Diabetes Multidisciplinary Team

Pilot Project Handbook

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

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Introduction

This Handbook has been developed to support your participation in our Diabetes Multidisciplinary Team Pilot Project.

The Department of Health, Disability and Ageing's 10-year Primary Health Care Plan 2022-2032[1] outlines the importance of multidisciplinary teams in primary care. Primary Health Networks have received funding to commission multidisciplinary healthcare teams to improve the management of chronic conditions and reduce avoidable hospitalisations. This funding is intended to support general practices that are too small to engage their own multidisciplinary workforce through other funding streams and to determine what needs to be considered to support multidisciplinary teams within primary care settings.

We have identified type 2 diabetes as a priority area for this project. According to Primary Sense data[2], 27,398 active patients in the Nepean Blue Mountains region have a diagnosis of diabetes, with the majority (85.88%) of patients having type 2 diabetes. Approximately 70% of diabetes diagnoses made in solo or small practices are in the Penrith and St Marys Statistical Area 3. The eastern side of Penrith (including suburbs such as North St Marys, St Marys, Oxley Park, Colyton, Penrith, Werrington and Cambridge Park) has some of the lowest Socio-Economic Indexes for Areas scores in the Penrith local government area.

Consultations held with general practitioners in the eastern Penrith area identified that their patients have limited access to allied health services for diabetes management due to barriers such as transport, gap fees and availability of services in their local area. During the consultations, general practitioners identified credentialled diabetes educators and accredited practising dietitians as the most suitable allied health professionals to effect positive change for their patients and the practice.

Consultations held with consumers living with type 2 diabetes confirmed that seeing an allied health professional for diabetes support is often too expensive, hard to access and therefore hard to prioritise. Consumers agreed that education and diet support could play a pivotal role in improving their diabetes management.

As a result of these consultations, we commissioned two local credentialled diabetes educators and one local accredited practising dietitian to work across four solo and/or small general practices in eastern Penrith. Prior to the commencement of services, foundational work to develop the model of care was undertaken during two co-design workshops facilitated by Dr Paresh Dawda and Angelene True from Prestantia Health[3]. A learning workshop was held for the commissioned allied health professionals to prepare them to work in a general practice setting, with support from Sue Cummins from Train IT Medical[4], Mitchell Beggs-Mowczan, our Aboriginal Health Lead[5], and the team at Prestantia Health.

The Diabetes Multidisciplinary Team Pilot will run from February 2025 until 30 June 2028. Participating general practices will engage with other general practitioners, practice staff, commissioned allied health professionals and our staff through formal review meetings, pilot progress meetings and national evaluation workshops. In recognition of the time taken to attend workshops and provide clinic space for this pilot, support payments will be available to participating general practices.

We acknowledge the invaluable contributions that participating healthcare professionals have made to the development of this model of care. We look forward to working closely with participating general practitioners, practice staff and commissioned allied health professionals throughout the duration of the Diabetes Multidisciplinary Team Pilot Project. This pilot is an exciting opportunity to test a multidisciplinary model of care in general practice with the goal of improving both the outcomes for patients living with type 2 diabetes, and the overall experience of participating healthcare providers.

Lizz Reay
Chief Executive Officer

About the Diabetes Multidisciplinary Team Pilot

Aim of the Diabetes Multidisciplinary Team Pilot

The aim of the Diabetes Multidisciplinary Team Pilot is to demonstrate what is required for multidisciplinary team care to work in a small general practice setting.

This pilot aims to:

- Improve collaboration between primary healthcare professionals involved in the health management of people living with type 2 diabetes
- Provide equity of access to allied health services
- Enhance the patient experience of care
- Improve health outcomes
- Improve provider experience
- Achieve the best value for all resources invested

Multidisciplinary Team-Based Care

Multidisciplinary teams are groups of health professionals who may be part of different professions or businesses, who work together to coordinate care for patients. Allied health professionals are an important part of collaborative primary care for many patients, particularly for those with complex or chronic conditions such as type 2 diabetes. For this pilot, the multidisciplinary teams will be made up of the following healthcare professionals and general practice staff:

- Credentialled diabetes educators
- Accredited practising dietitian
- General practitioners
- Practice nurse (available at one general practice)
- Practice managers or administrators

If required for optimal patient care, pilot members may recommend the involvement of other healthcare professionals not listed above.

