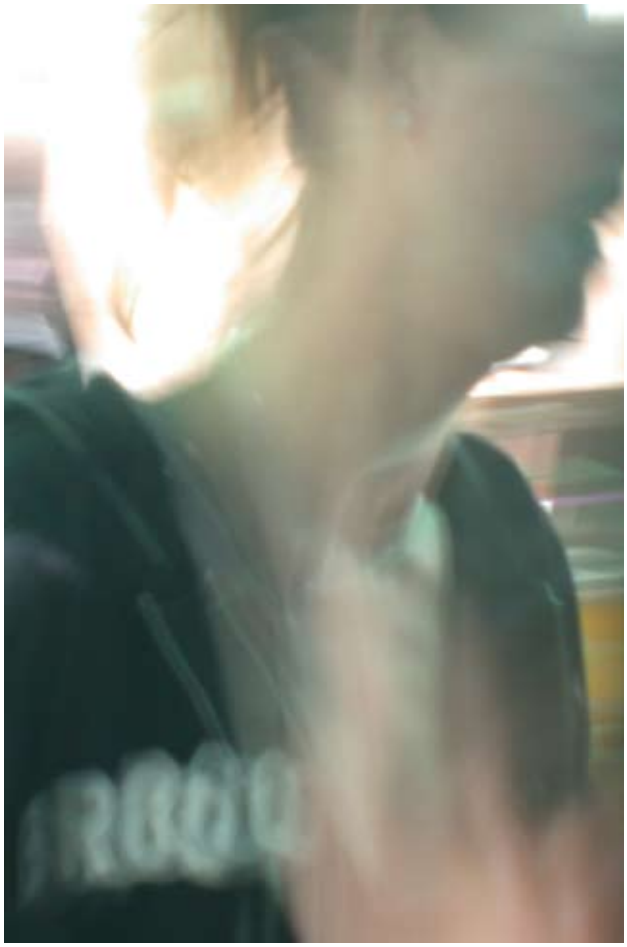
WHITEHORSE DIVISION
OF GENERAL PRACTICE

Nurse Led Clinics©



General Practice

Chronic Disease Management

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WHITEHORSE DIVISION OF GENERAL PRACTICE

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GPDV GENERAL PRACTICE DIVISIONS VICTORIA

Good Life CLUB

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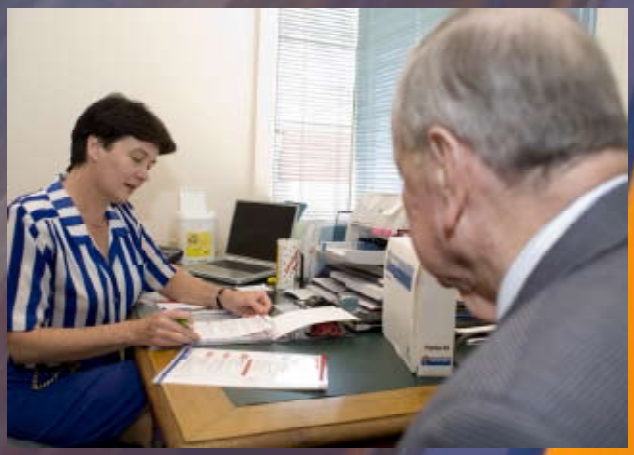

1. About this Information Package

This section of the Information Package provides readers with an understanding of the:

- Contents and purpose of the Information Package
- Intended audience for the Information Package
- Process undertaken to develop the Information Package
- Terminology and Acronyms used in the Information Package

1.1 What is in the Information Package?

The Information Package on nurse led chronic disease clinics in general practice:

- Explores what the evidence tells us about nurse led chronic disease clinics, in particular the benefits for stakeholders including GPs, nurses, and patients
- Provides detailed information about what is involved in running a nurse led chronic disease clinic, including clinic and systems requirements
- Provides information on the pros and cons of employing a Clinical Nurse Specialist (i.e. a Diabetes Educator or an Asthma Educator) to run a nurse led chronic disease clinic
- Provides information and case study examples of two different business models the Contracted Clinic and the Practice Operated Clinic
- Sets out the financial incentives and funding issues related to nurse led chronic disease clinics including information about the effective utilisation of the Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items, the role of subsidies and the pros and cons of charging patient fees
- Provides a step by step guide to establishing and operating a nurse led chronic disease clinic
- Details other useful resources and documents

1.2 Who is this Information Package for?

Divisions of General Practice can play a central role in supporting practices and GPs to establish, operate and continuously improve nurse led chronic disease clinics.

This Package provides information and advice to support Divisions of General Practice to assist their practices, and GPs to develop and implement nurse led clinics for patients with a chronic disease.

Divisions can support practices and GPs in a number of ways, in particular through the provision of:

- Contracted clinics, offered to practices on a fee-for-service basis
- Consultancy support to practices which want to establish and operate their own clinics
- Advice, training, professional development and peer support for nurses who run chronic disease clinics

1.3 How was it developed?

The Information Package was developed in 2007 with funding by the Australian Government Department of Health & Ageing, Sharing Health Care Initiative, and is a joint project between the Whitehorse Division of General Practice (WDGP), Good Life Club and General Practice Divisions Victoria (GPDV).

A Working Group comprised of WDGP, GPDV and Australian Practice Nurse Association (APNA) guided the project and provided technical support and advice to the project consultants. The Information Package was researched and written by Juliet Frizzell, from Effective Change Pty Ltd.

1.4 Terminology

Practice Nurse. A Practice Nurse is a registered nurse or enrolled nurse (Div 1 or Div 2) who is employed by, or whose services are otherwise retained by, a general practice.

Clinical Nurse Specialist. The term Clinical Nurse Specialist, when used in this Information Package, refers to a registered nurse who has completed a post graduate qualification (recognised by the relevant peak body) who is employed to run a nurse led chronic disease clinic in a general practice. A Clinical Nurse Specialist could be either a Diabetes Educator who has completed post graduate qualifications recognised by the Australian Diabetes Educators Association (ADEA) or an Asthma Educator who has completed post graduate qualifications recognised by the Australian Asthma and Respiratory Educators Association (AAREA).

Credentialed Diabetes Educator. A Credentialled Diabetes Educator is a Registered Nurse who:

- Has completed an ADEA Accredited Course in Diabetes Education
- Has undertaken a minimum of 12 months supervised clinical practice
- Maintains a continuing professional development program
- Is a member of the Australian Diabetes Educators Association (ADEA)
- Adheres to the ADEA Code of Conduct for Diabetes Educators

A Credentialled Diabetes Educator can be registered to claim the Diabetes Educator Medicare Item (10951).

Credentialled Asthma Educator. The AAREA recognises 3 levels of Asthma Educator. A nurse led chronic disease clinic in general practice should be staffed with either a level 2 or level 3 Asthma Educator. A Level 2 Asthma Educator is a registered nurse with at least 5 years full time equivalent post registration experience, with at least 3 years full time experience in the specialty field, plus approved post graduate qualifications.

A level 3 Asthma Educator is a registered nurse with at last 7 years full time equivalent post registration experience, with at least 5 years full time experience in the specialty field, plus approved post graduate qualifications in the field.

1.5 Acronyms

AAREA	Australian Asthma and Respiratory Educators Association
ADEA	Australian Diabetes Educators Association
AGPN	Australian General Practice Network
APNA	Australian Practice Nurses Association
BP	Blood Pressure
CDM	Chronic Disease Management
EPC	Enhanced Primary Care
GP	General Practitioner
GPMP	GP Management Plan
MAHS	More Allied Health Services
MBS	Medicare Benefits Schedule
PIP	Practice Incentive Program
PN	Practice Nurse
SIP	Service Incentive Payment
SWPE	Standard Whole Patient Equivalent
TCA	Team Care Arrangement
WDGP	Whitehorse Division of General Practice

1.6 Useful links

Australian General Practice Network

www.agpn.com.au

Australian Practice Nurses Association

www.apna.asn.au

Department of Health & Ageing

www.health.gov.au

General Practice Divisions Victoria

www.gpdv.com.au

Medical Benefits Schedule On line

www.health.gov.au/mbs/

Royal Australian College of General Practitioners

www.racgp.org.au

1.7 Acknowledgements

This Information Package was jointly funded by the Australian Government, Department of Health and Ageing and General Practice Divisions Victoria (GPDV).

The content of this Information Package was largely developed from the work of the WDGP, in particular Jill Kelly Project Manager of the Good Life Club, Leigh Barnetby, Melissa Glogolia, the Diabetes and Asthma Nurse Educators and general practices from the Whitehorse Division of General Practice.

This Information Package was produced with the commitment and assistance of many individuals and organisations. The authors would particularly like to thank the project Working Group for their guidance and advice.

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- Jenny Wilkins (General Practice Divisions Victoria)

The authors would also like to thank Julianne Crow, Otway Division of General Practice and Julie Mackay Practice Nurse at Corangamite Clinic who provided detailed information for some of the case studies.

Disclaimer

The information provided in this Information Package has been developed to support Divisions of General Practice assist practices and GPs to establish, operate and continuously improve nurse led chronic disease clinics. While all information has been assessed for accuracy and was up-to-date at the time of release, the information is provided on the basis that all persons using this Package:

- *Undertake the responsibility for assessing the relevance and accuracy of the content*
- *Check relevant legislation, MBS requirements and other references before making decisions and taking actions*

Rationale & evidence for nurse led chronic disease clinics

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2. Rationale and evidence for nurse led chronic disease clinics

This section of the Information Package explores what the evidence tells us about nurse led chronic disease clinics, in particular the benefits for general practice, GPs, nurses, and patients.

2.1 What the evidence tells us about effective chronic disease management in general practice

Australian and international evidence tells us that effective chronic disease management in general practice requires a combination of the following factors:

- Effective systems such as patient information and education resources, clinical decision making support tools, patient chronic disease registers, and recall and review mechanisms
- Patient education and support, in particular assistance with managing their own medical conditions and self management
- Establishing and maintaining good linkages with community resources and services
- Effective team work between health providers within the practice and with other health professionals

The literature suggests that business processes, systems and cultural change are required within general practice to strengthen primary care and chronic disease management. For example a practice may need to review the range of services offered, redevelop its infrastructure and systems, and introduce continuous improvement processes such as Plan-Do-Study-Act (PDSA) cycles.

"The growing burden of chronic disease and patient demand has increased GP workloads. Nurses in general practice work with GPs to provide efficient and effective health care to all patients".

The research also shows that the employment of practice nurses and/or the establishment of nurse led chronic disease clinics in general practice can improve patient care and outcomes for people with a chronic disease, as well as address practice issues such as systems and cultural change, and GP workload.

2.2 The benefits of nurse led chronic disease clinics in general practice

Australian and international research highlights a range of benefits that nurses and nurse led chronic disease clinics can bring to general practice. These include improved health outcomes in chronic disease, assistance in primary acute care integration, better coordination of care, increased workforce capacity, the provision of practical and professional support to GPs, and the enhancement in the range of services available to people attending the practice. (ADGP Nursing in General Practice and Recruitment and Orientation Resource Guide)

A summary of the benefits for each of the key stakeholder groups is presented below. This information can be used by Division staff when promoting nurse led chronic disease clinics to:

- The Division's Board, CEO and staff
- A practice or group of practices
- An individual GP or group of GPs
- Clinical Nurse Specialists such as Diabetes or Asthma Educators
- Patients or patient groups
- Funding bodies
- Primary care agencies such as Community Health Services, Primary Care Partnerships and private providers

2.2.1 Benefits for the practice

A well managed and efficient nurse led chronic disease clinic can provide the following benefits to a practice:

- Increased income and profit, contributing to the long term viability of the practice
- Increased range of service offered at the practice
- Improved systems such as appointment bookings, billing, and recall and review
- Improved integration and partnerships with the acute sector and the primary care system
- Improved working relationships and a multi-disciplinary approach within the practice, and with external health professionals
- Improved quality of care for patients including meeting clinical guidelines and systematically delivering the requirements of the annual cycle of care
- Reduced patient waiting times
- Improved management of patients with a chronic disease including self management support
- Improved health outcomes through screening, prevention, assessment, patient education, management, care planning and reviews
- Enhanced patient satisfaction

2.2.2 Benefits for General Practitioners

A well managed and effective nurse led chronic disease clinic in general practice can provide the following benefits for the GP/GPs:

- Increased number of patients who can be seen by the GP
- Increased income generated through the involvement of a Clinical Nurse Specialist
- Improved work satisfaction from working in a multi-disciplinary team and improving patient outcomes
- Increased capacity and expertise within the practice eg. A Clinical Nurse Specialist will have specialist knowledge about the management of Diabetes and/or Asthma
- Increased range of services available for patients
- Improved efficiency in the use of GP time spent in chronic disease management
- Shared responsibility for chronic disease management
- Increased ability to claim the Diabetes and/or Asthma Service Incentive Payment (SIP)
- Increased numbers of completed General Practice Management Plans (GPMP) and Team Care Arrangements (TCA)
- Improved recall and review system
- Improved self management and behaviour change by patients

2.2.3 Benefits for patients

A well managed nurse led chronic disease clinic in general practice can provide the following benefits for patients:

- Increased satisfaction from having their needs met and adequate time to discuss issues related to their chronic disease
- Improved clinical outcomes such as reduced HbA1c and improved weight management
- Increased knowledge and understanding of their chronic disease
- Supported self management eg. Motivation, diet, exercise, life style change, medications management and device use, symptom monitoring and complications prevention
- Increased range of services available at their general practice
- Improved access to health professionals ie. through the MBS Allied Health items
- Improved quality of life

"Nurses in general practice have the time and caring characteristic that patients believe enables the nurse to have a significant role in providing support, health information or in assisting patient understanding".

