 – Practice selection

Purposive sampling was used to identify a total of 10 General Practices. To ensure an adequate range of responses participants were selected on the basis level of location (urban / rural and state / territory). Divisions were selected and telephone contact was then made with the diabetes program officers who then provided contact details for 2-3 general practices who might be willing to be involved in the study. Some Division program officers chose to contact practices first and ask for their consent to participate and then contact details were provided to the research assistant. Practices were not paid and a number declined to be interviewed on the grounds of the amount of time required.

4.3 Phase 3 – Implementation

Telephone contact was made with PMs from the selected practice and these were followed-up with faxed information about the project, an invitation letter and consent forms. Consent forms were signed by participating practice staff and faxed back to the research assistant. All interviews were conducted over the telephone or face to face and recorded for transcription purposes.

4.4 Data collection and analysis

Each interview was transcribed by the research assistant and recordings were then destroyed. Thematic analysis was conducted by coding individual responses for emergent themes and issues.

4.5 Findings

Findings are presented from telephone and face to face interviews conducted with General Practitioners (GP), Practice Nurses (PN) and Practice Managers (PM) from 2 rural practices and 8 urban practices from 4 different states. Case studies were compiled from detailed interviews with several staff in 3 practices from a rural, regional and urban location.

The focus of the interviews was to identify the enablers and barriers to the use of the Diabetes SIP and the Chronic Disease items from the perspective of general practice. The findings are presented as barriers and enablers and are illustrated by case studies. Two of the case studies are place after the “barriers” section as an illustration of how those barriers applied in the particular practices, and the third is placed later to illustrate the “enablers” findings.

5 Barriers

These findings are described under the key themes identified in the interview namely;

- the structure of the items;
- the time pressures and workloads facing the practice;
- the personal preferences of GPs;
- the way the items and their structure fitted in with the ways in which practices operate;
- the attitudes of and behaviour of patients; and
- external factors.

5.1 Structure of the items

A number of the practice staff identified barriers to uptake of the items that related specifically to properties of the items themselves. Many believed that the items increased the workload for GPs and practice staff, particularly through additional paperwork. One GP said he had no difficulties using the items but said:

> *"It is impossible to do these things in a 30 minute consultation and the fee for such consultations is not adequate."*

The complexity of the items also acted a barrier to their use. Many respondents reported occasions where GPs had been confused about which items to claim and when. Of particular concern were selecting the right item numbers and knowing which items could be claimed and in what sequence they should be claimed. One PN commented:

> *"Never before has the onus been so much on certain billing arrangements and certain spaces between billing."*

Some staff believed that undertaking the requirements for the SIP was a task mostly up to the GP. Therefore the potential role a PN could play was limited. Staff from one practice recalled a procedure they had set up where a PN had been given the dedicated task of completing the diabetes checklist before patients saw the GP for their annual visit. Staff believed that during this time more SIPs were being claimed but the procedure was discontinued on the request of the GP. The GP felt that his lack of involvement in this aspect of care opened him up to making mistakes and was not in the

best interest of the patients. He also believed that the time he saved with this process was minimal because he had to double check each element of the checklist.

5.2 Time

The most common difficulty with using the items was a lack of time to carry out the requirements and claim the items. GPs and PNs reported that they were struggling to cope with the workload and time demands placed upon them, which limited their ability to undertake paperwork or introduce new systems and ways of working in the practice. In busy surgeries the opportunity cost of using the items was seen to be too high since there were large numbers of patients to be seen every day.