Integrated Multidisciplinary Team-Based Care

The Diabetes Multidisciplinary Team Pilot will utilise Fulop's typology of integrated care[6], encompassing:

- Organisational integration – how the organisation of care is structured.
- Functional integration – how non-clinical and back-office functions are integrated.
- Service integration – how clinical services are integrated with each other.
- Clinical integration – at the clinical team level is care for patients integrated in a single process both intra and inter-professionally through, for example, the use of shared guidelines along the entire pathway of care.

Principles of an Effective Team

The 5 principles and values of effective team-based health care[7] will be used as a reference point for the success of this pilot:

1. Shared Purpose

   The team works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood and supported by all team members.

2. Clear Roles

   There are clear expectations for each team member's functions, responsibilities and accountabilities, which optimise the team's efficiency and often make it possible for the team to take advantage of division of labour.

3. Mutual Trust

   Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

4. Effective Communication

   The team prioritises and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

5. Measurable Processes and Outcomes

   The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and the achievement of the team's goals. These are used to track and improve performance immediately and overtime.

Chronic Condition Management

Individuals living with chronic conditions, such as type 2 diabetes, rely on their general practitioners, specialists, allied health professionals and carers/family/friends to support them. An integrated approach to managing chronic conditions includes several different health care providers who work together to support the needs of the patient. Allied health professionals can be involved in a coordinated care effort through a chronic condition management plan, organised by the general practitioner. Under this chronic condition management plan, a patient has access to five subsidised sessions with allied health professionals per year. Patients who identify as Aboriginal and Torres Strait Islander peoples, can access up to 10 subsidised sessions with allied health professionals per year.

Key allied health professionals often involved in the management of type 2 diabetes are:

- Diabetes educators
- Dietitians
- Podiatrists
- Exercise physiologists
- Physiotherapists
- Pharmacists
- Psychologists
- Counsellors
- Social workers
- Optometrists
- Dentists

Optimal Diabetes Care

The Australian National Diabetes Strategy 2021-2030 outlines the importance of developing, implementing and evaluating an integrated and coordinated approach to improve health outcomes by reducing the social and economic impact of diabetes in Australia[8]. Prevention, awareness raising, and early detection are equally important to the management of diabetes.

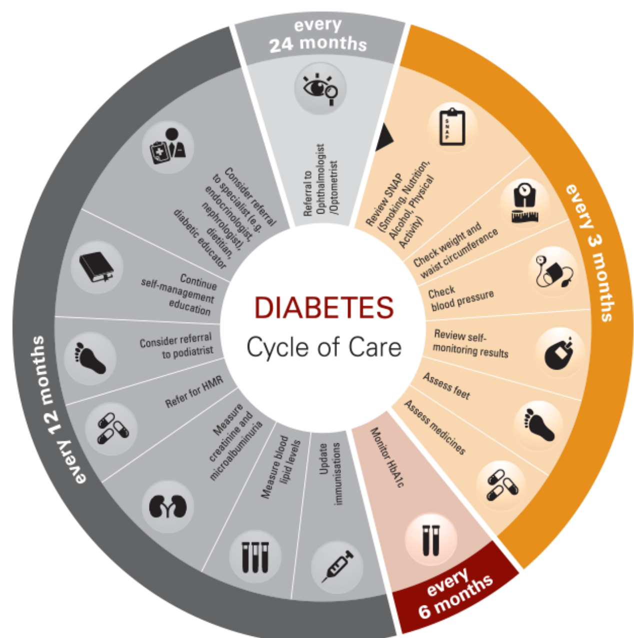
There is a range of evidence-based resources available to support the management of people living with type 2 diabetes. For example:

- Diabetes Australia[9] administers the National Diabetes Services Scheme[10], an initiative of the Australian Government. Healthcare professionals involved in this pilot are encouraged to utilise the resources available from the National Diabetes Services Scheme to support their patients. Diabetes Australia delivers services and support locally in New South Wales[11]. Their office is in Glebe, New South Wales and can be reached on 1800 177 055.
- The Living Evidence for Diabetes Consortium has developed evidence-based clinical guidelines for diabetes which contain recommendations regarding medications for blood glucose management in adults with type 2 diabetes. These living guidelines are regularly updated to reflect the most recent recommendations or new evidence[12].
- The Agency for Healthcare Research and Quality specifies the internationally recognised composite measure of optimal diabetes care as:

  The percentage of adult patients who have type 1 or type 2 diabetes with optimally managed modified risk factors.[13]
- The Australian Diabetes Educators Association is the national peak body for diabetes education, management and care in Australia[14]. The Australian Diabetes Educators Association has created referral pathways to provide guidance for the care of people with diabetes. These referral pathways can help general practitioners, allied health professionals and people with diabetes navigate diabetes education and management services from the time of diagnosis. There is a specific referral pathway available for type 2 diabetes[15] and for type 2 diabetes – insulin initiation and stabilisation[16].

General practice plays a central role in the early identification and optimal management of people with type 2 diabetes. Example resources for general practice:

- The Royal Australian College of General Practitioners have provided a handbook for general practice on the management of type 2 diabetes[17].
- The National Diabetes Services Scheme diabetes annual cycle of care is a checklist for reviewing diabetes management and general health each year[18]. A general practitioner will do this review to help patients and their diabetes health professionals to manage their diabetes and their risk of diabetes-related complications.



The Power of Co-Design

Prior to the commencement of service delivery, all participating providers participated in two co-design workshops facilitated by Prestantia Health. These co-design workshops provided the opportunity to meet other members of the pilot, share knowledge and develop a multidisciplinary model of care for patients with type 2 diabetes.

Prestantia Health facilitated these workshops using consumer centric and experience-based co-design methodology (see figure)[19].

Areas of focus in the co-design workshops were:

- Team building
- Population health management
- Consumer-centric care and consumer engagement
- Organised and evidence-based care
- Health service and system transformation
- Contemporary and integrated team-based models of care
- Patient reported measures and data driven improvement
- Use of digital health tools and technologies
- Communication methods and information sharing
- Barriers and enablers for change

The photos below show two of the activities completed during the co-design workshops.

SHARED GOALS

Very essential to be clear

Improving access to care & equity

Setting goals that are SMART and serve the purpose of patients and the practices

Better patient care

To empower pts to take responsibility for own health

Understand the patient's own goals.

- Communication
- Practice meetings
- Set goals
- Reflect
- Incentives

Building/ gathering credible Diabetes resources

Improved Patient Care

Shared tasks (take some pressure off from GP)

EFFECTIVE COMMUNICATION

Documenting in the same software to allow continuity in care!

Identifying preferred types of communication and what works

Shared? Patient Health Records, Pathology etc. Allied Health Access

clear communication to patients & between the team

Scheduling + Confirming appointments by practice admin

→ Access to MHR (my Health Record)
→ Secure messaging.
→ Primary Sense.
→ PRODA

- Clear simple language
- Feedback from staffs

Case conferencing regarding pt progress

Design a schedule/ Program the patient journeys through to see all healthcare providers Instead of as needed

MUTUAL TRUST

Spend time getting to know each other

Rely on each other's expertise

may be build by Time

Feedback from patients can increase mutual trust

Comes with time. Communication regarding processes

- Finding reliable & "good" staffs + team members
- Takes time to establish trust
- Communicating credentials, roles
- Feed back from members of the team