2.2.4 Benefits for nurses

A well managed nurse led chronic disease clinic in general practice can provide the following benefits for nurses:

- Improved recognition of the nurse contribution to care
- Increased employment and career opportunities
- Improved job satisfaction
- Increased opportunity for training and specialisation eg. a Practice Nurse may undertake a post graduate qualification and become a Diabetes Educator
- Increased opportunity to use skills and knowledge
- Increased team work and the opportunity to work in a multi-disciplinary team

2.2.5 Benefits for the Division of General Practice

A well managed and effective nurse led chronic disease clinic in general practice can provide the following benefits for the Division:

- Increased recognition of the Division's role in supporting practice improvement and nursing services
- Increased opportunity for the Division to promote and lead the expansion of Clinical Nurse Specialists (Diabetes and Asthma Educators) in general practice
- Increased learnings about the benefits and opportunities of nurses in general practice
- Enhanced opportunity for the Division to build effective working relationships and trust, and to roll out other programs such as e-messaging and Quality Use of Medicines etc in the practice
- Increased Division profile and rapport with GPs, practice nurses and practice staff
- Enhanced quality of data management in the practice and use of this data to improve health outcomes

2.2.5 Benefits for funding bodies

Well managed and efficient nurse led chronic disease clinics in general practice can provide the following benefits for funding bodies:

- Increased public health benefits such as improved health outcomes
- Improved use of clinical guidelines, clinical pathways and annual cycles of care
- Increased utilisation of MBS items such as GPMP and TCA
- Reduced reliance on project funding and subsidies through the development of a sustainable service model
- Cost effective service provision
- The provision of systematic self-management.

2.2.7 Benefits for the health service system

Well managed nurse led chronic disease clinics in general practice can provide the following benefits for the service system:

- Improved working relationships and communication between general practice and other primary care providers
- Improved capacity to provide self management support to patients with a chronic disease
- Increased referrals to other health professionals (for example Allied Health) and local programs (such as exercise groups, health promotion activities) for people with a chronic disease
- Increased business for private providers willing to work collaboratively with general practice eg. Using the MBS Allied Health and Dental Services items

2.3 References

Further information about the benefits of nurses and nurse led chronic disease clinics in general practice can be found in the following key documents:

- Australian Division of General Practice (ADGP). Demonstration Divisions Nursing in General Practice National Resource Kit (2005)
- Australian General Practice Network (AGPN). Nursing in General Practice Recruitment and Orientation Resource: A Guide for General Practices, Practice Nurses and Divisions of General Practice (2006)
- AGPN Website www.agpn.com.au
- Royal Australian College of General Practice (RACGP). Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting (2nd edition) 2006. The 'Green Book' can be downloaded from www.racgp.org.au/guidelines/greenbook.
- Australian Division of General Practice (ADGP). Nursing in General Practice Business Case Models (2003)
- Australian General Practice Network (AGPN). Nursing in General Practice Recruitment and Orientation Resource: A Guide for General Practices, Practice Nurses and Divisions of General Practice (2006)
- Landa A. Collaborating for care: when joining forces helps patients. AM News April 2003
- Mckernon M. and Jackson C. Is it time to include the practice nurse in integrated primary health care? Australian Family Physician 30 (6) 610-615
- Royal College of Nursing Australia. Nursing in General Practice: A Guide for the General Practice Team (2001)
- UNSW Centre for Primary Health Care and Equity. Managing chronic disease: what makes a general practice effective? (2005)
- Wagner E. The role of patient care teams in chronic disease management. BMJ 320: 7234: 569-572 (2000)
- Zwar N., Harris M., Griffiths R., Roland M., Dennis S., Powell D., and Hasan I. A systematic review of Chronis Disease Management

Nurse led chronic disease clinics - what's involved

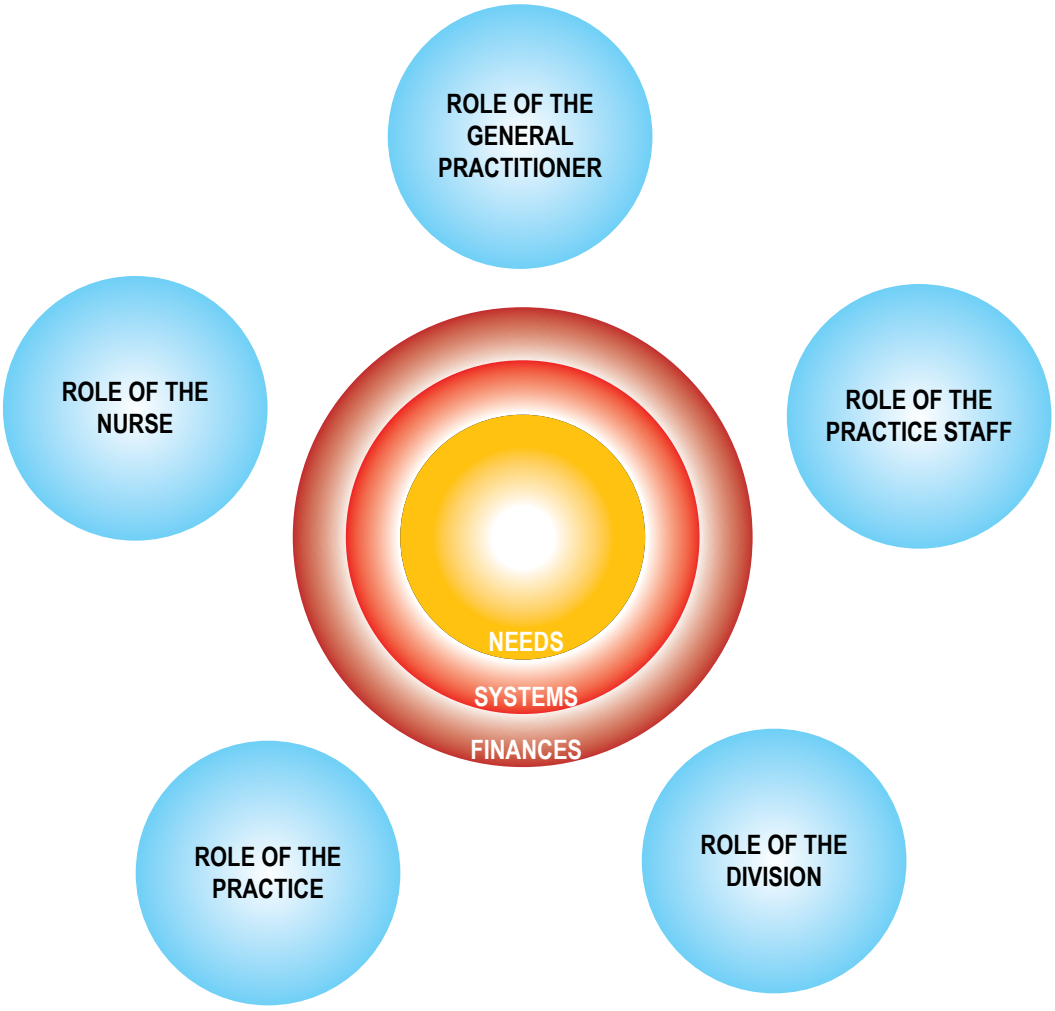
3

3. Nurse led clinics - what's involved?

This section of the Information Package describes the essential features of a nurse led chronic disease clinic in general practice. The essential features are relevant to both business models for a nurse led chronic disease clinic, that is:

- The Contracted Clinic Model
- The Practice Operated Clinic Model

The diagram below provides an overview of the essential elements of a nurse led chronic disease clinic in general practice.



3.1 What is a nurse led chronic disease clinic?

A nurse led chronic disease clinic is designed to provide patients who have a chronic disease with additional support and strategies to self manage their illness. A clinic usually runs in a set and protected time during a practice's usual business hours, so that patients can access both nursing and GP support for their chronic disease.

A clinic can focus on a specific chronic disease such as Diabetes or Asthma, or have a general focus on care for people with a chronic disease. Patient appointments in the clinic are booked in advance, usually for a half an hour block, with a long appointment booked (one hour) for the initial assessment or reassessment.

3.1.1 What is the role of a Clinical Nurse Specialist?

A nurse led clinic should be staffed by a Clinical Nurse Specialist such as a Diabetes Educator or an Asthma Educator, as advanced nursing practice is required.

The role of a Clinical Nurse Specialist is:

- To provide advanced clinical support to the patient and the practice
- To manage and run the clinic in conjunction with practice staff
- To provide quality care to patients with a chronic disease
- To work as part of a team
- To ensure systems support the effective operation of the clinic

The core activities of a chronic disease clinic include:

- An initial assessment
- Management of the annual cycle of care
- Development and implementation of a patient education program
- Discussion and setting self management goals, and re-establishing these if the patient relapses
- Setting clinical targets and strategies to pursue ie. HbA1c of less than 7% or Cholesterol of less than 4.0mmol/L
- Strong linkages with GP management including medication management
- Development of a care plan (GP Management Plan)
- Shared care with other health professionals (Team Care Arrangements)
- Referral to other health professionals for specific care requirements
- Ongoing review and support (GPMP, TCA, self management goals etc)

CASE STUDY

An initial assessment for a patient with Diabetes who is referred to a nurse led chronic disease clinic, is likely to include:

- Completion of anthropometric tests including height, weight, blood pressure and blood glucose
- Discussion of the pathophysiology of Diabetes and general treatment
- Detailed investigation and analysis of diet and exercise
- Assistance to undertake home glucose monitoring
- Discussion of Medications
- Complications screening
- Development of a Care Plan
- Patient's self-management goals

CASE STUDY

An initial assessment for a patient with Asthma who is referred to a nurse led chronic disease clinic, is likely to include:

- Completion of tests including a Spirometry test
- Discussion of the pathophysiology of Asthma and general treatment
- Review of device use
- Development of a written Asthma Action Plan

The initial assessment can be funded through the MBS using key items such as the GP Management Plan (GPMP) and Team Care Arrangements (TCA).

3.2 Clinic requirements

3.2.1 The chronic disease management team

Literature and evidence based clinical pathways indicate that effective management of patients with a chronic disease requires a multi-disciplinary team based approach. Within general practice, a team would usually include the GP, Practice Nurse and the Clinical Nurse Specialist (ie. Diabetes Educator), with other health professionals such as Dietitian, Podiatrist, Optometrist etc brought in as part of team care arrangements.

3.2.2 The Clinic room and equipment

The room and equipment requirements for a nurse led chronic disease clinic include:

- Sufficient space to conduct a practical and confidential assessment
- Access to patient records, including a computer and printer, if the practice has computerised patient files
- A telephone for internal communication with the GPs and external communication with other health professionals for referral and Team Care Arrangements
- Access to equipment for measuring height and weight, blood pressure etc
- Hand washing facilities
- Room to store resources including information brochures and demonstration equipment such as puffers and spacers

Equipment required for a Diabetes Clinic

- Patient information and self management resources
- Blood glucose meters for clinic use
- Insulin pens
- Medical management references
- Clinical guidelines
- Demonstration equipment such as blood glucose meters and insulin pens
- Evaluation tools

Equipment required for an Asthma Clinic

- Patient information and self management resources
- Spirometer and consumables for clinic use
- Testing equipment
- Medical management references
- Clinical guidelines
- Demonstration equipment such as puffers and spacers
- Patient education equipment to support patient learning

3.2.3 Clinical Guidelines

The key clinical guidelines for nurse led chronic disease clinics are listed below:

- The Royal Australian College of General Practitioners and Diabetes Australia. Diabetes Management in General Practice (2006/2007) 12th edition www.diabetesaustralia.com.au and www.racgp.org.au
- National Asthma Council Australia. Asthma Management Handbook (2006) www.nationalasthma.org.au
- Clinical guidelines produced by the National Health and Medical Research Council (NHMRC) such as the Evidence Based Guidelines for the Management of Type 2 Diabetes, and Diabetes and Coronary Heart Disease: Best Practice Guidelines for Diabetes type 1 and 2 www.nhmrc.gov.au
- Pharmaceutical Benefits Scheme (PBS) Guidelines www.pbs.gov.au
- Medicare Benefits Schedule Book www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicarebenefits-index.htm
- Professional organisations such as Australian Diabetes Educators Association (ADEA) core competencies and guidelines for Diabetes Educators www.adea.com.au and Australian Asthma and Respiratory Educators Association (AAREA) www.aareducation.com
- Self Management Guidelines such as the Flinders Self Management Guidelines www.flinders.edu.au
- Stanford Model of patient chronic disease management www.education.stanford.edu/programs/

3.3 Systems requirements

There are four important systems which underpin effective nurse led chronic disease clinics. They are:

- Clinic Marketing
- Appointment booking
- Clinic billing
- Recall and review

3.4.1 Clinic marketing

There are a range of strategies that can be used to market a nurse led chronic disease clinic. The most important strategy is the GP identifying patients with a diagnosed chronic disease who would benefit from the services of the clinic, and encouraging them to attend.

Other strategies include:

- Sending personalised letters to all patients who have a chronic disease (e.g. a practice's Diabetes Register can be used to identify potential patients) inviting them to attend the clinic
- Sending publicity material to patients advising them of what the clinic has to offer and the benefits of attending
- Displaying posters in the waiting area and having brochures available for patients to take home
- Information provided on the practice's call waiting system
- Cold calling patients from the practice's chronic disease register
- Face-to-face planned or opportunistic marketing by front of house staff, the Practice Nurse or GPs

Like all activities, the practice will need to carefully manage any marketing of its chronic disease clinic. The most important thing is to have a steady steam of new patients (approximately 2 patients who have not previously been referred to or seen at each clinic). The nurse and front of house staff should regularly check that appointments for new patients are being filled, if not, then the GPs should be prompted to make more referrals and/or the practice's marketing strategy should be activated.

CASE STUDY

Our clinic only has 2 appointments available each week for new patients. We made the mistake of sending out a flier promoting our Diabetes clinic to all the patients on our Diabetes Register (over 100 people). The following week, we had more than 30 patients ring up for an appointment, and we could not accommodate them all with the appointments available. We won't make that mistake again.

Next time, we'll only send out 10 letters!

