type 2 diabetes

Medicare group services information pack

AUSTRALIAN ASSOCIATION FOR EXERCISE AND SPORTS SCIENCE

DAA Dietitians Association of Australia

Medicare Group Items for People with type 2 diabetes

From 1 May 2007, new Medicare items will be available for group services for people with type 2 diabetes provided by Credentialled Diabetes Educators (CDEs) and/or Accredited Exercise Physiologists (AEPs) and/or Accredited Practising Dietitians (APDs) who are registered providers with Medicare Australia.

More detailed information about these new items (81100 to 81125) can be found on the Department of Health and Ageing (DoHA) website at: www.health.gov.au/epc.
This site provides a range of material:

- Allied health group services under Medicare for patients with type 2 diabetes – Information for allied health professionals
- Allied health group services under Medicare for patients with type 2 diabetes – Information for GPs
- Referral form for Allied Health Group Services under Medicare for patients with type 2 diabetes
- MBS Item Descriptors (items 81100 to 81125)
- MBS Explanatory Notes (items 81100 to 81125)

This booklet has been prepared by representatives from the Australian Diabetes Educators Association (ADEA), the Australian Association for Exercise and Sports Science (AAESS) and the Dietitians Association of Australia (DAA), to complement the material produced by DoHA and assist CDEs, AEPs and APDs to develop and provide best practice group services.

The multidisciplinary approach: what does it mean?

A collaborative, multidisciplinary approach to delivery of these group services is encouraged. Multidisciplinary practice is a team approach to the provision of healthcare, involving all relevant medical and allied health disciplines. In the case of the Medicare group items, this would involve general practitioners (GPs), CDEs, AEPs and APDs working together to deliver services aimed at improving the health of people with type 2 diabetes.

As well as delivering benefits to patients, collaboration can also provide benefits for allied health professionals. Such benefits include sharing the management of program administration such as coordinating engagement with local GPs, sharing of educational resources and program evaluation, professional development, access to venues and reinforcing positive group dynamics.

Working with GPs and engaging with the local Division/s of General Practice to promote services and seek their input on preferred referral and feedback practices, will also enhance collaboration and produce better patient outcomes. Divisions of General Practice may assist with local referral directories, website links and newsletter promotions.

ADEA, AAESS and DAA have all significantly enhanced their websites to facilitate the easy identification and location of Medicare registered providers and the services they provide. Ensuring you are listed on these websites and that your details are current will promote your services and enable GPs to refer to your programs.

The evidence for group interventions

A recent Cochrane review[1] on literature up until 2003 has concluded that group-based, patient-centred training results in effective clinical, lifestyle and psychosocial outcomes for people with type 2 diabetes. Benefits to group participants included reductions in glycosylated haemoglobin (HbA_{1c}), fasting blood glucose, body weight and systolic blood pressure, improved diabetes knowledge and reduced need for diabetes medications. Recent literature[2] supports these findings and indicates patients may also benefit from groups by improving blood lipids[3, 4] and locus of control[5], reducing anxiety/distress[3, 6, 7], increasing knowledge[3, 4, 8, 9] and satisfaction in knowledge[10], improving quality of life[3] and feelings of well-being[11] and by eliciting positive changes in health care behaviours (exercise, diet and other self-management strategies)[3, 10, 12-14].

Most interventions reviewed were multidisciplinary and achieved positive outcomes for participants.