5.3 Personal preference

The inconsistent attitudes and preferences of GPs in some of the larger practices were a barrier to introducing consistent systems of planned care. Staff reported that some GPs claimed the items regularly for their patients with diabetes and others did not. This created other difficulties within the practice as described by one respondent:

> *"It is generally personal preference and I guess experience. If they've had concerns in the past.... Some will say that they give appropriate care but just don't want to bill."*

And also:

> *"Because of the variety of GP use and attitudes to the items within this practice it makes it hard to set up standardised systems to assist. They [GPs] are all totally justified in their opinions but it makes using the items in the practice difficult."*

Some GPs and practice staff reported frustration with the structure of the items and the requirements for claiming the items. Not only were these frustrations affecting current use but they have the potential to affect future uptake of similar government initiatives. One respondent commented:

> *"In 2001 we used the old care plans. I think our GPs were never really satisfied with them and had difficulties arranging them so that has cast a shadow on current use of the items."*

Another stated:

> *"…the government side of things is saying that the doctor has to do this that and the other and that's what frustrated them. They are thinking well we are doing it so why should we have to do it the way that you say. And me personally I think they've just got no idea, they're not in the real world and it's a time problem. That's just a personal perspective and then any nurse that I know would say the same. How are we supposed to do all this, we haven't got the time. And I get frustrated with it too."*

These GPs felt that they were being told how to provide care for their patients and that this was inappropriate.

5.4 Fit with GP skills and patterns of working

GPs who believed the items did not fit with their current working style or patterns of care were less likely to the claim the items. One PN mentioned that in her practice variation in the use of the SIP among the various GPs was caused by different styles of care and methods for recording the care that patients receive. Some GPs had records of the annual cycle of care for their diabetic patients linked electronically to their patient records while others wrote on the patient records. One respondent commented:

> *"Some GPs choose to be opportunistic in the way they carry out the annual cycle of care whereas others prefer to use the recall system to make appointments to see patients with diabetes."*

Other behaviours which hindered use of the items were a lack of understanding of how to use the items, the lack of a teamwork approach within the practice and GPs or PNs not remembering to claim them.

In some practices there were GPs with poor computer literacy which added to the difficulty of developing recall systems and claiming for cycles of care.

5.5 Practice factors

Many respondents identified poor systems and procedures in the practice to support use of the items as a major barrier. Practices reported that a lack of reminder/recall system and register of patients with diabetes made completion and documentation of the annual

cycle of care more difficult. The absence of links between the recall system and patient register made the task of carrying out systematic care and keeping track of this care even more difficult. One PN reported:

> *"There is minimum use of the diabetes register even though it is very up to date and accurate. It doesn't necessarily trigger reminder and recall for SIP."*

Also, without an up to date and accurate register of patients with diabetes it was difficult to keep track of the annual cycle of care, and preventive care was limited to patients who choose to present to the practice, usually with a specific health problem that needed addressing. But as one PN mentioned:

> *"The systems take time to establish. You can't push to hard with the GPs because then you just get resistance."*

A number of respondents mentioned that there were not enough PNs in the practice and therefore the GP did not have sufficient support to provide appropriate care and claim for the items. They reported that without appropriate levels and expertise of staff in the practice the GP would be forced to give all the care and carry out all the paperwork on his/her own.

> *"Here the SIP is basically up to the GPs."*

Poor communication was a barrier in some practices. Most of the practices where staff were interviewed employed a system of claiming the items with the involvement of GPs, PNs and reception staff. Some reported occasions where communication breakdown, particularly between GPs and receptionists had led to items not being claimed.

5.6 Patient factors

Patient level factors were also mentioned as barriers to use of the items by a number of respondents. In particular, interviewees reported the effect that patient compliance had on completing the annual cycle of care, and thus claiming the SIP. Some recalled times where patients refused to have certain diabetes checks done, or refused to see a specialist for a certain test. This suggests some difficulties in understanding the items in particular practices. Some practices also reported difficulty in getting patients to attend

for their annual review. The key reason given was that if patients feel healthy then it is harder to get them to comply with preventive care requirements. One nurse commented:

> *"It's up to the GP to say to the patient you need a review of your diabetes and if they don't see its relevant or if they've just been to the endocrinologist and the podiatrist and they say it's all under control, they don't want to come in."*

Another patient level factor was the complex care needs of many patients with diabetes. Many patients had multiple chronic conditions and the GP had to prioritise the care they would provide and the tests and assessments they would carry out. For these patients, carrying out the requirements for the SIP might not be the first priority and thus the item would not be claimed. GPs and practice staff mentioned the importance of not 'overloading' patients with demands. One PN commented:

> *"For some patients we have several things on the recall system. You have to determine what's the most important. The patients can only cope with so much."*

5.7 External factors

Some GPs and PNs reported lack of support from Medicare to help the practice better understand how to use the items. One GP commented:

> *"Getting universal interpretation from HIC [Health Insurance Commission] is a problem. Every time I call I talk to different people and get a different answer."*

Case Study 1: A small rural low claiming practice

What is the practice like?