3.3.2 Appointment booking

Active management of the appointments system is essential for a successful chronic disease clinic. There are two important components:

- Maintaining a balance of new patients (who have not previously been referred to or seen at the clinic) and existing patients attending the clinic
- Maximizing the number of patients booked into and attending each clinic, and minimising the 'no shows'

Most practices will need to reorient their appointment booking system to support the nurse led chronic disease clinic, because:

- The clinic is likely to operate during set hours only, and patients will need to be booked in back-to-back during this time for the clinic to be financially viable and to ensure efficient use of the nurse's time
- The appointments are longer – usually an hour for the initial assessment, followed by half hour appointments
- To be financially viable most clinics need to have at least 75% patient attendance and patients need to complete all components of GPMP and TCA including reviews, and SIP payments require annual cycles of care to be completed within particular timelines
- The clinic will not be effective if patients are double booked

CASE STUDY

When we started our clinic, we sent a letter out to all the patients on our books with Diabetes, promoting the clinic and encouraging them to attend. We had lots of interest, and booked new patients in back to back for the first three months. After the first clinic, the nurse wanted to rebook a patient to come back the following week to start on insulin, but there wasn't a spare appointment for 3 months. After that, we realised we needed to limit our promotion of the clinic and book in no more than 2 new patients per week.

CASE STUDY

We have no trouble filling the appointments in our clinics. We have never needed to market or promote the clinic. All appointments are filled with patients referred by our GPs.. We also;

- Telephone all patients to remind them of their clinic appointment 48 hours before they are due to come in
- Ensure all patients who ring up to change an appointment are given another appointment at the time they ring

CASE STUDY

To be financially viable our clinic needs to have 75% of all appointments attended, and for patients to have a GPMP and TCA and associated reviews. This meant we had to do things differently, and we actively manage the clinic appointments. We now:

- Rebook each patient for their next appointment at the end of their clinic appointment
- Send a written confirmation of appointments which have been booked more than one month in advance
- Telephone all patients to remind them of their clinic appointment 48 hours before they are due to come in
- Ensure all patients who ring up to change an appointment are given another appointment at the time they ring

Our nurse follows up all patients who do not attend, or cancel an appointment without rebooking another one.

3.3.3 Clinic billing

The financial viability of a chronic disease clinic will be dependant on the practice ensuring an appropriate billing system is in place and that it is being implemented. For most practices, this will involve simply refining existing systems to ensure:

- All relevant MBS items (such as the Diabetes SIP) for the chronic disease clinic are programmed into the computer
- Reception staff are familiar with the relevant MBS items for the clinic and how to claim them, for example the Diabetes Educator Item (10951) may need to be manually batched
- There is a clear process for the clinic to communicate to front of house staff which MBS items need to be claimed
- It is clear how the patient will be charged ie. bulk-billed, co-payment or privately billed

To ensure all the appropriate items are being claimed correctly, the practice should review its billing system:

- At the end of the first clinic, the end of the first month and at the 3 month mark
- When there are changes to the Medicare Benefits Schedule Book (usually May and November each year)
- When there are staff changes either in the clinic or in Reception

CASE STUDY

We didn't provide information to the Reception staff about the new MBS items we would be using in the clinic. As a consequence they were unfamiliar with the MBS item numbers the nurse was billing, and assumed she was mistaken, and they continued to bill for standard consultations using the MBS items they were used to using.

Further information about setting up an effective clinic billing system can be found in section 6.1.3 of this Information Package.

3.3.4 Recall and review

Effective recall and review has three key benefits. It will:

- Support quality patient care in chronic disease management
- Achieve the best financial outcome for the practice
- Meet the requirements of clinical guidelines and annual cycles of care

There is no right or wrong way to set-up a recall and review system. Each practice will need to determine the system that is right for them. A computerized system is ideal, but recall and review can work equally well in paper diaries or exercise books.

CASE STUDY

In our practice the Clinic nurse sets a follow up or review appointment with the patient before they leave the clinic. The appointment gets entered into our GP clinical software so it is not lost, and Reception staff telephone the patient a week before their next appointment, to remind them and confirm their attendance. If the patient cannot attend a scheduled appointment, we reschedule the appointment while we have them on the telephone.

No patient leaves without an appointment being made!

CASE STUDY

The only real recall and review system we had in our practice was for Pap Smears. So we just mirrored that system for the Diabetes Clinic. It works well, as long as the nurse determines when the next appointment is required before the patient leaves, and Reception rebook cancelled appointments.

3.4 What is the role of self management in nurse led chronic disease clinics?

Most of the day-to-day responsibilities for the care of chronic illness fall on patients and their families. Therefore it is necessary to enable patients to play an active role in their health by delivering care in collaboration with the patient. Only then will it be most effective.

Enabling patients to play an active role in their health requires health services to provide not only good medical and clinical treatment but also to improve the knowledge and self management skills of these patients with chronic illness. Improving knowledge and skills involves more than the provision of education. Rather health professionals need to adopt a more structured approach to supporting improved patient self management.

Supporting patients in improving their self management includes activities that develop patient problem-solving skills, improve self-efficacy and support the application of knowledge in real-life situations that matter to patients.

3.4.1 What is self management?

Self management involves the person with the chronic disease:

- engaging in activities that protect and promote health
- monitoring and managing of signs and symptoms of illness
- managing the impacts of illness on functioning, emotions and interpersonal relationships
- and adhering to treatment plans

Tasks of self management

The traditional focus of health care has been around illness and the relief or cure of symptoms. Patients with chronic disease however, are more suited to a wellness perspective where they are encouraged to remain well for as long as possible. To maintain wellness, patients need to concentrate on three tasks:

1. Medical management such as taking medication, monitoring symptoms and/or adhering to a healthy diet
2. Maintaining, changing and creating new meaningful behaviours or life roles, for example, people with back pain may need to change the way they participate in their favourite sports
3. Dealing with the emotional impact of having a chronic illness, which alters one's view of the future. Emotions such as anger, fear, frustration and depression are common.

3.4.2 What is self management support by a health professional?

Self management support involves the support that a general practice provides to patients to carry out the above three main tasks. Self management is NOT patient education which is simply knowledge-based instruction for a specific disease.

Self management support can include any of the following strategies:

Technique	Description/Information
Problem solving and action planning	Problem-solving is a necessary skill for patients with a chronic illness to learn. It can be taught to patients to enable them to make confident decisions concerning their health. *See next page for sample problem solving and goal setting frameworks* Using problem-solving techniques enables health professionals to assist patients to identify their problems, solve barriers to change, and raise key clinical issues.
Identifying patients readiness to change	Change is a process where people move through different stages, each requiring effort and energy for thinking, planning and doing. Motivation is what provides the impetus for the focus and energy needed to move through the entire process of change. Understanding patient 'readiness' will enable health professionals to assist patients to accomplish the various tasks required to transition through each stage
Refer patients to community interventions	Provide patients with information about community services or making space within the practice available for community groups. Programs could include the 6 week "Stanford" course Better Health Self Management program which assists patients in improving their self management skills and decision-making. *www.patienteducation.stanford.edu*
Reflective listening and using open-ended questions	Reflective listening is an active process that reflects back to the patient the meaning of what they have just communicated. It is a way of checking rather than assuming that you already know what is meant. *"The Skilled Helper" by Gerard Egan (2006)* Well-formed reflective statements are less likely to evoke resistance from patients and encourage them to express arguments for change. Reflective listening is one of the most important skills of coaching and motivational interviewing Open-ended questioning creates an atmosphere of acceptance and trust and allows patients to explore their concerns When using this skill, patients do most of the talking and the health professional listens intently with reflective listening The questioning style allows patients to establish their own reasons for change
Motivational interviewing / Coaching	Motivational interviewing is an in-depth counselling approach to decision making. It is intended to help patients come to their own decisions by exploring their uncertainties using directive questions and reflective listening. It allows patients to identify problems and find their own solutions. *Motivational Interviewing. By Miller W.R. & Rollnick. 2002*

Problem solving – Action Planning

Targeting problem identification allows health professionals to focus on one problem at a time. The problem chosen should be based on the importance of the problem to both the health professional and patient, and patient readiness for change.

Goal-setting and action planning are part of the five core skills required by patients to self-manage. Patients should be taught how to set their own goals.

Conducting goal-setting in self management consultations enables health professionals to assist patients to focus on a specific problem, establish realistic objectives and develop a personalised action plan.

Setting self management goals with patient (example);*

What is the problem?	
What do you see as your main problem?	*I don't eat out as much as I would like to because I don't know what to choose from the menu*
How does this problem affect the way you live?	*I feel isolated from my family and friends*
How does this make you feel?	*I feel depressed and sad*
Setting a goal	
What would you like to do that this problem stops you from doing? (Make it realistic and achievable)	*I would like to know how to make healthy choices from a restaurant menu*
What do you need to do to make this happen? (first steps)	*I need to make an appointment with a dietitian*

3.5 Preparing the Division

It is essential that your Division has a clear mandate and vision for its role in promoting, establishing, supporting, resourcing and continuously improving nurse led chronic disease clinics in general practice. The following questions will help guide you in determining the most appropriate role for your Division.

- Why should the Division get involved?
- What are the needs and priorities of our practices and GPs?
- How should the Division get involved? For example, through:
  - the provision of contracted clinics offered to practices on a fee-for-service basis
  - consultancy support to practices which want to establish and operate their own clinics
  - capacity building around Information Management (IM) and Information Technology (IT), or multi-disciplinary team work
  - training and peer support for the Clinical Nurse Specialists who run chronic disease clinics
- Who in the Division will be involved? Do we need to set-up a separate company or entity?
- How will this fit with other Division responsibilities and activities?
- What resources will be required to make it work?
  - Do you need to recruit new staff or train existing staff?
  - Do you need an internal Reference Group and a Clinical Advisor for guidance?
  - Will funding for subsidies and inducements for practices be required? If so, where will the money come from?
  - What information and materials will be needed for practices and GPs?

Once you have worked through these questions, gaining Board and Executive Officer approval is critical. It is also important to consider how the nurse led clinics fit with the Division's strategic direction and business plans, and to provide clear objectives, activities, costs and outcomes, in order to measure the progress and success of what you propose.

Our exerience shows that some of the critical success factors associated with effective Divisional support for nurse led chronic disease clinics in general practice include:

- Divisional Management and Board commitment
- Adopting 'whole of practice approach' by the Division
- Availability of core funding (start up funding) and in rural areas eg., MAHS funding
- Use of experienced registered nurses to facilitate Divisional Practice Nurse Programs
- Effective use of the EPC items
- Face to face communication via practice visits
- Educational activities linked to income generating Australian government initiatives such as EPC and Asthma 2+ program
- Information about how to use the Practice Nurse Incentive Payment
- Promotion of the benefits to practices
- The provision of ongoing practice support and professional development programs
- Nurse access to supporting/mentoring programs provided by the Division
- Capacity building such as setting up recall and reminder systems

*Adapted from The Flinders University - Problems & Goals Statement

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Options for implementing nurse led clinics for patients with a chronic disease within General Practice

4

4. Options for implementing nurse led clinics for patients with a chronic disease within General Practice

This section of the Information Package explores two different models for delivering nurse led chronic disease clinics in general practice, they are the:

- Contracted Clinic Model
- Practice Operated Clinic Model

Both models can be established, financed and operated effectively within existing frameworks ie. MBS items and practice infrastructure. The models adopted within each Division's catchment area will depend on:

- The Division's strategic direction, preferred approach and resources. For example some Divisions will choose to offer Contracted Clinics on a fee-for-service basis, while other Divisions will prefer to provide assistance and advice to individual practices on how to establish, operate and continuously improve a practice operated clinic. Some Divisions may offer both services.
- The preferences, resources and capacity of individual practices, for example a practice which employs a Practice Nurse may be able to easily expand the role to provide a chronic disease clinic, while other practices such as those which have been unable to recruit a Practice Nurse may prefer to recruit a Clinical Nurse Specialist specifically for the clinic role.

4.1 Contracted Clinic Model

4.1.1 How the model works

The Contracted Clinic model describes a clinic which is delivered in a practice by the Division (or a separate company/entity owned by the Division) on a fee for service basis. In this model the Division (or Division owned company) recruits and employs the nurse to deliver the clinic. The Division (or Division owned company) invoices the practice an agreed fee for each clinic.

The practice is responsible for ensuring all appointments for the clinic are full with patients, providing the venue and systems support such as appointment bookings, billing, and recall and review. This model is usually staffed by a Clinical Nurse Specialist such as a Diabetes Educator or Asthma Educator, but can be staffed by a Practice Nurse who has obtained additional qualifications in chronic disease management.

4.1.2 Pros and cons of the Contracted Clinic Model

The pros and cons of the Contracted Clinic Model are presented in the table below.

4.1.3 An example of a Contracted Clinic – Whitehorse Division of General Practice

The Whitehorse Division of General Practice through its company General Practice Support Services (Vic) Ltd (GPSS) has been providing contracted Diabetes and Asthma clinics to individual practices on a fee for service basis since 2001.

The WDGP works with interested practices to scope and set-up nurse led chronic disease clinics and GPSS delivers the clinics. The GPSS clinics are staffed by a Clinical Nurse Specialist.

GPSS recruits, employs, trains and provides ongoing support for the Clinical Nurse Specialist, and has responsibility for staffing and resourcing the clinic. The Clinical Nurse Specialist is contracted to an individual practice to run the clinic in partnership with the GPs and other practice staff on a weekly or fortnightly basis. GPSS invoices the practice monthly on a full cost recovery basis. The cost to a practice of a 5 hour clinic is less than $355.00 per clinic.

The practice is responsible for marketing, appointment bookings, provision of a suitable clinic room and equipment (scales, height chart, BP machine), recall and review, GP involvement and billing Medicare. A 5 hour clinic can generate approximately $1000.00 per clinic in income from Medicare for the practice.

CASE STUDY

The WDGP GPSS delivers a fortnightly 5 hour clinic (staffed by a Diabetes Educator) for a small practice in the eastern suburbs. GPSS bills the practice per clinic. The practice generates between $900.00 and $1000.00 from Medicare, depending on the services provided (GPMP, TCA, etc) and the number of patients who attend the clinic appointments.