CLEAR ROLES

Team speaking the same language - clear messaging

Identifying true scope of practice

Clear discussion and documentation of roles

Roles should be clear and specific

- Communication within the practice
- Clear procedure template for agreed
- Patient education of different roles

Brochures outlining CDE & educator roles within the practice & their role in pt care

New team Member (Nurse)

Understanding How a GP practice works

Understanding & learning different ways to do things

The Diabetes Multidisciplinary Team Pilot Framework

How This Pilot Will Work

The Diabetes Multidisciplinary Team Pilot will run over a period of three years and will consist of activity periods, data collection, practice-based progress meetings, review workshops, upskilling workshops and a national evaluation.

Service delivery will commence in May 2025 and run through to 30 June 2028. All participating parties in this pilot have service agreements in place with our organisation. General practitioners will not be required to submit activity reports to our organisation. All participating general practices use Primary Sense, and this de-identified data may be used to inform the pilot. Allied health professionals will submit monthly activity reports and quarterly reports across the three-year period.

Baseline Data Collection

Patient-level data:

Baseline de-identified data is collected by the allied health professionals in their initial consultation with each patient. This data is reported on per general practice. This provides a snapshot of each practice's patients before implementing the model of care.

Provider-level data:

Provider readiness for change was measured in the co-design phase. This showed a snapshot of the state of each provider before making changes/improvements to their practice.

Activity Periods

Activity periods are the periods of time between review meetings (practice-based or whole group). They enable the multidisciplinary team to test the model of care in practice. Progress is measured through ongoing monthly data collection by the allied health professionals. Progress specifically regarding provider experience and satisfaction is measured through quarterly reports submitted by the allied health professionals and practice review meetings held bi-annually.

Pilot Progress Meetings

Two face-to-face meetings will be held per year at each participating general practice. These meetings will be up to 1.5 hours in duration. These meetings will involve the allied health professionals providing services at that practice, the practice administrator(s), the practice nurse, general practitioners and our organisation's staff. These meetings will be facilitated by us and focus on successes and challenges at each participating general practice. These meetings will occur at 6-monthly intervals throughout the project to measure progress and capture changes and/or improvements.

6-Month and 12-Month Review Workshops

During the first year of the pilot, two formal review workshops will be held with all participating providers in the Diabetes Multidisciplinary Team Pilot. One will be held at the 6-month mark of service delivery and the second will be held at the 12-month mark of service delivery. These workshops will be facilitated by Prestantia Health and hosted by our organisation in Werrington.

The workshops will start at 6:00pm and finish at 8:30pm, with dinner provided. The dates for these workshops will be confirmed by us and instructions for how to register will be distributed closer to the date of each workshop.

Practices must send at least two members of their practice team (1 general practitioner and 1 practice administrator) to each workshop. All allied health professionals are required to attend both review workshops. The purpose of these workshops is to identify and review the successes and challenges of the model of care and make any necessary changes. The whole group will also reflect on their experience and satisfaction as a member of this pilot. Consumers may also be present at these review workshops to provide feedback on their experience of their care.