This is a small practice located in a rural area. The practice employs two full time GPs, one part time GP, one PN, three part time receptionists, and one PM. The practice houses a community health centre and other allied health workers. Their patient list includes a significant indigenous population and pension holders are bulk billed. The local Division of General Practice provides support through a diabetes educator and a counsellor (once a month), and partially funds the PN through the More Allied Health Services (MAHS) program. They utilise a practice based paper and electronic register of

patients with diabetes.

Use of the items

GPs in this practice have been claiming the SIP since 2001; however, use is very limited. It was estimated that only one had been claimed in the last twelve months. The claiming of GPMPs and TCAs is also very occasional. The key reason given for low use of the items are the GPs forgetting to keep track of the annual cycle of care and forgetting to notify reception to bill for the items.

The process for carrying out the requirements and claiming the items follows a standard practice procedure but this is not always followed in a way that results in the items being claimed. Firstly the patient sees the PN who then refers the patient to the GP for consultation. The GP then identifies whether a GPMP or TCA is needed, carries out the requirements, and presents them to the receptionist to be claimed. The PN also supports this process by querying patient records in advance to identify patients who might need a GPMP or TCA.

The main barrier to use of the SIP within this practice is not keeping track of the diabetes annual cycle of care. The GP is required to register that the patient has ended the cycle and notify the receptionist, who can bill for the item. The process falls down because GPs are not remembering to bill and find it difficult under the current circumstances to keep track of the cycle. The practice plans to give the PN the task of reminding the GP when a SIP is to be claimed.

Another difficulty is the fact that many of the practice's diabetic patients present with problems other than diabetes. Addressing other presenting problems often takes priority over the preventive care requirements for the SIP.

Having a PN has enabled the practice to effectively care for their diabetic patients and is likely to be invaluable in future expansion of use of the items. The PN is already well utilised for the care of patients with diabetes but there is room for enhancing her role.

Where to from here?

The practice has plans for expanding use of the SIP and CDM items. Planned actions include updating the electronic system to accommodate recording of the cycle of care and a review of current practice procedures. They recognised a need for better planning

and more proactive care of patients with diabetes supported by a more systematic approach to care which makes it easier for GPs to remember what items to bill and when.

Case Study 2: A large regional low claiming practice

What is the practice like?

This practice is located in a regional town and has been operating for less than 12 months. Since the practice was established it has employed two full time and three part time GPs, two part time PNs, three administration staff and one PM. It is situated in an area of chronic general practitioner and allied health professional shortages. The practice uses the MedTech practice management system which incorporates electronic patient records and recall templates for patients with diabetes.

Experience using the items

While the practice has 'signed on' for the SIP, use of the item has been very limited. The major reason given by the practice is the fact that the SIP cannot be claimed within three months of the GPMP, which doesn't fit well with current GP ways of working in this practice. The GPMPs and TCAs are utilised well but this varies considerably between individual GPs.

Patients with diabetes are encouraged to see their GP every 3-6 months. Before the patient sees the GP, one of the PNs conducts a 30 minute consultation with the patient where she conducts assessment using a standardised diabetes template developed by one of the GPs in the practice and incorporated into the MedTech system. The template includes the diabetes annual cycle of care components. The nurse also conducts patient education and preventive care. The patient then sees the GP who initiates or updates a GPMP and TCA.

GPs in the practice vary in their attitudes, experiences and behaviours and this has an effect their use of the items. There is an attitude within the practice that the SIP isn't really worth doing.

"It's not worth as much. We are doing exactly what is required for the SIP and more.