Pros and cons for the Contracted Clinic Model for the Practice

Pros	Cons
• The Division (or company) is responsible for recruiting and employing the nurse, hence reducing the burden of administration (PAYG, superannuation, insurance) and risk to the practice (sustainability of employment)	• The practice must pay for the clinic irrespective of whether it has sufficient patients or not
• The Division (or company) is responsible for the ongoing professional development and technical support for the nurse, which may include peer support or training	• The practice may not feel that it owns the clinic
• The Division (or company) provides key clinic resources such as health promotion material	• The practice is responsible for ensuring policies, procedures and systems are in place to support the clinic
• The Division has an ongoing role in ensuring the clinic is successful and working well	
• The clinic is still responsible for the nurses Professional Indemnity insurance and ensuring the nurse is acting within their competencies	

4.1.4 The role of the Division

The role of the WDGP, encompasses the following activities:

- Promoting the benefits of nurse led chronic disease clinics amongst its practices and GPs
- Providing advice and assistance to practices interested in establishing a nurse led chronic disease clinics
- Assisting practices to establish a clinic including support to review and redevelop systems, the development of templates for care planning, and assistance to develop policies and procedures to support the operation of the clinic
- Providing on-the-job training to practice staff including Receptionists, in key areas such as appointment bookings, billing, recall and review
- Providing proforma material such as marketing materials and health promotion resources
- Assisting practices to review and continuously improve clinics
- Providing information and advice on evidenced based best practice and annual cycles of care, MBS items etc
- Trouble-shooting advice and support
- Supporting Clinical Nurse Specialists' professional development, to implement systems change, with insurance and legal issues

4.2 Practice Operated Clinic

4.2.1 How the model works

The Practice Operated Clinic describes the model where a practice or GP/s directly employs a nurse to:

- run a specific chronic disease clinic on a set day/s and time/s
- provide specific chronic disease sessions and activities. For example, the practice may book extended appointments for patients with a chronic disease for purpose of developing a GPMP or TCA

In this model, the practice is responsible for all aspects of the clinic including staffing, resourcing, infrastructure and legal aspects including insurances.

4.2.3 An example of a Practice Operated Clinic – Otway Division of General Practice

CASE STUDY

The Corangamite Clinic, a general practice in the rural Victorian town of Colac, has been running nurse led Diabetes and Asthma clinics for more than 2 years. The Corangamite Clinic which has five GPs and up to three or four GP Registrars, runs a nurse led Diabetes Clinic between 9.00am and 5.30pm on Monday, Wednesday, Thursday and Friday each week, and an Asthma Clinic every Tuesday.

The practice employs two part-time Diabetes Nurse Educators and an Asthma Educator to run the clinics. The clinics have the capacity to offer six one hour appointments each day for patients referred by the practice's GPs.

The nurse led chronic disease clinics at the Corangamite Clinic are funded using the MBS items: #23 Level B - Surgery Consultation, #36 Level C - Surgery Consultation, #721 GPMP, #723 TCA, #725 GPMP Review, #727 TCA Review and the Diabetes SIP.

The nurse led clinics are conducted in a dedicated clinic room, which includes access to a telephone, the clinical software, a printer and plenty of space to store patient information and resources.

4.2.2 Pros and cons for the Practice Operated Clinic Model

Pros	Cons
• The practice has total control over the clinic including expansion of hours, room set up, resources to be provided	• The practice is responsible for recruiting, employing and managing the nurse
• The Division can assist with ongoing support to ensure the clinic is successful and working efficiently	• The practice is responsible for the ongoing professional development and technical support for the nurse
• The nurse can strengthen linkages between the practice and other local health services	• The practice and nurse may not have a good knowledge and/or working relationships with the local primary health care system

• The practice has total control over the clinic leading to greater satisfaction by practice staff and GPs	• The nurse may need to develop:
	  • skills and knowledge in the areas of chronic disease management eg. Diabetes clinical pathways,
	  • an understanding of the technical requirements of MBS items,
	  • formal relationships with external health professionals for TCA

• Increased flexibility to provide clinics when patients are available	• Practice concern about the cost and risk of employing a nurse
	• Shortage of appropriately trained nurses leading to recruitment difficulties

4.2.4 The role of the Division

The Otway Division of General Practice (ODGP) has been actively promoting the benefits of nurse led chronic disease clinics amongst its practices and GPs, using the Corangamite Clinic as an example of best practice. The Division, through its Practice Support Program, also supports its practices to establish new nurse led clinics by:

- Providing advice and encouragement to practices interested in establishing a nurse led chronic disease clinic
- Introducing staff from other practices to the Clinical Nurse Specialists at the Corangamite Clinic
- Funding Clinical Nurse Specialists at the Corangamite Clinic to provide advice and mentoring activities to staff from other practices
- Assisting practices to establish nurse led clinics including advice on how to review and redevelop systems
- Providing information and advice on evidence based best practice and annual cycles of care, MBS items etc
- Assisting practices to develop disease registers
- Trouble-shooting advice and support
- Coordinating a Practice Nurse Network

4.3 Selecting the right nurse to run a chronic disease clinic

A practice establishing a chronic disease clinic will need to recruit a Clinical Nurse Specialist to manage the clinic. A Clinical Nurse Specialist can perform a more advanced clinical role and take on greater responsibility for patient care in a nurse led chronic disease clinic than a Practice Nurse working within the practice.

The Clinical Nurse Specialist role in a nurse led chronic disease clinic is one of advanced clinical practice and is likely to include the following clinical activities:

- Provision of a thorough patient assessment
- Setting clinical targets and strategies to achieve them
- Provision of advanced care for patients with complicated histories such as co-morbidities or psycho-social issues
- Clinical interventions
- Trouble shooting and problem solving in conjunction with the GP
- Starting patients on insulin and insulin stabilization prescribed by GPs
- Review of Asthma device use
- Comprehensive patient education in all aspects of their disease

The pros and cons of employing a Practice Nurse with chronic disease management expertise, to run the nurse led chronic disease management clinic include:

Pros	Cons
• A Clinical Nurse Specialist can provide clinical support to GPs in their area of expertise eg. Diabetes and/or Asthma	• A Clinical Nurse Specialist's rate of pay will be higher, than a Practice Nurse
• A Clinical Nurse Specialist can provide a broad range of clinical support and interventions such as assisting patients to achieve a smooth and safe transfer to insulin	• A Clinical Nurse Specialist may be hard to recruit
• A Clinical Nurse Specialist can achieve better clinical outcomes	• A Clinical Nurse Specialist may only be available during the clinic hours, and for occasional sessions
• A Clinical Nurse Specialist would require less direct management from the GP	• A Clinical Nurse Specialist may not take on Practice Nurse duties
• A Clinical Nurse Specialist can potentially generate Medicare income (MBS Item 10951 Diabetes Educator)	
• A Clinical Nurse Specialist will have a good understanding of the local service system, external health professionals and the range of health professionals who should be involved in patient care	
• A Clinical Nurse Specialist will come with the support and resources of their peak body ie. ADEA and AAREA	

Financial incentives for nurse led chronic disease clinics in General Practice

5

Financial incentives for nurse led chronic disease clinics in General Practice

This section of the Information Package provides details on how nurse led chronic disease clinics in general practice can be funded and sustained using the MBS items.

5.1 Chronic Disease Management (CDM) Items

In July 2005, new Chronic Disease Management (CDM) items were introduced to the MBS to provide rebates for GPs to manage chronic disease by coordinating, reviewing or contributing to CDM plans. The chronic disease management items are for:

- Preparation by a GP of a GP Management Plan (GPMP)
- Coordination by a GP of Team care Arrangements (TCA)
- Review by a GP of a GPMP
- Coordination by a GP of a review of TCA
- Contribution to a multidisciplinary care plan or contribution to a review of a multi-disciplinary care plan (for patients who are not residents of aged care facilities)
- Contribution to a multi-disciplinary care plan or contribution to a review of a multi-disciplinary care plan (for residents of aged care facilities) [1]

These CDM items apply to the treatment of people with asthma, diabetes, mental illness and other chronic conditions. A Clinical Nurse Specialist may work in conjunction with a GP in undertaking the requirements of the CDM items.

The Chronic Disease Management items:

- reinforce international and Australian evidence which shows that multi-disciplinary care and a proactive approach can improve outcomes for patients with a chronic disease/illness
- value a team based approach to the management of chronic diseases
- enable a nurse led chronic disease clinic to be financially viable in general practice and add value to the services already available in the practice

If used effectively, the CDM Items can finance a nurse led chronic disease clinic[2] in general practice, which will result in:

- an increase in the services available to patients through the practice
- an improvement in the quality of care for patients through better use of clinical pathways and the annual cycle of care
- additional income for the practice and potentially an increase in profit

Divisional staff, practice staff and GPs must familiarise themselves with the descriptors and requirements of the CDM items. Further information can be obtained from the Medicare Benefits Schedule Book or from the following links www.health.gov.au/epc and www.health.gov.au/mbs/

5.2 Allied Health and Dental Services MBS Items

The Allied Health and Dental Services MBS items provide for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. Before a rebate can be paid for the allied health service on referral from a GP, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and received payment for that claim from Medicare Australia[3].

The following groups of allied health professionals are currently eligible to provide services under the Medicare Allied Health and Dental Care initiative. Allied health professionals must meet the provider eligibility requirements and be registered with Medicare Australia. Allied health services may include services provided by:

- Aboriginal Health Workers
- Audiologists
- Chiropodists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental Health Workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

Medicare benefits are available for up to five private health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (eg. five physiotherapy services) or a combination of different types of services (eg. one dietetic and four podiatry services). Where a practice employs a Credentialled Diabetes Educator, allied health referrals can be made to this position, if the services are required by the patient.

The Allied Health and Dental Services items:

- reinforce international and Australian evidence which shows that multi-disciplinary care can improve outcomes for patients with a chronic disease/illness
- value a team based approach to the management of chronic diseases
- enable a nurse to build working relationships with other health professionals to provide care to patients with a chronic disease

GPs and nurses must familiarise themselves with the descriptors and requirements of the Allied Health and Dental Services items. Further information can be obtained from the Medicare Benefits Schedule Book or from the following links www.medicareaustralia.gov.au and www.health.gov.au/mbs/

5.3 Service Incentive Payment (SIP)

The SIP[4] is intended to remunerate individual GPs for services. This payment is made in addition to the Medicare rebate for consultation, and is paid quarterly via PIP. The two SIP payments most relevant to supporting and financing nurse led chronic disease clinics are the:

- Diabetes SIP
- Asthma SIP

5.3.1 Diabetes SIP

The Diabetes SIP is part of the Chronic Disease Initiative commenced by the Federal Government in late 2001. It is a monetary incentive to encourage GPs to provide a least a minimum annual cycle of care for patients with Diabetes. The requirements are based on the current guidelines Diabetes Management in General Practice produced by Diabetes Australia and the Royal Australian College of General Practitioners.

1. Medicare Benefits Schedule Book (effective 1 November 2006). DOHA p.54
2. Please note, that the Medicare Benefits Schedule changes from time to time, and the information presented in this Information Package is based on the MBS Book (effective from 1 November 2006). Readers must obtain a current copy of the Medicare Benefits Schedule Book to ensure they are working from current information. See www.health.gov.au/mbs/
3. www.health.gov.au/mbsonline
4. A discussion of PIP has not been included in this document.

The minimum requirements of care for the Diabetes SIP are:

Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out	At least once every two years
Measure weight and height and calculate BMI	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet	At least twice every cycle of care
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Provide self care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate elves of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of Medication	Medication review

The Diabetes SIP can be used to fund the delivery of the annual cycle of care, but a GP must claim the SIP to benefit financially.

Suggestion for claiming the Diabetes SIP

Level B GP Consultation (2517), plus the Diabetes SIP - $72.10
Level C GP Consultation (2521), plus the Diabetes SIP - $100.95
Level D GP Consultation (2525), plus the Diabetes SIP - $129.75

Source: Medicare Benefits Schedule Book
(effective 1 November 2006). Department of Health and Ageing

5.3.2 Asthma SIP

The Asthma SIP initiative rewards GPs for improving the quality of clinical care provided to people with moderate-to-severe asthma through the completion of the Asthma cycle of care and the development of an Asthma Plan[5]. At a minimum the Asthma cycle of care must include:

- At least two asthma related consultations within 12 months for a patient with moderate to severe asthma, at least one of which (the review consultation) is a consultation that was planned at a previous consultation
- Documented diagnosis and assessment of level of asthma control and severity of asthma
- Review of the patient's use of, and access to, asthma-related medication and devices
- Provision to the patient of a written asthma action plan
- Provision of asthma self management education to the patient
- Review of the written or documented asthma action plan[6]

The Asthma SIP can be claimed by a GP once a year.

GPs and nurses must familiarise themselves with the descriptors and requirements of the Diabetes and Asthma SIP items. Further information can be obtained from the Medicare Benefits Schedule Book or from the following links www.medicareaustralia.gov.au and www.health.gov.au/mbs/ It is recommended that Division staff attach this link as a shortcut on their computer.

5.4 Other MBS Items relevant to a nurse led chronic disease clinic

There are a number of other MBS items which can be used to support and finance a nurse led chronic disease clinic including:

- Respiratory Function Tests (Item 11503)
- Spirometry (Item 11506)
- Stick Prick Allergy Testing (12000)
- Diabetes Education Service (Item 10951)
- Health Assessments (Items 700 to 706)
- Wound Management (Items 10996)
- Immunisation by a Practice Nurse (Item 10993)
- CDM Item for Practice Nurses (Item 10997)

Please refer to the following web site for up-to-date information on items and rebates www.health.gov.au/mbs/

5.5 Summary of Medicare Item numbers that can be used in a nurse led chronic disease clinic

5.5.1 Overview of key MBS items which can be used in a nurse led chronic disease clinic

The table on the following page provides a list of the MBS item numbers and rebates (from the MBS Benefits Schedule Book effective from 1 November 2006) which can be utilised to finance a nurse led chronic disease clinic[7].