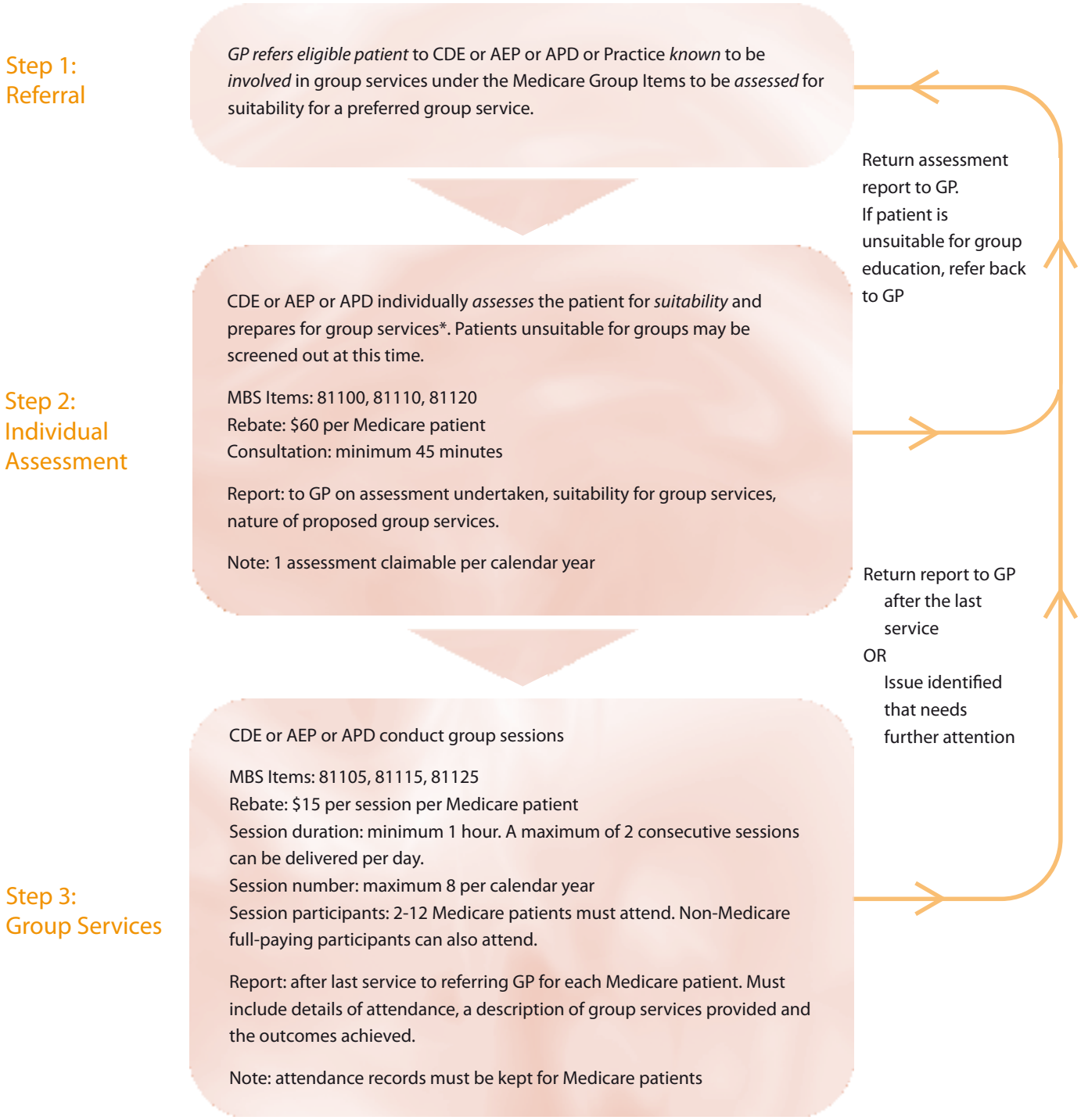
Group practice pointers

The resources provided on the DoHA website (see above) provide detail on the requirements for the group services. Figure 1 summarises these requirements in flow chart format.

Allied health professionals may also find the following group practice pointers helpful:

- Information and education needs of individuals vary[15]. Evidence and current practice suggest that adult groups may often be mixed for age and gender, however disease stage (e.g. newly diagnosed) and cultural, language and other specific needs may be targeted[2]. Group education should be learner-centred[15] and each individual assessed for available and appropriate group interventions.
- The literature[2] and current practice suggest that groups of ten or less participants work well. The success of larger groups is not precluded by these findings.
- Multidisciplinary practice is strongly encouraged but it is recognised that all 3 disciplines may not be available to provide group services. For certain group services a single discipline approach may be appropriate. Dual/multi qualified practitioners appropriately registered with Medicare Australia may deliver sessions under all disciplines in which they are credentialled/ or accredited.
- There is no set length of session that appears best. Sessions of 1-3 hours were common in reviewed literature[2].
- There is no set number of sessions or standard content type that appears to be best. The number of sessions may vary according to the content and goals of each program.
- Group programs should be developed according to a plan with achievable and measurable goals and objectives. Evaluation of the success of group sessions can be measured against key indicators of success using process and impact indicators at the group and individual level.

Figure 1- Flow Chart: Summary of Group Service Process



Phone Medicare Australia for claim enquiries on 132 150

*The CDE or AEP or APD carrying out the assessment would ideally be part of the group delivery team, however, this is not an essential requirement.

Eligibility

To be eligible for allied health group services, a patient must:

- have type 2 diabetes;
- have a relevant care plan in place; and
- be referred by their GP to the eligible allied health professional for assessment for group services.