It's all in the template. If you could claim them both [GPMP and SIP] we would."

Establishing the systems, procedures and practice culture that supports use of the items takes time. This is a new practice and systems are still being tried out. Some GPs have poor computer literacy which has made use of the computerised template difficult. It is also taking time for these GPs to get used to the electronic software.

A major reason for good uptake of the CDM items has been the work of the two part time PNs. They play an integral role in diabetes care by consulting with patients before they see the GP, organising the TCAs and conducting administrative tasks related to use of the items such as filling in the electronic diabetes template.

Leadership within the practice has been important in establishing good systems and procedures in this new practice. This has come from some of the GPs and PNs, and is largely based around improving electronic systems and developing standardised procedures for claiming the GPMP and TCA items. They have driven many of the improvements that have occurred within the last 12 months and encouraged other staff to work more systematically and utilise the GPMP and TCA items.

"We have pushed the GPMPs because they are doing the goals as well as the cycle of care."

Where to now?

Being a new practice, they have had extra time to set up IT systems and plan for the future while the patient base was developing. Expansion of use of the GPMPs and TCAs will continue as practice staff become more familiar and confident using the IT systems and following standardised procedures. The practice is continuing to focus their efforts on improving chronic disease management and investing time to set up systems that will enhance diabetes care, but it is unlikely that use of the diabetes SIP will increase substantially in the near future.

6 Enablers

Some of the enablers are the opposite of the barriers but other factors come into play. The themes are described using a similar structure to the findings about barriers.

6.1 Structure of the items

Although most respondents agreed that the structure of the SIP was administratively complex, some reported that it facilitated their use in general practice: for example in one practice the PN reported that it matched well established pathways of care. Others mentioned that the GPMP and TCA were easier to use than the Enhanced Primary Care (EPC) items they replaced because they allowed PNs to undertake some of the tasks formerly restricted to GPs.

6.2 Fit with GP patterns of working

As well as being barriers, the personal preference of GPs, their attitudes and experiences can support the use of the items. GPs and practice staff noted that some GPs had attitudes or practice styles that resulted in quicker uptake of the new items and greater use and commitment to setting up systems that enhanced their use. For the SIP in particular, GPs who were already providing a systematic annual cycle of care, who valued the financial remuneration from the items, and who believed that patients benefited from planned care were reported as higher users of the SIP. One PN commented:

> *"They certainly make a difference to the GPs' income and they are happy with that. And I think for that reason alone the GPs want to keep using them, because they realise that they're overworked and overwhelmed in a complex health system and if they're not going to get remuneration for individual items then this is a way of being remunerated. But the logistics of the SIP payments are just so much more complicated."*

GPs who described themselves as proactive in their care of patients with diabetes reported greater use of the items. A GP from one self reported high claiming practice said:

> *"This practice takes its preventative role seriously."*

6.3 Practice factors

At the practice level one of the most commonly reported enablers was having systems for the recall and registering of patients with diabetes and their care. For the diabetes SIP in particular, the role of a register and recall system was felt to be very important. Respondents reported the use of recalls for completion of the annual cycle of care and having this system linked to patient records to assist with the SIP. One GP said:

> *"Most patients show up with a problem so doing preventive care is difficult. We've got good systems and we utilise our nurse very well. We've got lots of systems and we utilise recalls"*

Some respondents said that having a register alone was not sufficient; the register must also be accurate and kept up to date.

All practices mentioned the role of the PN as important to use of the CDM and SIP items. Sharing roles among practice staff was thought to enable use by freeing up the GPs time and having a staff member who could focus more consistently on chronic disease management and setting up systems to enable use of the items. Respondents reported that the sharing of clinical tasks such as the diabetic checklist, sharing the paperwork burden, and setting up a recall/reminder system within the practice had enabled them to better utilise the items. Referring to the GPMP and TCA items, one respondent said:

> *"It goes a little bit back and forth between the GP and nurse, but that's the only way you can do it because they [GPs] don't have the time to do it. They don't have the time to actually sit there and type it all out."*