5. Please note, in 2007 the Asthma 3+ Plan was changed to the Asthma 2+ Plan.
6. Medicare Benefits Schedule Book (effective 1 November 2006). Department of Health and Ageing p. 68.
7. This list was accurate at the time the Information Package was developed and information has been sourced from the MBS Benefits Schedule Book (effective 1 NOV. 2006). Division staff and GPs must familiarise themselves with the latest set of items and specific item requirements contained in the Medical Benefits Schedule Book.

Item Number	Service	Fee[8]
721	GP Management Plan (GPMP)	$124.95
723	Team Care Arrangements (TCA)	$98.95
725	GPMP Review	$62.50
727	TCA Review	$62.50
2501	Level B GP Cons	$32.10
2517	Level B GP Cons/SIP Diabetes	$32.10 + $40.00
2521	Level C GP Cons/SIP Diabetes	$60.95 + $40.00
2525	Level D GP Cons/SIP Diabetes	$89.75 + $40.00
2517	Level B GP Cons/SIP Asthma	$32.10 + $25.46
2521	Level C GP Cons/SIP Asthma	$60.95 + $25.52
2525	Level D GP Cons/SIP Asthma	$89.75 + $25.58
740	Case conference > 15 minutes	$83.75
742	Case conference > 30 minutes	$125.65
744	Case conference 45+ minutes	$167.45
10990	General medical services - metro	$5.30
10991	General medical services - Rural	$8.00
10950 & 10970	Allied Health and Dental Care Services	$55.05
10951	Diabetes Educator	$55.05
729& 731	Contribution to a Multidisciplinary Care Plan	$43.40
700 - 706	Health Assessment	$167.45
10993	Practice Nurse immunisation	$10.60
10996	Wound management	$10.60
12000	Skin Sensitivity Testing	$34.40
11506	Measurement of Respiratory Function	$18.10
10997	CDM Practice Nurse	$10.60

Please note, in certain circumstances DVA items numbers can also be used.

5.5.2 Calculating the income for a nurse led chronic disease clinic

GPs may use a nurse to assist with the completion of the requirements of the EPC items. Other items are specifically for nurses or can involve the nurse.

The following two examples illustrate how a practice can calculate the potential income that could be generated for the practice by a nurse led chronic disease clinic.

CASE STUDY

Within a 12 month period a practice can be paid approximately $348.90 for each patient for whom a GPMP and TCA are prepared and reviewed. This is made up of:

- GP Management Plan $124.95
- Team Care Arrangement $98.95
- Review of GP Management Plan $62.50
- Review of Team Care Arrangement $62.50

Additional rebates may also be claimed if the requirements of the Diabetes SIP (currently $40.00) are met, that is, the annual cycle of care as outlined in the Medical Benefits Schedule Book is completed also the CDM Practice Nurse item can be claimed.

If a clinical nurse specialist such as a Diabetes Educator is employed, it may be possible for the practice to claim an Allied Health referral rebate of $46.80 for Diabetes Education.

Similarly if all GP MBS items are bulk billed, a further $5.30 or $8.00 can be claimed for each service. DVA items can also be claimed in certain circumstances.

CASE STUDY

Using an Income Generation Calculator for Care Plans[9] based on the estimate that 10% of all patients managed in general practice will require a care plan each year, the following calculation can be used to estimate the total income from care planning in a typical year.

Total # patients 2500 x 10% = 250 patients

GPMP 150 patients x $124.95	$18,742.50
Review of GPMP	
In one year 150 patients x $62.50	$9,375.00

Total extra potential income for GPs derived from most commonly used EPC items

GPMP	$18,742.50
Review of GPMP	$9,375.00
TCA	$14,842.50
Review of TCA	$9,375.00
Total (per annum)	**$52,335.00**

Other MBS items may be able to be claimed eg. Diabetes or Asthma SIP, Allergen testing, wound management etc.

Divisions assisting practices to establish nurse led chronic disease clinics should be familiar with all MBS items and item requirements, and how these items can be used to finance a nurse led chronic disease clinic, in order to be able to provide advice to practices in this area.

8. These figures were sourced from the MBS Schedule Book (effective 1 November 2006). Please note, for some items, only 75%-85% of the scheduled fee will be paid, when the practice bulk bills.
9. Adapted from the Australian Division of General Practice (ADGP). Demonstration Divisions Nursing in General Practice National Resource Kit (2005).

5.5.3 Calculating the cost of running a nurse led chronic disease clinic

Divisions may also need to give advice to practices on the cost of running a nurse led clinic. In general, the Contracted Clinic is easier to cost as it is a fee for service model.

The typical costs of a Practiced Operated nurse led chronic disease clinic would include:

- Nurse wages and on-costs
- Insurance
- Clinic consumables such as educational materials, patient equipment, bacterial filters etc
- Clinic overheads such as electricity, telephone, etc
- Training and professional development

CASE STUDY

A nurse led clinic which operates for 4 hours could generate $697.80 in income if the following services are provided:

Two GP Management Plans	$249.90
Two Team Care Arrangements	$197.90
Four TCA Reviews	$250.00
TOTAL per clinic	**$697.80**

Other MBS items may be able to be claimed eg. Diabetes or Asthma SIP, Allergen testing, wound management etc.

Assuming the nurse's salary including on-costs is four hours at $40.00 per hour ($160.00), plus overheads (electricity, telephone etc) and consumables of $200.00, the total cost of each clinic would be $360.00. If the practice income is $697.80, less costs of $360.00, the clinic would generate approximately $338.00 of additional income for the practice.

Please note, GP and other practice staff time has not been factored into the overheads listed above.

CASE STUDY

Research conducted by the WDGP shows that in the Contracted Clinics run through the GPSS:

- solo to small practices earned on average between $2.60 – $4.70 for each dollar of the clinic's contract cost, and
- medium to large practices earned on average $2.50 - $3.00 dollars for each dollar of the clinic's contract cost.

The WDGP also found that the length of time the practice had to run a clinic did not impact on the clinic's financial viability or profitability.

5.6 Using subsidies

Some Divisions have used subsidies to assist practices to implement nurse led chronic disease clinics. A subsidy can be useful in that it can:

- defray the set up costs which need to be met by the clinic eg. recruitment of a nurse, staff training, GP time etc
- take the pressure off the practice when the first bills are coming through, therefore smoothing cash flow
- minimise the financial risk to the practice in the first few months when the clinic is being established and systems embedded

To offer a subsidy or set-up grant, the Division will need to find the money. Potential sources of funding include:

- Grants for Diabetes Education
- Hospital Admission Risk Program (HARP) in Victoria only
- More Allied Health Services (MAHS)
- Pharmaceutical companies
- Practice Nurse subsidies
- The Division's own budget

CASE STUDY

The WDGP offers a start-up subsidy to practices interested in establishing a nurse led chronic disease clinic. The aim of the subsidy is to ameliorate the perceived barriers [i.e. the effort required to implement systems and staff changes, and the potential risk of not being able to cover initial and ongoing costs] and swing the balance in favour of trying the clinics.

Initially funding for the subsidy came from the Division itself and in more recent times from HARP, which recognised the role general practice and Diabetes Educators play in preventing hospital admissions and presentations to the Emergency Departments, and/or reducing the number of days spent in hospital.

Depending on the funding available, at different times subsidies have ranged from $3000.00 to $4000.00.

To be eligible for a subsidy, the WDGP asks the practice to commit to a number of clinics over and above the number that are subsidised i.e. the subsidy may cover some of the costs for the first 3 months, but the practice agrees to maintain the clinics for 6-12 months.

The WDGP is flexible about how the practice uses the subsidy, for example the practice can use the subsidy to:

- compensate for time spent by practice staff to change the appointment and billing system
- fund changes to the GP appointment schedules
- meet the costs of up-grading rooms
- purchase new equipment for the clinic such a computer and printer.

5.7 Charging Patients

The decision about whether to bulk bill, privately bill or charge patients a co-payment will need to be made on a practice-by-practice basis. Bulk-billing removes the cost barrier for patients wanting to access the services offered by the clinic (patients can access 3-5 visits in the first year). Most practices which establish nurse led chronic disease clinics opt for a bulk-billing approach or charge a small annual fee ($30.00).

CASE STUDY

At the Corangamite Clinic patients who attend the Diabetes and Asthma clinics are bulk billed. Having a chronic disease is costly, and for many of our patients it would cost too much to come back to the clinic on a regular basis.

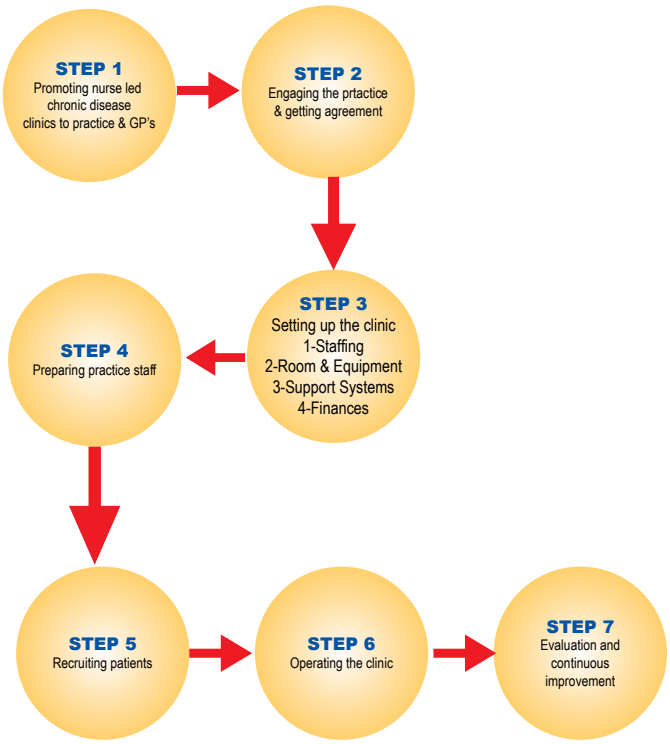
How to set up a nurse led chronic disease clinic in General Practice

6

6. How to set up a nurse led chronic disease clinic in General Practice

This section of the Information Package outlines the steps involved in setting up a nurse led chronic disease clinic in general practice.

6.1 The steps involved in setting up and operating a nurse led chronic disease clinic in General Practice



6.1.1 Promoting the concept to practices and GPs - Step 1

The value of nurse led chronic disease clinics can be promoted to general practices and GPs in your Division using a range of existing communication strategies, such as:

- Promotional material about nurse led chronic disease clinics on your website including information about how the Division can help a practice to establish a clinic
- Articles promoting successful nurse led chronic disease clinics in your regular newsletter
- Division staff leaving promotional material with GPs, Practice Managers or Practice Nurses during routine practice visits
- Promotional material sent directly to practices
- Promoting clinics through Continuing Professional Development (CPD) events and clinical audits e.g. chronic disease clinics come up as a suggested system change in how GPs can use new MBS item numbers to deliver evidenced based guidelines
- Executive and Division staff promoting nurse led chronic disease clinics at conferences, workshops, forums and training events
- Promoting clinics through the practice support and practice n urse programs
- Cold calling GPs who have expressed an interest in chronic disease management or have an interest in specific diseases such as Diabetes

Remember, your promotional material and marketing strategy needs to reflect the type of service your Division has decided to offer. For example, if your Division is offering Contracted Clinics, the content of your marketing strategy will be different from a Division that is offering practices advice and support to set up a Practice Operated Clinic.

Some Divisions may choose a dual role that involves, supporting practices to set up a Practice Operated Clinic and offering Contracted Clinics to other practices. While other Divisions may only offer assistance in enhancing the role of the Practice Nurse, through the provision of chronic disease management training and professional development activities and peer support.

6.1.2 Engaging the practice and getting agreement - Step 2

The establishment and operation of a nurse led chronic disease clinic requires the practice to contribute resources, time and effort to make it work. It is important to explain the options, requirements and risks upfront, so that the practice can make an informed decision about whether it wishes to proceed or not.

It is likely that some practices will opt out at the initial enquiry stage. To ensure that you don't waste the time of the practice or the Division we suggest that you raise the following issues when contacted by a GP or practice with an initial enquiry or for further information about setting up a nurse led chronic disease clinic:

- A nurse led chronic disease clinic has costs including staff wages, overheads and consumables (or a clinic fee in the case of a Contracted Clinic) irrespective of whether patients attend or not
- A practice will need at least 70 patients with a chronic disease to run a viable clinic (ie. a fortnightly clinic of 5 hours duration), and each clinic will need to be 75% booked at least 75% of the time
- A clinic will need robust appointment, billing, recall and review systems, and the support of practice staff including GPs, Reception, Practice Manager etc
- The role and responsibilities of the key stakeholders, in particular the importance of the patient's GP being available to attend the clinic at the end of a patient's appointment to discuss care planning issues, provide medical input and sign off on MBS items such as the GP Management Plan and Team Care Arrangements
- Minimum venue and equipment requirements for a clinic, include access to:
  - a suitable clinic room
  - patient records
  - a computer and printer
  - medical equipment such as BP machine

Key risks to the practice such as changes to MBS Items, recruitment issues etc

If the practice is still interested after the initial enquiry, the next step is to set up a meeting at the practice to discuss the best model, roles and responsibilities, and logistics. It is important that key personnel such as the Practice Principal, the Practice Manager and Reception staff attend the meeting. If the practice has a Practice Nurse, they should be encouraged to attend also.

