Appendix A. Accessing government support for diabetes care in general practice

Support for developing management plans and organising team care

The Australian government supports general practices that are taking a high-quality and proactive approach to diabetes care through Medicare Benefits Schedule (MBS) payments to general practitioners (GPs), nurses, allied health professionals and general practices. These include the chronic disease management (CDM) items (formerly enhanced primary care), Service Incentive Payments (SIPs) and the Practice Incentives Program (PIP).

The CDM items provide support for developing management plans and organising team care.

General practice management plan (GPMP, Medicare item number 721)

These are documented plans developed together by the GP and the patient. They incorporate the patient's needs and goals, how these are to be achieved, and reference to any resources used. Templates are available via medical software and various general practice networks and Primary Health Networks (PHNs).

Payments are made for development and for structured reviews of GPMPs.

Team care arrangement (TCA, Medicare item number 723)

These are expansions of the GPMP that detail allied healthcare professionals and other members of the team who implement any part of the GPMP. This includes active participation by at least two other providers who contribute to the GPMP or TCA and the goals of management for the patient.

Both GPMPs and TCAs can have practice nurses or similar practice team members involved in their development.

Payments are made for development and for structured reviews of the GPMP and TCA under MBS item number 732.

There is evidence that GPMPs that are reviewed on a regular basis can result in improvement in process and clinical outcomes.[17] Medicare payments also support the involvement of suitably qualified allied health members in providing care as documented in the TCA. Up to five treatments per year are subsidised at the time of publication.

Medicare has strict eligibility criteria for claims for MBS items 721 and 723, and the structured reviews under MBS item 732. Further information is available at www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

Support for the annual cycle of care

The annual cycle of care is a method of incentivising quality diabetes care. However, the scope of the annual cycle of care recommendations is less than the guidelines' recommendations.

Completion of an annual cycle of care requires assessment of a number of parameters (refer to Table A.1), and the professional attendance and appropriate documentation by a GP, with any clinically relevant issues including:

- taking a patient history
- performing a clinical examination
- arranging any necessary investigation
- implementing a management plan
- providing appropriate preventive healthcare.

Patients and practitioners need to discuss desired outcomes and agree on goals to achieve these. An example of a structured patient-centred care plan is provided in Appendix B. Structured patient-centred care plan.

For practitioners – Support payments are provided for completing the annual cycle of care. When a patient with diabetes completes their annual cycle of care, their GP notifies Medicare and is paid a SIP.

For practices – When more than 50% of practice patients with diabetes have completed their annual cycle of care, practices are automatically paid a quality outcome payment. This is calculated by Medicare and is dependent on the number of SIP payments claimed by GPs.

Table A.1. Medicare Benefits Schedule item number 2517 – Minimum requirements of care to complete an annual diabetes cycle of care for patients with established diabetes mellitus

Minimum requirements	Frequency
Weight and height plus body mass index (BMI)	At least twice every cycle of care
Blood pressure index	At least twice every cycle of care
Feet examination	At least twice every cycle of care
Measure total cholesterol, triglycerides and high-density lipoprotein-cholesterol (HDL-C)	At least once every year
Glycated haemoglobin (HbA1c)	At least once every year
Microalbuminuria	At least once every year
Estimated glomerular filtration rate (eGFR)	At least once every year
Self-care education, diet, physical activity, smoking evaluation	At least once every year
Medication review	At least once every year
Ensure that a comprehensive eye examination is carried out at least once every two years	At least once a year if complications are detected
NB: A new item on the Medicare Benefits Schedule (MBS) for retinal photography with a non-mydriatic retinal camera will be available for general practice use from November 2016. The listing is expected to benefit Aboriginal and Torres Strait Islander peoples and communities in rural and remote locations, where there is limited access to optometric and ophthalmic services to diagnose diabetic retinopathy	