Most practices recognised the value of a full time PN available to do chronic disease management and support the GP(s). Having a nurse employed with protected time set aside for chronic disease management and to set up systems was a major enabler. One PN commented:

> *"Once it's in place it will be great, but you basically need another person employed just to do that."*

While all practices mentioned the use of PNs as helping to use items some practices emphasised the importance of a full time nurse. One PN said:

> *"I don't support nurses being contracted to come in and do CDM. There needs to be that continued patient contact. I know from experience with the Practice Nurse Network that there is a great need for nurses to be supported in their role to provide CDM."*

Also important at the practice level was a practice culture that supported CDM and preventive care and sufficient time to get used to using the items and establishing appropriate systems and procedures

6.4 Patient Factors

One well established practice reported that many of its patients had been withy the practice for more than 20 years and there was no problem in asking them to attend for an element of diabetes care. This was not such a simple issue in a bulk-billing practice in an area where the costs of care was important and there were alternative practices which patients could easily attend.

6.5 External factors

Some respondents reported external factors that had enabled them to make better use of the items. One reported utilising the education sessions offered by pharmaceutical companies to improve their skills and education. Two practices mentioned being part of the National Primary Care Collaboratives, which had, among other things, encouraged them to make better use of their register of patients with diabetes.

Case study 3: A large urban high claiming practice

What is the practice like?

This is a large practice situated in a capital city. Within the practice are six full time and ten part time GPs, working from two to eleven sessions per week. The practice also employs two full time PNs, one community nurse, three full time and six part time receptionists/administrative staff, one executive officer, and one PM. The practice is part of the National Primary Care Collaboratives. The practice uses an electronic register of patients with diabetes but this is not linked with the remainder of the electronic practice

management system.

Experience using the items

The SIP was not being claimed regularly until a practice nurse was employed specifically for this role this year. Use of the item is increasing. GPMPs and TCAs are utilised often by GPs in the practice.

Use of the items in this practice follows the following process. When the patient with diabetes attends the practice the annual cycle of care electronic template is updated to record all relevant tests and assessments that have been completed and assesses whether the criteria for the SIP have been met. The GP also looks at items which have previously been claimed for the patient and decides whether to produce a GPMP, TCA and/or claim the diabetes SIP. The PN is involved in assessing the patients and completing the relevant documentation. The PM has an informal role of reminding GPs to claim for the various items.

Claiming the diabetes items had been difficult in the past for a number of reasons. GPs found the SIP to be time consuming and complicated. There was previously no PN with protected time to assist with diabetes care and completing the requirements for claiming the SIP and CDM items. However, good processes are now in place, with the appointment of a PN responsible for these tasks.

GPs also found that the extra time needed to complete documentation for the GPMPs was problematic and use was limited. However, the recent development of an electronic template to support this process has resulted in better use of the item.

Another difficulty has been the fact that the electronic register of patients with diabetes does not link with the remainder of the records system. This means that pathology reports relating to the annual cycle of care, and the recall system cannot be linked with the register, which limits the GPs ability to track patient progress through the cycle of care and proactively care for patients.

Practice staff also attribute better use of the items to clearer guidelines from Medicare on the sequencing of the items and inclusion criteria for patients with chronic diseases.

Where to from here?

The practice would like to expand use of the items and the introduction of the PN with a defined role in diabetes care and IT system development, and the GPMP template in recent months are ways in which staff believe that this will be achieved.

7 Discussion

This study has investigated practice level barriers and enablers to the uptake of the chronic disease management items and service incentive payment for diabetes There was little published literature, most of which focused on earlier items which have since been redesigned. However a number of points have continuing relevance. There remains a variation in uptake between items, between geographical areas, and between different types of GP and patient (Wilkinson 2002 a,b,c,d,e, 2003). Items which do not involve the active cooperation of other practitioners remain more popular, and those that require provider activity across a full cycle of care, the cooperation of patients and good systems within the practice are, not surprisingly, most difficult. Registers remain important and the strength of incentives remains a major issue (Blakeman 2001, 2002)

Most of the information came from key informants, many of whom had considerable experience of developments in chronic disease care in Australia. A number of issues emerge as important factors influencing the uptake of the items.