Initial establishment visit to the Practice

The purpose of the initial meeting at the practice is to:

- Engage the Practice Principal and other key staff and to ensure they understand what is required and are committed to making a nurse led chronic disease clinic work

- Discuss the two different models ie. Contracted Clinic Model or a Practice Operated Clinic Model
- Discuss the pros and cons of employing a Clinical Nurse Specialist versus a Practice Nurse with professional qualifications in chronic disease management
- Provide advice and information about the roles, responsibilities, requirements and risks, to assist the practice to make an informed decision about whether it wants to proceed and establish a nurse led chronic disease clinic
- Gain an understanding of the business model, culture and needs of the practice. This will enable the Division to provide advice on key aspects of a successful clinic (hours, staffing, systems change requirements), should the practice wish to go ahead
- Discuss the various options open to the practice, for example:
  - Does the practice want to establish a Diabetes Clinic, an Asthma Clinic or a general chronic disease clinic?
  - What is the most appropriate day and time/s for a clinic to operate and how frequently should it run?
  - Will the clinic be staffed by the Practice Nurse or will a new nurse be recruited specifically for the clinic?
  - What role will the GPs, practice staff and other health professionals have in the clinic?

CASE STUDY

These are the frequently asked questions the Division Consultant usually get asked at the initial visit to the practice:

- How will the clinic run and sessions be conducted?
- What type of patients would use the clinic? Who is eligible?
- How will we pay for it? How do the finances add up? Will it be sustainable?
- How will a clinic complement the current services of the practice?
- How will a clinic complement / impact on the Practice Nurse role?
- How do we get patients to come along to the clinic?

No two clinics will look the same, the most appropriate clinic for a practice will depend on a variety of factors such as the:

- Size of the practice
- Practice business model ie. GP/s owner (solo or group practice), Associates, Salaried or Employee GP, Contractor GP, Corporate or locum GP
- Physical layout of the practice and access to a clinic room
- Staff profile, for example if a practice current employs a Practice Nurse, Practice Manager, Reception staff, other health professionals, and the number of GPs
- Existing practice services, for example the practice may already have a Practice Nurse who is preparing GPMPs or TCAs, or a visiting Dietitian or Asthma Educator
- Business systems eg. the practice may be fully or partially computerised

Practice buy-in

If the practice wishes to go ahead, the Division should discuss and finalise its involvement and how it will support the practice.

If the Division is going to provide a Contracted Clinic it is important to clearly define the service to be provided and document this in an Agreement or Contract (see appendix). A typical agreement between the practice and the Division for a Contracted Clinic would include:

- Period of agreement
- Details of the services to be provided (how, where, when) ie. clinic location, days, hours etc
- Roles, responsibilities and qualifications of the nurse ie. Clinical Nurse Specialist or Practice Nurse
- Roles and responsibilities ie. Practice, GPs, the Division
- How the practice will support the clinic (clinic room, consumables, equipment, other obligations)
- Payment for services eg. invoicing
- Insurance requirements
- Confidentiality and privacy issues
- Termination and disputes

If the Division is going to provide consultancy advice and assist the practice to set up its own Practice Operated Clinic, it is still worth documenting the roles and responsibilities. It is good idea to do this in a letter from the Division to the practice. A typical letter would include:

- A description of the support to be provided by the Division eg. assistance recruiting the nurse, advice on how to redevelop appointment booking and recall systems, training for Reception staff
- An outline of any costs involved
- Timelines
- Information about ongoing support such as participating in reviews, evaluation or continuous improvement activities

CASE STUDY

If a practice tells me (Division Consultant) that their data base shows they don't have sufficient patients for a nurse led chronic disease clinic (70 people), I usually question this. In most cases, if the practice sits down and takes a closer look at their patient data, they will find that their data is not up-to-date, and in fact they do have enough patients. This may be because all the Diabetes patients have not been placed on the Diabetes Register, or all patients with a diagnosis of Diabetes have not had this information recorded correctly in the GP Medical Software.

Remember, the Division has an important role assisting practices to continuously improve their patient information management systems. In assisting a practice to set up a nurse led clinic, it enables the Division to meet some of its Key Performane Index, such as Continuous Improvement of Patient Information Management and Quality Data.

6.1.3 Setting up the clinic - Step 3

Before the clinic can open its doors, there is a lot of set up work required. The Division has an important role to play in assisting practices with the set-up phase. The four essential areas to consider in the set-up stage are:

- Staffing the clinic and identifying the chronic disease team
- Preparing the clinic room and equipment
- Redeveloping systems to support the clinic ie. appointment booking, recall and review
- Organising the billing and clinic finances including MBS items and paying clinic costs

During the set up stage there are also some risks and barriers to look out for including:

- Reluctance by Reception staff to change "We've always done it this way!"
- A lack of skills and competencies in key areas such as recall and review, billing and marketing
- Communication difficulties, such as the GPs roles not being explained properly and as a consequence GPs not understanding their roles and responsibilities. In particular, GPs may need to be available during clinic times to attend each patient at the end of their clinic
- Negative attitudes such as a reluctance by GPs to promote the clinic or a reluctance by Reception staff to contact patients to remind them to attend appointments

Staffing the clinic and identifying the chronic disease team

Once the scope and nature of the clinic has been determined, then appropriate staff should be recruited and the care team identified

- If the clinic is a Contracted Clinic, the Division will be responsible for recruiting and employing an appropriately qualified and skilled nurse such as a Credentialed Diabetes Educator for a Diabetes Clinic
- If it is a Practice Operated Clinic, the Division can assist the practice to develop the position description and recruit the nurse. In this option, the practice will be responsible for employing the nurse and the ongoing management of this position
- If the clinic is an expansion of the Practice Nurse role, the Division can provide advice to the practice about clinic requirements and training for the Practice Nurse in key areas such as billing, recall and review, clinical guidelines, disease management etc

Remember, it is important to orient the new nurse, by taking them around to meet the staff and GPs, and giving them a tour of the practice before the first clinic.

Importantly managing chronic disease requires a team based approach. This will usually require the establishment of new working relationships within the practice as well as building links with health professionals outside the practice. At the set-up stage it is worth considering what local services and health professionals can be included in the team (private and non government) and approach them to build your team approach.

Preparing the clinic room and equipment

For a clinic to operate effectively and efficiently, it requires an appropriate space (room) and equipment. Ideally the practice will have a separate room for the clinic, or perhaps a consultation room which is available. The minimum requirements for a clinic room include:

- Sufficient space for a comprehensive assessment and the provision of appropriate clinical care
- Room for a desk, phone, computer and printer to enable the nurse to access patient records and make referrals in a timely manner
- Appropriate equipment eg. Scales, height chart, BP machine. Specific clinics may require specific equipment eg. Blood Glucose Meter, Spirometer etc
- Storage space for clinic resources, such as health promotion materials and patient aids
- Adequate safeguards for patient privacy and confidentiality
- Occupational health and safety standards

Systems to support the clinic

The key systems which are needed to support a nurse led chronic disease clinic are:

- Appointment bookings
- Patient billing
- Recall and review
- GP input and sign off

Appointment bookings

The introduction of a nurse led chronic disease clinic is likely to require the practice to reorient its existing appointment booking system. Clinics generally operate for fixed hours and need to be 75% full, 75% of the time to be financially viable. This means that the practice will need to actively manage appointment bookings to ensure patients:

- Are booked in back to back (for all available appointments) and for the appropriate length of time, and that a minimum of 75% of patients with appointments attend the clinic
- Receive a reminder call at least 48 hours before the clinic, to minimise the number of patients who do not attend booked appointments
- Are given a new appointment, when they cancel one

The practice will need to meet clinic costs irrespective of whether patients attend or not. To be viable, the Reception staff must actively ensure appointments are filled and minimise the number of patients who do not show up.

CASE STUDY

To ensure the clinics meet clinical guidelines including the Diabetes annual cycle of care and are financially viable, the policy of the Contract Clinics operated by the WDGP mean that no patient leaves the clinic without a follow up appointment.

If appointments are cancelled, they are automatically rebooked by the Receptionists at the time of cancellation. In addition, the patient receives a written confirmation letter setting out the details of the new appointment time, and then they receive a reminder call a week before the appointment.

The nurse activates the practice recall system as a final back up for all appointments, This:

- Ensures patient attends all appointments proactively which reduces reactive and acute appointments
- Enables practices to maximise income from CDM items
- Supports the achievement of the annual cycle of care (including the Diabetes SIP)
- Ensures clinic appointments are at least 75% full at each clinic

If patients regularly cancel, the nurse rings to discuss barriers and encourage the patient to return to the clinic.

Clinic billing system

As a nurse led chronic disease clinic will predominantly make use of the Enhanced Primary Care Chronic Disease Management items and other less common items such as item 10951 Diabetes Education, it is important that the practice's billing systems are geared up to claim the appropriate items. This may be as simple as adding a couple of extra tick boxes to the billing slip the GPs give to patients to take to Reception at the end of the consultation. In fully computerized practices, it may be as simple as providing training in this area for Reception staff. Whatever system the practice chooses to use, it is recommended that the practice regularly review its billing and billing processes to ensure it is claiming correctly and meeting the MBS requirements.

Recall and review system. For both effective care and financial reasons a nurse led chronic disease clinic needs a robust recall and review system. As many practices do not have effective recall and review systems, it is important to ensure the existing system is redeveloped to support the clinic or where systems do not exist they are developed. The GPMP and TCA have regular reviews built in (and specific timelines for completion), and an effective system will enable the practice to book patients in for these review appointments and send reminder letters when appointments draw near.

GP input and sign off. GP involvement in the nurse led clinic is essential, as the GP has overall responsibility for the patients care and ensuring compliance with the MBS item number requirements. Therefore for a clinic to operate effectively GPs need to be able to attend the clinic at specific times during the session. This may mean that special appointments are made or times flagged for the GP to attend the clinic. At other times the nurse may need to seek advice from the GP, hence flexibility of and access to GPs on clinic days is essential.

CASE STUDY

The clinic nurses make all the patient appointments for the chronic disease clinics. When a patient is booked for an appointment at the clinic, the practice's clinical software is used to make the appointment. This enables the nurses to check when the patient's GP will be available, and link clinic appointments with the GP's appointment schedule.

By speaking directly to patients who are making appointments, the nurses are also able to:

- provide information about the clinic and what the patient can expect
- prioritise clients who are newly diagnosed or "stressed" about their illness
- provide advice and counselling to new and existing patients over the phone
- inform each patient about pre-visit testing requirements ie. HbA1c

When the patient attends an appointment at the clinic, the GP is advised on his/her appointment schedule. The GP then knows he/she will be required to be present towards the end of the appointment. The clinic nurse rings the GP 5-10 minutes before the patient has finished their clinic appointment, allowing the GP time to finish with their current patient and then attend the clinic in a timely manner.

Effective operation of the clinic can also be supported by a set of templates, within each system, in particular templates for:

- Communicating with patients such as letters for welcoming them to the clinic, or reminding patients that a review appointment is due
- Communicating with health professionals and specialists such as referrals for Allied Health appointments or engagement in TCAs
- Care Planning and Team Care Arrangements

Finances including using MBS items and paying for the clinic

For the clinic to be financially viable and sustainable, the practice will need to have in place a clear financial and business model, which includes systems for billing appropriately for the clinic services (see section 5 of this Information Package).

6.1.4 Preparing practice staff - Step 4

By taking a whole of practice approach and addressing each person's role in a process, everyone becomes part of the team and works more effectively towards a systematic approach.

An important role for the Division can be to assist the practice to clarify roles and responsibilities of practice staff. The following role statements have been provided as an example only, as the Division will need to work with individual practices to determine the most appropriate allocation of roles and responsibilities.

Role of Reception staff

- To be openly supportive of the clinic and promote its benefits to patients
- To have a working knowledge of all the components and systems required to support the clinic
- To actively manage booking of appointments, rebooking and cancellations
- To organise the reminder and recall requirements
- To coordinate clinic billing
- To participate in continuous improvement

Role of Practice Manager

- To ensure Reception staff support the clinic
- To ensure systems support the effective operation and funding of the clinic
- To ensure ready access to the clinic room, clinic equipment and resources
- To ensure appropriate billing practices
- To support the nursing role and a team based approach to care
- To regularly review and continuously improve the systems which support the clinic
- To provide support to the nurse and encourage a team based approach

Role of the General Practitioner

- To provide medical management eg. Medications, pathology and diagnostic requirements
- To identify and refer suitable patients to the clinic
- To promote the clinic to patients
- To provide ongoing medical care for patient involved in the clinic
- To prescribe medications and assess effectiveness
- To communicate effectively with and liaison with all team members
- To sign off on MBS items such as GPMP and TCA

- To monitor and assess clinical data and provide regular `screening of health indices
- To work as a team with nurse and other health professionals

Role of the Practice Nurse

- To provide nursing support as part of a structured chronic disease program
- To manage and run the clinic in conjunction with practice staff
- To provide quality care to patients with a chronic disease
- To work as part of a team
- To ensure systems support the effective operation of the clinic

Role of Clinical Nurse Specialist

- To provide advanced clinical support to the patient and practice
- To manage and run the clinic in conjunction with practice staff
- To provide quality care to patients with a chronic disease
- To work as part of a team
- To ensure systems support the effective operation of the clinic

A Practice Manual is a useful way of setting out the roles and responsibilities of all those involved in the Clinic and helps to orient new staff. A Practice Manual could include:

- Information on clinic day, hours etc
- Patient eligibility, specific target groups and referral pathways
- Letters and templates, with guidelines on how to use them
- Roles and responsibilities statements for GPs, Reception staff, Practice Nurse, clinic nurse etc
- Booking Guidelines
- Appointment Guidelines
- Medicare Item numbers used in the clinic
- Privacy and consent requirements
- CQI and PDSA cycles and tools

See appendix for example Procedure Manuals

As a rule of thumb, a 5 hour clinic operating once a fortnight, needs to recruit the following numbers of new patients to be financially viable:

1st Clinic – 4 new patients

2nd Clinic – 2 new patients

3rd Clinic – 2 new patients

4th and subsequent clinics 1-2 new patients

The formula allows for existing patients to be booked in for review appointments and urgent appointments such as a patient starting insulin to be accommodated.

A full day clinic will need to recruit

1st clinic – 6 new patients

2nd clinic – 2 new patients

3rd clinic – 2 new patients

4th and subsequent clinics 1-2 new patients

6.1.5 Recruiting the patients - Step 5

A nurse led chronic disease clinic will not be successful without a steady flow of new patients. The Division can play an important role by assisting the practice to develop strategies to recruit patients for the nurse led chronic disease clinic.