In some cases, a patient may not be suitable for any of *your* group services but these patients should still be assessed as eligible for group services. These patients can be directed to an appropriate group program elsewhere. These aspects of patient suitability should be included in the assessment report to the GP.

Individual Assessment

All prospective clients must be assessed before commencing a group program. This includes taking a comprehensive patient history, identifying individual goals and preparing the patient for an appropriate group program. The assessment will also determine the patient's suitability for group services.

The assessment

- must be conducted by a CDE or AEP or APD (registered with Medicare Australia) as an entry point to any allied health group services available; and
- can only be conducted once per calendar year for each patient.

A generic assessment checklist is provided (Figure 2). This assessment checklist should provide the basis for the assessment conducted by any one of the three disciplines. Additional discipline specific assessment should be undertaken as required and as relevant to the type of group program requested.

As the assessment is generic in nature a CDE or AEP or APD can then direct patients to any type or combination of group services. For example, a person newly diagnosed with type 2 diabetes may not be appropriate for inclusion into a group program targeting participants with longstanding diabetes but may be suitable for another program being offered in the local area. Similarly, patients with limited spoken English and/or specific cultural needs may not suit your program/s but may be suitable for another group service where these particular needs are met.

Exclusions

Items 81100 to 81125 do not apply for services that are provided by any other Commonwealth or State funded services except where an exemption under sub-section 19(2) of the *Health Insurance Act 1973* has been granted. These items also can not be provided to a person who is an admitted patient of a hospital.

Figure 2: Assessment checklist and outcomes

CLIENT DETAILS

- Name
- Date of birth
- Contact details
- Next of kin and contact details
- Occupation
- Social / family
- Identifies as Aboriginal or Torres Strait Islander YES/NO

CORE ASSESSMENT

Diabetes History

- Year of diabetes diagnosis
- Family history of diabetes/CVD
- Complications/co-morbidities
- Recent hypoglycaemic episodes (frequency/severity)
- Review of BGL log book
- Any change in medical history since GP referral

Previous diabetes care/education

- Diabetes educator/diabetes education program
- Dietitian
- Exercise physiologist
- Other

Biomedical

- Glycosylated haemoglobin
- Lipid profile
- BP

Anthropometry

- Weight, height, BMI
- Waist circumference

Current activity level

- Current activity
- Contraindications to physical activity
- Mobility issues

Smoking status

Alcohol Intake

PATIENT ELIGIBILITY AND REFERRAL PARTICULARS

- Confirm that the person has been diagnosed with type 2 diabetes.
- Confirm patient is eligible for Medicare rebates for the group intervention.
- Confirm that the patient has a relevant care plan in place under Medicare
- Not exceeded eight group interventions in calendar year
- Check that patient understands that the referral involves participation in a group program.

Medications

- Prescribed (type, dose)
- Over the counter

Current Self Care

- Self blood glucose monitoring (frequency / self efficacy)
- Carries ID
- Carries 'hypo' treatment (if applicable)
- NDSS registration

Relevant Special needs

- Vision
- Hearing
- Physical
- Cognitive
- Literacy
- English as a second language
- Need for interpreter
- Any current signs / symptoms of hyperglycaemia

Readiness to change and ability to participate

- Previous experience in group programs
- Stage of change specific to proposed intervention
- Willingness / capacity to participate in group program as specified (eg, capacity to participate in exercise program, willingness to discuss eating issues in nutrition program or confidence to manage feelings in a group setting with regard to their diabetes)

OUTCOMES OF THE ASSESSMENT

- Discuss outcomes of assessment and suitability for specified group program with patient
- Check the patient understands the focus, content, timeframe, costs and billing arrangements for the group program
- Make arrangements for enrolment in specified group program or discuss alternative intervention in conjunction with referring medical practitioner

Possible Format for Group Services

Practitioners may develop a sequential program with sessions building on different aspects of diabetes management, or stand alone sessions that may be "cherry picked" according to patient needs. An example of the content of an eight week sequential program delivered by all three professionals working in their scope of practice might include:

1. Program introduction and overview, professional introduction, participant introduction, group guidelines for success, overview of type 2 diabetes (CDE or AEP or APD).
2. Introductory nutritional principles for type 2 diabetes, including glycaemic index, glycaemic load, fats, protein, carbohydrates, portion sizes & food labelling (APD).
3. Hypoglycaemia and hyperglycaemia, blood test results, blood glucose monitoring (CDE).
4. Physical activity overview, physical activity guidelines for people with type 2 diabetes and strategies to overcome barriers to participation (AEP).
5. Associated healthcare issues for people with type 2 diabetes - foot care, kidney function, eye tests, vascular function etc (CDE).
6. Nutrition guidelines for weight management and optimal cardiovascular function (APD).
7. Exercise strategies for weight management and optimal cardiovascular function (AEP).
8. Review of core program components, Q&A, evaluation & participant feedback (CDE or AEP or APD).