First, financial incentives alone are not likely to be sufficient to change patterns of care in many practices. Many GPs believe that they have enough work already and may doubt whether the promises of new or additional income will be achieved in their particular context with their patients. They may adopt the position of followers waiting for other practices to lead and expecting to adopt tested ways of working later. Fortunately there is an increasing number of leading practices that have have established systems that allow them to use the new items to improve income both income and quality of care.

The capacity for change in many practices is small. The heavy workload makes it difficult for GPs and other staff to take the time out to develop better ways of providing care. Many practices do not have a history of teamwork and some GPs are constrained by their sense of responsibility for the clinical care of the practice and for the success of the business. This means that innovations which appear compelling to an observer may seem daunting to those in the practice.

Informants stressed the importance of information systems. Practices which lack effective systems or are not computer literate are at a considerable disadvantage. Once again there are model practices, and the gradual improvement in the use of computers may, over time, lift most practices into a situation where they have effective systems. However it appears that there is some way to go before this occurs.

The diabetes and chronic disease items are not always seen to fit well with clinical priorities as identified by the GP. Most practices agreed that planned processes of care were appropriate for patients with diabetes but they often had different ideas about what constituted planned care. In the general practice setting GPs see patients with co-morbid conditions and with associated social and psychological problems. GPs commented that the top priority for care might not be completing an element of diabetes care and therefore in the interests of providing good care and not over-burdening patients the GP or nurse addressed what they felt was the priority issue.

Finally, many general practices operate on a long time frame which does not easily respond to a changing policy environment. Fortunately as teamwork develops practices is likely to become a more flexible organisation, with systems for identifying the need to change and responding to new circumstances. This means that practices that do adopt new ways of working may enter a virtuous spiral which supports further innovation. However in practices where the capacity for change is limited, the perceived complexity of the current items works against their adoption.

It follows that practices may need help in developing the systems, skills and teamwork needed to make good use of the items. That help can come from a range of sources, including support from the Divisions Network, participation in the National Primary Care Collaboratives and information from Medicare Australia. Most Divisions have provided information to practices on the use of the diabetes and chronic disease items and in some cases have supported them in the introduction of practice nurses. The Collaboratives were thought to have helped in the development of new systems and ways of providing care giving information, expertise and support and funding practices for attendance so they did not lose money in the process. Medicare Australia was lauded when it was seen to give clear and helpful answers about the use of the items and it was criticised where it was thought to be unclear.

In conclusion, while a few practices are well set to provide planned care using the diabetes and chronic disease items, many have little capacity for change in the short term and face large patient workloads with immature information management systems, poorly developed teamwork skills and GPs who are cautious about leading major changes and would prefer to follow their colleagues. They are likely to need practical help in developing the skills and systems required and will benefit from consistent policy and readily available and consistent help from trusted sources.

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9 Appendices

9.1 Division Questions

The diabetes program officer or another suitable person within the Division will:

- Recommend practices to take part in the study
- Provide details of a key contact within the recommended practices and
- For each practice will provide the following information:

Name of the Practice	
Key contact within the Practice	
Contact details	
Practice location	☐Rural ☐Urban
Size of the practice	☐Solo ☐<4 GPs ☐>=4 GPs ☐ Not sure
PIP registered	☐Yes ☐No ☐Not sure
Has a Practice Nurse	☐Yes ☐No ☐Not sure

9.2 Practice Questions

The key contact person from the practice (identified by the Division) will provide the following information to determine suitability for participation:

Name of the Practice:

Name of Division:

1. How many GPs work in your practice? *FT and PT*

☐Solo ☐<4 GPs ☐>=4 GPs ☐Not sure

2. How many Practice Nurses do you employ?

3. How many hours a week do they work?

4. Do you employ a Practice Manager?

☐Yes ☐No ☐Not sure

5. Is the practice PIP registered?

☐Yes ☐No ☐Not sure

6. Has the practice claimed the diabetes incentive 'sign on' payment? (For practices with a diabetes patient register and recall/reminder system)

☐Yes ☐No ☐Not sure

7. *If yes,* do you claim the Diabetes Service Outcome Payment (SOP)?