There are many ways to recruit patients including:

- Regular promotion of the clinic, its services and its benefits through newsletters, fliers, letters, and posters
- Opportunistic referral of patients to the clinic by the GPs and other practice staff such as referring all newly diagnosed patients or patients who present for other care and who would benefit from the services of the clinic
- Generation of chronic disease lists /registers by the practice and targeted marketing to these patients

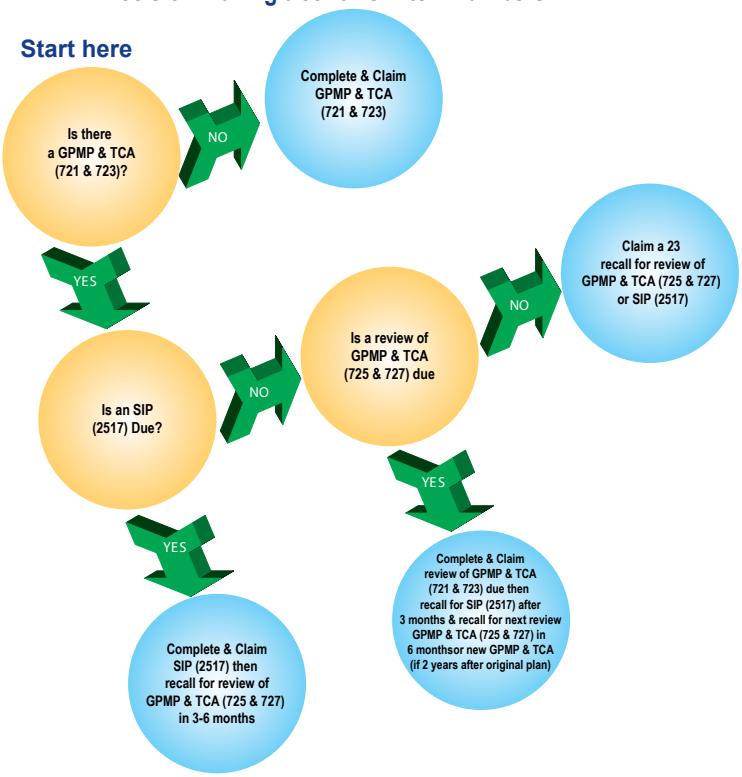
6.2 Operating the clinic

6.2.1 Operating a viable clinic - Step 6

The Practice Manager and/or Practice Principal are responsible for the viability and sustainability of the clinic. However, the nurse should be responsible for managing the day-to-day operation of the clinic such as organising his/her own time, re-ordering health promotion materials, building relationships with external health professionals, alerting the practice to areas for improvement etc.

It is anticipated that appointments will run consecutively and the maximum number of patients will be booked into each session. The clinic time should be used at the nurse's discretion, with appropriate time before and after each patient to complete paper work and follow up. For example the nurse may choose to complete paper work and phone calls at the end of each appointment or at the end of the session.

Decision making tree for GP item numbers



The flowchart above illustrates a decision making tree for GP item numbers for a patient with Diabetes which could be used by a nurse during a clinic.

Please note, if a practice employs a credentialled Diabetes Educator, the nurse may be able to claim the Diabetes Educator MBS Item for each appointment which has an Allied Health referral.

6.2.2 Managing risks and opportunities - Step 7

There are both risks and opportunities for a practice establishing and operating a nurse led chronic disease clinic. Typical risks include:

- Insufficient patient referrals or interest from patients, and the clinic does not make sufficient money to cover costs
- Practice staff do not support the clinic and the clinic does not make a profit
- The nurse employed does not have the competencies to manage the clinic and the clinic patient outcomes are not achieved
- The opportunity for the practice to employ another GP arises, and the room for the clinic is no longer available
- The nurse leaves and the clinic can't be re-staffed with a suitably qualified nurse
- The Commonwealth Government makes changes to MBS items which mean that nurse led chronic disease clinics are no longer viable
- There is an increase in clinic costs (wages and equipment)
- GPs do not promptly see the patients attending the clinic and as a result many patients leave the clinic before being seen by the GP, and the practice is unable to claim the relevant MBS items
- There are high numbers of patients who fail to attend appointments and the clinic does not generate sufficient income to meet costs
- Demand for the clinic is high, but there are no appointments available, as a result patients get frustrated
- Workforce shortages

If the practice is aware of the risks and develops a plan to manage these risks, then risks can be minimised and turned into opportunities which benefit the whole practice.

The following template can be worked through with the practice to assist with the identification and management of risks

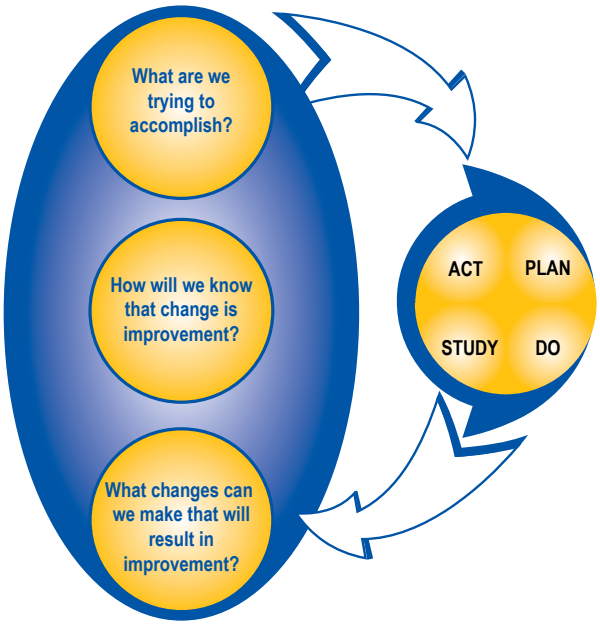
Managing Risks

Risk	Suggestions for Practice Management	Action
Practice staff do not support the clinic and the clinic does not make a profit	• The Division works with the Practice Manager and / or Practice Principal to reorient practice staff	• Nurse or Division to speak with Practice Manager • Practice Manager or GPs to provide support and training to practice staff
The nurse employed does not have the competencies to manage the clinic and patient outcomes are not achieved	• Provide additional training for the nurse in-service, Division or specialist chronic disease courses	• Employ nurse on a short term contract • Include a performance appraisal review in the nurse's contract • Involve the Division in recruitment process • If 'Contracted Clinic' go back to the Division
There are high numbers of patients who fail to attend appointments and the clinic does not generate sufficient income to meet costs	• Ring and remind patients • Always rebook cancelled appointments • Send out a written reminder and make follow up phone call	• Include active management of appointments in front of house role and position description • Notify nurse about patients who repeatedly cancel appointments so the nurse can follow them up
High demand but no available appointments	• Discuss with nurse and GP how to prioritise patients • Develop a protocol for prioritising patients	• Increase hours of the clinic • Run extra clinics (one-off) to meet peak demand
GPs do not promptly see the patients attending the clinic and as a result many patients leave the clinic before being seen by the GP, and practice is unable to claim MBS items resulting in the clinic losing money	• Discuss with GPs how best to support their involvement in the clinic	• Reschedule GP patient load • Reschedule clinic day and time
Tension between clinic overheads and GP billing practices	• Discuss with practice manager how MBS billing for the clinic is/would be split between the practice and individual GPs	• Practice determines percentage MBS billing for clinic and cost allocations between practice and individual GPs • SIP Calculator in appendix

6.2.3 Evaluation and quality improvement - Step 8

As with all areas of the practice, the nurse led chronic disease clinic should be subjected to regular review, evaluation and continuous improvement. The Division can play an important role in assisting practices to review and continuously improve all aspects of a nurse led chronic disease clinic.

The Plan-Do-Study-Act (PDSA) cycle is a useful tool which can be used



to test the change (in this case the introduction of a nurse led chronic disease clinic). This PDSA cycle involves developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Further information about evaluation and continuous quality improvement can be found on the National Primary Care Collaborative website at www.npcc.com.au.

6.3 Supporting the nurse

The Division can play an important role in supporting the nurses involved in nurse led chronic disease clinic, such as providing:

- Peer support and networking opportunities through Practice Nurse groups or by establishing Special Interest Groups for Clinical Nurse Specialists such as a Diabetes Educators Group
- Induction and orientation of nurses to general practice and the requirements of chronic disease clinics eg. Clinical pathways and annual cycles of care
- Ongoing support and advice including effective use of MBS items, information about clinical pathways and best practice care
- Formal education sessions
- A phone help desk or hotline staffed by a senior experienced registered nurse
- Regular newsletters

As the Division is an important reference point for practices and the nurse, it will need to have staff with the expertise and knowledge required to provide professional support to general practices wanting to set up, operate and evaluate nurse led chronic disease clinics.

If your Division does not currently have the relevant expertise it will need to recruit new staff. A Division worker employed to assist practices set up nurse led chronic disease clinics would require the skills and knowledge in the following areas:

- Nursing
- Chronic disease management
- Clinical pathways and annual cycles of care
- Self management
- Business systems and financial management
- Change management
- Training
- MBS items
- Information Management and Information Technology
- Systems development and redevelopment
- Policies and procedures
- Review, evaluation and continuous improvement techniques

Your State Based Organisation (SBO) is also an important resource for orientation and professional development.

Resources and examples

7

7. Resources and useful documents

This section of the Information Package provides information on and links to other useful resources and documents for Divisions and Division staff wanting to get further information about nurse led clinics in general practice

Websites

Whitehorse Division of General Practice at www.wdgp.com.au

Australian Practice Nurse Association (APNA) at www.apna.asn.au

General Practice Divisions of Victoria (GPDAV) at www.gpdv.com.au

Australian General Practice Network (AGPN) at www.agpn.com.au

Appendices

A. Diabetes Nurse Educator – Position description example

B. Asthma Educator – Position description example

C. Diabetes Clinics in General Practice Information sheet example

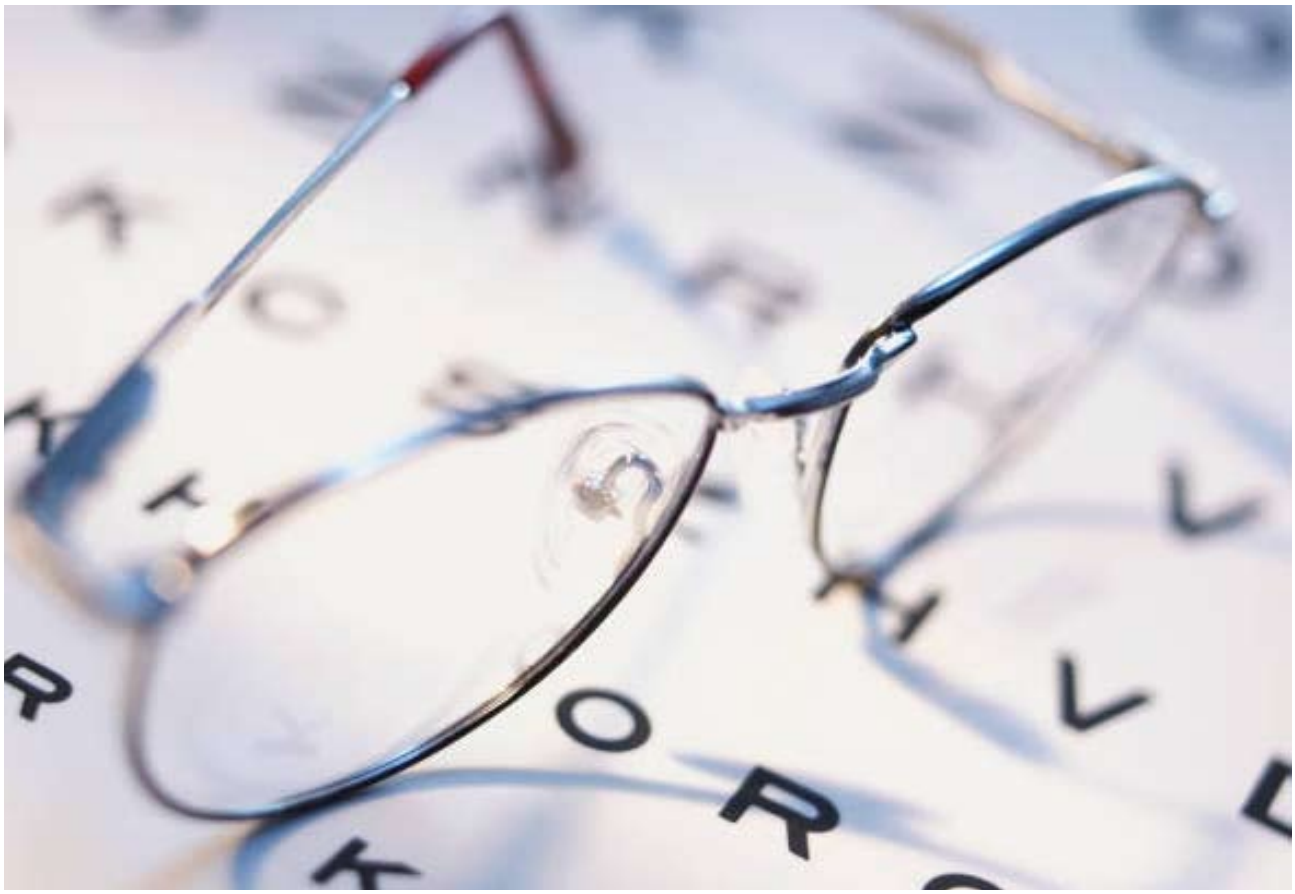
D. Asthma & Respiratory Clinics in General Practice Information sheet example

E. Clinic Contract – example

F. Procedure Manual Asthma Clinic - Example

G. Procedure Manual Diabetes Clinic - Example

H. Service Incentive Payment and Service Outcome Payment calculator



The following are helpful resources in setting up of a nurse led clinic in general practice.