Possible Program Variations

While the evidence supports a multidisciplinary team approach this may not always be possible (for example in rural and remote locations). Group sessions will still be available under the group item for patients who are assessed as suitable whether one or a combination of the three eligible professions deliver the group program.

A practitioner who is dual qualified may deliver separate discipline-specific group sessions and have the claims lodged under the relevant items for the discipline. For example a dual qualified AEP/APD can run a physical activity-specific group session and a separate nutrition-specific group session with the sessions being claimed under MBS items 81115 and 81125 respectively.

Groups may also be designed for Indigenous, culturally and linguistically diverse (CALD) communities and other groups with specific needs. Groups may target specific aspects of diabetes management or different stages of the diabetes continuum (for example weight loss, managing cardiovascular disease, interpreting self monitoring of blood glucose, insulin therapy in type 2 diabetes). Suitable patients may also access a group program that includes people without diabetes providing the program is delivered by an eligible provider and includes topics to assist with the management of their diabetes.

Examples of such programs include general weight loss programs, healthy heart programs and general physical activity programs. There must be at least 2 Medicare-funded patients in any of these groups for the new Medicare items to apply.

Tips for conducting successful group programs

Engaging with your local GP Division/s

- Advertising groups sessions through the Division via newsletters.
- Using flyers to target local GPs
- Posters in GP surgeries
- Offering flexible session times for varying clientele
- Ensuring your practice and group services are listed on your Association website
- Offering an information session at a GP continuing education event or meeting
- Liaison with practice nurses/practice managers

Maximising group attendance

- Offering flexible session times for varying clientele
- Reminder letters or telephone calls
- Encouraging support (within group/bring a partner)
- Social engagement: incorporating educational outing (supermarket tours, walks)
- Giving participants "homework" for the next session
- Allow opportunities to make-up or "cherry pick" sessions within a suite of potential sessions

Maintaining group dynamics

- Establishing group / program 'rules'
- Time allocated at commencement of each session for participants to share experiences in achieving goals set the previous week, barriers encountered and group problem solving

Program Evaluation

Evaluation is an essential process to assist with quality assurance within your group practice.

Process Evaluation
This is related to the program activities (quality and implementation) and reach (of target group and within target group)[16].

Possible indicators of success include;

- Referrals to the program
- Requests for further consultation
- Feedback from participants and GP
- Satisfaction of participants and GP
- Attendance/dropouts
- Audience involvement/participation

Impact Evaluation
This is related to the immediate effects of the program[16].
Possible indicators of success include;

Change in pre-/post-testing of

- self-management behaviours: physical activity, diet, medications achieving set goals, problem solving
- knowledge and skills
- self-efficacy, empowerment, coping, quality of life, stress
- Fasting glucose, glycosylated haemoglobin levels

Reporting

The CDE or AEP or APD must provide a report to the referring GP after the assessment *and* after the last group service in the program.

The assessment report needs to include the following:

- an outline of the assessment undertaken
- whether the patient is suitable for group services
- the nature of the group services proposed

At the completion of the group program a written report for *each Medicare* patient is required which includes the following:

- attendance record
- a description of the group services provided for the patient
- outcomes achieved

Useful Resources, References and Links

- Department of Health and Ageing: www.health.gov.au/epc
- Medicare Australia: http://www.medicareaustralia.gov.au/providers/
- Australian General Practice Network (AGPN) www.agpn.cam.au
- Australian Diabetes Educators Association: http://www.adea.com.au
- Australian Association for Exercise and Sports Science: http://www.aaess.com.au
- Dietitians Association of Australia: http://www.daa.asn.au
- Diabetes Australia: http://www.diabetesaustralia.com.au/

Acknowledgements

This booklet has been funded by the *Australian Better Health Initiative: A joint Australian, State and Territory Initiative*.

The Advisory Group developing this booklet included representatives from DoHA, AGPN, ADEA, AAESS and DAA. We wish to express our gratitude to the various members of ADEA, AAESS and DAA for their assistance in preparing this document.

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