☐Yes ☐No ☐Not sure ☐N/A

8. *If no,* do you have a register of all known patients with diabetes?

☐Yes ☐No ☐Not sure

9. Could you recommend a key person most suitable to answer questions about the care of patients with diabetes and claiming for the practice as a whole? *Can be yourself.*

9.3 Practice Manager/ Practice Nurse Questions

1. What items are claimed for the care of patients with diabetes in your practice?

☐ GP management Plan (items 721 and 725)

☐ Team Care Arrangements (items 723 and 727)

☐ Diabetes SIP (items 2517-2526, 2620-2635)

2. When did the practice start claiming the Diabetes SIP?

☐ 2001 ☐ 2002 ☐ 2003 ☐ 2004 ☐ 2005 ☐ 2006

3. Is your register for patients with diabetes paper based, electronic or both?

☐ Paper based

☐ Electronic

☐ Both

4. Is it practice or Division based?

☐ Practice

☐ Division

☐ Both

5. What do you use the register for?

☐ Reminder/ recall

☐ Monitoring patients progress through the annual cycle of care and checking when the SIP can be claimed

☐ Identifying patients at high risk of complications

☐ Identifying patients with health risk factors e.g. smoking lack of physical activity etc.

☐ Other

6. How frequently do you use the register to review the service use of patients with diabetes?

☐ Regularly

☐ Depends on the patient

☐ Adhoc/ opportunistically

7. How often is the register updated?

- ☐ At least monthly
- ☐ Quarterly
- ☐ Half yearly
- ☐ Annually
- ☐ Other_____

8. Please describe the steps involved in claiming the diabetes SIP, GPMP and TCA items (if applicable) in your practice?

9. What role do you play in undertaking the annual cycle of care and claiming the items?

10. Have you experienced any difficulties or barriers using the:

- ☐ Diabetes SIP
- ☐ GP Management Plan
- ☐ Team Care Arrangements
- ☐ Review of GPMP or TCA

11. What factors have assisted you to use the Diabetes SIP, GP Management Plan and Team Care Arrangement items? (patient, provider, practice, external factors)

12. What plans does your practice have for use of the Diabetes SIP, GP Management Plan and Team Care Arrangement items in the future?

- ☐ Same
- ☐ Increased
- ☐ Decreased
- ☐ Not sure

9.4 GP Questions

1. Have you claimed the

☐ Diabetes SIP?

☐ GP Management Plan item?

☐ Team Care Arrangements item?

2. Do you think the Diabetes SIP is a good idea for practices and patients?

☐ Yes ☐ No ☐ Not sure

Why/why not?

3. Do you think the GP Management Plan item is a good idea for practices and patients?

☐ Yes ☐ No ☐ Not sure

Why/why not?

4. Do you think the Team Care Arrangements item is a good idea for practices and patients?

☐ Yes ☐ No ☐ Not sure

Why/why not?

5. Have you had any difficulties using the diabetes SIP?

☐ Yes ☐ No

What were they?

6. Have you had difficulties using the GP Management Plan for diabetes patients (Items 721 and 725)?

☐ Yes ☐ No

What were they?

7. Have you had difficulties using the Team Care Arrangements (Items 723 and 727)?

☐ Yes ☐ No

What were they?

8. Have you had difficulties using the Diabetes SIP with the GPMP or TCA items?

☐Yes ☐No ☐N/A

What were they?

9. Do the GPMP and TCA Items and the Diabetes SIP assist your practice with the clinical management of patients with diabetes?

☐Yes ☐No ☐Not sure

10. What factors have assisted you to use the Diabetes SIP and CDM items? (patient, provider, practice factors)

11. Do you have any further comments or suggestions regarding the diabetes SIP or annual cycle of care?