A. Diabetes Nurse Educator - Position description example

Skills and Qualifications

Essential:

- Registered Nurse-Division 1, with Australian Diabetes Educator Association (ADEA) recognized Diabetes Education qualifications.
- Ability to work independently and as part of a team
- Excellent communication and interpersonal skills
- Well developed organizational and time management skills
- Good problem solving skills
- Professional Indemnity (eg current ANF member or private insurance)
- Reliable car and current Victorian drivers licence

Desirable:

- Credentialled diabetes educator
- Experience working with GPs and other health professionals
- Experience in working with medical software programs

Tasks - Diabetes Education

- To provide diabetes self management education, clinical care and support for patients attending the diabetes clinic through a multidisciplinary approach, including insulin initiation and stabilisation, pre and post pregancy counselling, etc
- To provide support for GPs in their care and management of diabetes patients
- To participate in, and where necessary to assist GPs to prepare diabetes related chronic disease management plans and case conferences
- To promote and assist in the diabetes annual cycle of care
- To enhance the clinics sustainability by supporting the practices to meet the Medicare item criteria for diabetes related services
- To actively participate in evaluation and data collection

B. Asthma Nurse Educator - Position description example

Skills and Qualifications

Essential:

- Registered Nurse-Division 1, with recognized Asthma Education qualifications. Minimum qualification – Introduction to Asthma Educators Course. Other courses include Graduate Certificate in Asthma/Respiratory Education Management.
- Completed a course in Spirometry
- Ability to work independently and as part of a team
- Excellent communication and interpersonal skills
- Well developed organizational and time management skills
- Professional Indemnity (eg current ANF member or private insurance)
- Reliable car and current Victorian drivers licence

Desirable:

- Experience working with COPD patients
- Experience working with GPs and other health professionals
- Experience in working with medical software programs

Tasks -Asthma/COPD Education

- To provide asthma/COPD education, clinical care and support for patients attending the asthma & respiratory clinics through a multidisciplinary approach, including spirometry and allergen testing
- To provide support for GPs in their care and management of asthma/COPD patients
- To participate in, and where necessary to assist GPs to prepare asthma/COPD care plans and case conferences
- To promote and assist in the asthma 2 Plus Plan
- To actively participate in evaluation and data collection

C. Diabetes Clinics in General Practice - Information sheet example

Information Sheet - example

The Diabetes Clinics in General Practice program is a Your Division of General Practice initiative to support GPs and their patients. The program provides support to diabetes patients in more intensive management through deployment of a qualified diabetes educator in a formal diabetes clinic. The diabetes educator will be employed by the Your Division of General Practice and contracted out to individual practices on a fortnightly basis. The Division will provide a subsidy to "off set" the costs of the educator to allow the practice to establish a cash flow to sustain the clinics. The subsidy will reduce over the life of the project until the costs are fully covered by the individual practices and the diabetes clinics are self-sustaining.

Aims of the Clinics

- To support GPs and practices to provide quality diabetes care to all their patients
- To improve the health outcomes of patients with diabetes
- To reduce preventable diabetes admissions to hospital
- To be cost effective in the general practice setting

Clinics outline

The Program coordinator will be based at the Your Division of General Practice and will support practices to implement the diabetes clinics and oversee the evaluation process and report findings back to the practice.

The diabetes educator will work with the practices, GPs and patients to improve diabetes management and provide clinical care. They will be responsible for:

- Providing quality diabetes education, information, clinical care and support for patients and GPs
- Identifying diabetes patients at the participating general practices
- Explaining the aims of the program to patients through a plain language statement,
- Obtaining informed consent for collection of data for evaluation
- Collecting ongoing clinical data through general practice records
- De-identifying patient data for aggregation at the Your Division of General Practice for evaluation of the project.

The Practice will provide the diabetes clinic with a suitable room, access to patient clinical records, reception, billing and appointment support and prompt the clinic to its diabetes patients.

What a diabetes clinic can do for GPs?

- Complement the quality of diabetes care GPs provide for their patients
- Improve the efficiency in the use of GP time spent in diabetes management
- Contribute to the diabetes SIP

What a diabetes clinic can do for patients?

- Increase their knowledge & understanding of their diabetes
- Provide ongoing support with diet, exercise, home blood glucose testing, medications including insulin initiation & stabilisation and complication prevention
- Improved self-management & lifestyle change with regular reviews to maintain change

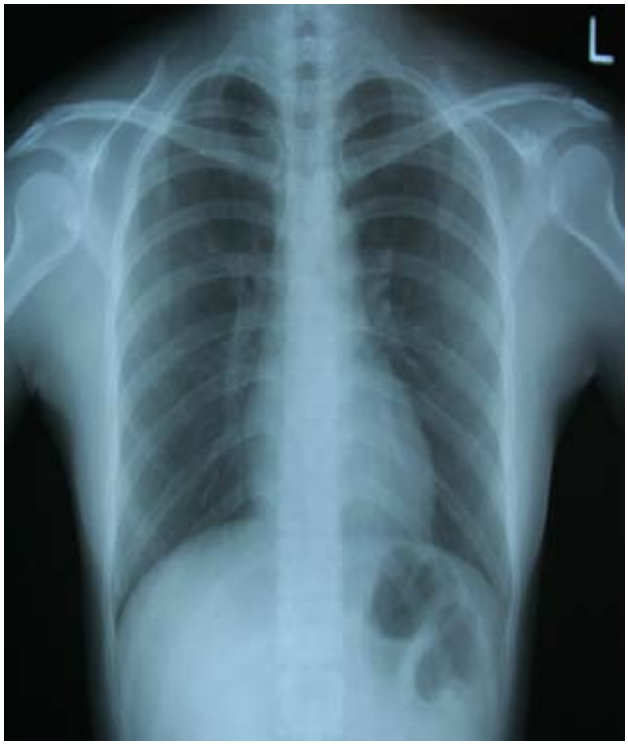
What a diabetes clinic can do for your practice?

- Add to the services provided through the practice
- Value add to the quality of diabetes management through a multidisciplinary approach
- Free GPs from repetitive diabetes information delivery, therefore able to see more patients
- Contribute to the long term viability of the practice

D. Asthma and Respiratory Clinics in General Practice

Information sheet - example

The Asthma & Respiratory Clinics in General Practice program is Your Division of General Practice initiative. The program provides the support through the deployment of a qualified Asthma/COPD Educator in a formal practice based Asthma & Respiratory Clinic. The Respiratory Educator is employed by Your Division and contracted out for a fee to individual practices on a fortnightly basis. The Division will provide a subsidy to "off set" the costs of the educator to allow the practice to establish a cash flow to sustain the clinics. The subsidy will reduce over the life of the project until the costs are fully covered by the individual practices and the clinics are self-sustaining.



Aims of the Asthma & Respiratory Clinics

- To enhance the quality of care for people with chronic respiratory diseases such as Asthma and COPD through General Practice.
- To increase the patients ability to self manage their respiratory disease/health while being supported by a multi-disciplinary health care team lead by the GP
- To support GPs to provide this quality of care in a timely and cost effective manner in their own practice.

Asthma & Respiratory Clinics will promote best practice guidelines including the Asthma and COPDX guidelines as recommended by the National Asthma Council and the Australian Lung Foundation.

The Asthma & Respiratory Educator will provide:

- Asthma and COPD education including self management skills (patho-physiology of asthma/COPD, trigger factors and avoidance strategies, medications, inhaler and device technique, peak flow/ symptom monitoring, related lifestyle issues ie smoking cessation, written action plans and emergency management)
- Skin Prick Allergen and Spirometry testing – including all consumables
- Verbal and written reports to patients GP
- Assistance with implementation of Chronic Disease Management MBS item numbers, e.g. Team Care Arrangements and GP Management Plans
- Assist with appropriate patient recall

A GP will be required to see each patient as they attend the clinic and will:

- Review results from spirometry and skin prick allergy tests
- Provide ongoing medical management for the patient
- Formulate and review the Action Plans

It is recommended that the Clinics operate on a fortnightly basis.

Requirements:

Provided by the Clinic

- GP support for the clinic (referral of patients; once established 1-2 new patients per clinic and prompt review of attendees)
- Reception staff to arrange appointments, confirmation of appointments. and processing of MBS claims
- A consultation room for the educator
- Access to patient records

Provided by the Division

- Trained Asthma & Respiratory Educator
- Spirometer and all consumables
- Skin Prick Allergen testing kit and all consumables
- Patient education literature and demonstration devices
- Assistance with implementation and ongoing support of clinics

Benefits of the Asthma & Respiratory Clinics
For the GPs:

- Complement and enhance the quality of respiratory health care provided by the doctors
- Improve the efficiency in the use of GP time spent in asthma/COPD management (Proactive approach to care to reduce emergency consultations)
- Contribute to and develop the Chronic Disease Management Plans, including GP Management Plans and Team Care Arrangements and Asthma Service Incentive Payment (SIP).

For the patients:

- Increase knowledge and understanding of asthma and/or COPD
- Provide information about respiratory medications and how to use them correctly
- Provide opportunities to develop self management skills
- Provide lifestyle support to maintain optimal health

For your practice:

- Add to the services provided through your practice
- Value add to the quality of asthma and COPD management through a multidisciplinary approach
- Contribute to the long term viability of the practice

E. Clinic Contract - Example

When establishing disease-specific contracted clinics with practices, Divisions need a very comprehensive contract with individual practices. The Whitehorse Division of General Practice recommends that Divisions gain legal advice on the contents of the contract. Below are examples of the types of headings in its contracts with clinics

Parties

Your Division and The Practice

Background

The parties agree that:

Period of Agreement

Providing the Services

How/Where/When

Laws and policies

Premises

Consumables etc

Other Practice obligations

Payment for Services

Price/GST/Tax invoice

Insurance

Obligation to effect and maintain

Terms and conditions

Confidentiality and Privacy

Restraint/Acknowledgment/No poaching

Termination By the Practice or By Your Division

Limit on effect

Notices

Address and fax number

Miscellaneous/Variation/Waiver

Severability

Relationship

Continuing effect

Governing law

Definitions and Interpretation

Execution

F. Procedure Manual Asthma Clinic - Example

Every clinic's practice manual will vary depending on existing systems within the practice and how the clinic will best run in the particular practice. The example table of contents below are a guide for clinics.

Example Table of Contents

Introduction

Asthma & Respiratory Clinics in General Practice – Flow Chart .

Role of the GP

Role of the Reception Staff

Patient Booking System Guidelines

Lung function testing for patients attending the Asthma Clinic

Clinic Guidelines Appointment Template

- NEW patients require a 1 hour appointment for the initial consultation.
- REVIEW patients require a 30-minute appointment.
- Please CONFIRM all patients 1-2 days PRIOR to the clinic being held.
- Please remind patient to :

Bring ALL PUFFERS AND SPACERS to appointment

No RELIEVER (eg Ventolin, Bricanyl), 4-6 hours prior to visit UNLESS REQUIRED

No SYMPTOM CONTROLLER or COMBINED medication
(eg Oxis, Serevent, Seretide or Symbicort) 12 hours prior to visit

No SMOKING 2 hours prior to visit

No ANTIHISTAMINES for 4 days prior to allergy testing, usually visit 2

Day:.....Date:.....

Only 1-2 new patients per clinic (To leave room for review appointments)

TIME	NEW or R/V	GP	FULL NAME	PHONE	CONFIRMATION

G. Procedure Manual Diabetes Clinic- Example

Every clinic's policy and procedure manual will vary depending on existing systems within the practice and how the clinic will best run in the particular practice. The example table of contents below are a guide for clinics.

Introduction
Role of the GP
Role of the Diabetes Educator
Role of the Practice Staff
Patient Booking Guidelines
Medicare item numbers used in diabetes clinics
Privacy and Consent
Privacy and Consent in General Practice
Diabetes Chronic Disease Management Items
Case Conferencing
Service Incentive Payments (SIP)
Insulin Stabilisation
APPENDICIES
Appendix 1: Practice Letter (Example only)
Appendix 2: Appointment Guidelines
Appendix 3: Appointment Booking Sheet
Appendix 4: Plain Language Statement
Appendix 5: Consumer Consent Form
Appendix 6: Patient Satisfaction Questionnaire
Appendix 7: GPMP and TCA
Appendix 8: Case Conference Record
Appendix 9: Allied Health Service Rebate Policy
Appendix 10: Medical Benefits Schedule Book, November 2006

H. Service Incentive Payment (SIP and Service Outcome Payment (SOP) Calculator*

This can be used to calculate SIP & SOP payments for practice. It is partcularly helpful with employee GP's

Income generated through Diabetes Service Incentive Payment (SIP) & Service Outcome Payment (SOP) for GP's & Practices

Diabetes SWPE	20% SWPE	Income	Income	GP Income (Pa)						Practice Income (Pa)			
	SIP	SIP	SOP (pa)	%	SIP	%	SOP	Total	%	SIP	%	SOP	Total
1000	200	8,000	20,000	50	4,000	0	0	4,000	50	4,000	100	20,000	24,000

Add your practices' SWPE for Diabetes or the number of patients on your Diabetes register

Put in your practices' split with its employee GP's

Calculator automatically demonstrates income

*Available on www.wdgp.com.au/resources/chronicillness

Further Reading

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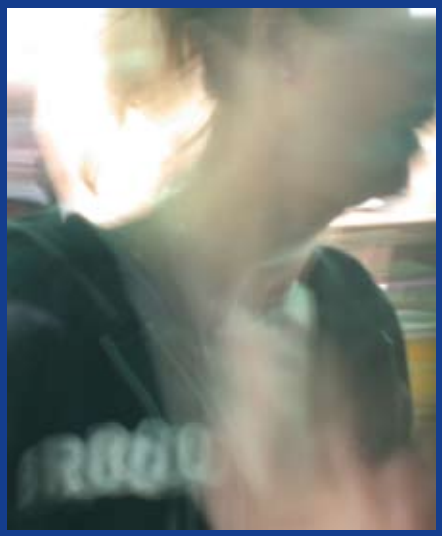

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OF GENERAL PRACTICE