National Evaluation

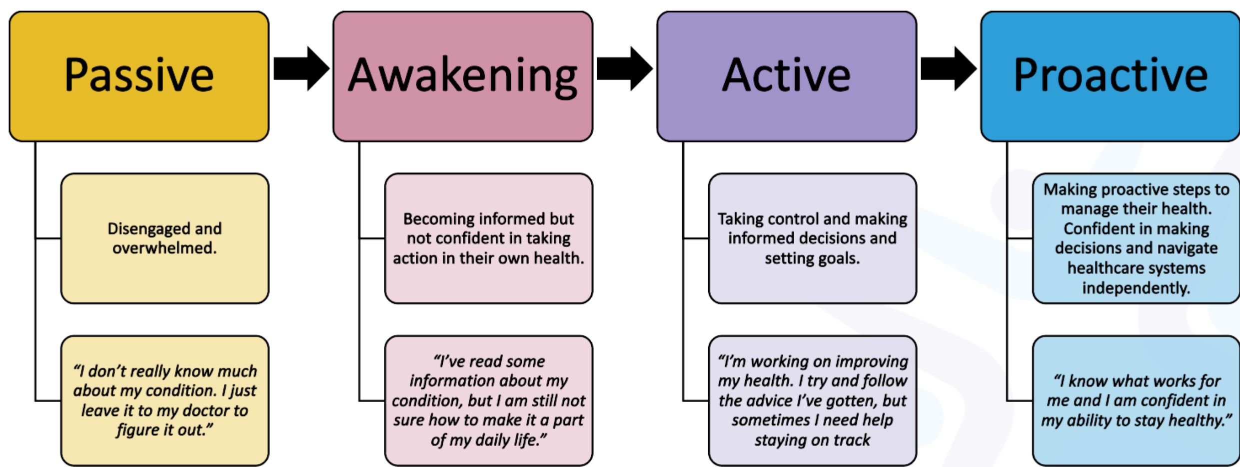
The Department of Health, Disability and Ageing will be conducting a national evaluation of the Multidisciplinary Team Commissioning program being implemented across Primary Health Networks in Australia. The Department of Health, Disability and Ageing has set specific activity measures, program information and patient reported outcome measures that all Primary Health Networks must collect throughout the duration of this project.

It is a requirement that all commissioned allied health professionals, participating general practitioners and their administrators participate in the national evaluation workshops that will be scheduled by the national evaluator.

Model of Care

Consumer Enablement

The model of care for this Diabetes Multidisciplinary Team Pilot is based on the Agency for Clinical Innovation's consumer enablement guide[20]. A consumer enablement foundation empowers individuals with the knowledge, skills and confidence to effectively manage their own health and healthcare[21]. The allied health professionals are focused on providing culturally appropriate, person-centred care that aims to optimise a person's diabetes management. Allied health professionals received training about leading their patients along a pathway of enablement (as seen below, provided by Prestantia Health, founded on a synthesis of consumer enablement resources and tools).



Strategies that assist with consumer enablement in practice are as follows:

- Health education & information accessibility
- Health literacy programs
- Digital tools & resources
- Patient-centred care
- Support networks & peer support
- Personalised care plans
- Feedback mechanisms
- Cultural competence

Allied health professionals are encouraged to use health coaching techniques to assist with consumer enablement, such as the Ask-Tell-Ask method[22]. Health literacy tools, such as the Health Literacy Questionnaire and the Partners in Health Scale, can be used to support consumer enablement[23].

The Service

Services provided by the credentialled diabetes educators and the accredited practising dietitian through this pilot are completely free of charge to all eligible patients. Patients who meet the eligibility criteria below can access the service at one of the participating general practices. We are paying allied health professionals a daily rate for their time in the clinic. We are paying all participating general practices a clinic support fee for each clinic session delivered by allied health professionals.

Patient Eligibility

To be eligible for this diabetes service, patients must be over the age of 18, be diagnosed with type 2 diabetes and be a regular patient of one of the general practices participating in this pilot. It is preferred that patients accessing the service are not currently seeing another credentialled diabetes educator and/or accredited practising dietitian.

Co-location Agreements

Allied health professionals participating in this pilot will be co-located fortnightly at the general practices and be considered as part of the practice team when operating at the practice. Allied health professionals will receive an induction to the practice, including policies and procedures they will need to follow. As part of the induction process, allied health professionals will sign a confidentiality agreement, as provided by the practice.

Allied health professionals will provide full-day clinic sessions at the participating general practices. See a sample monthly schedule below:

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1		CDE 1 @ GP1		CDE 2 @ GP4 APD @ GP3	
Week 2		CDE 1 @ GP2	CDE 2 @ GP3	APD @ GP1	APD @ GP4
Week 3		CDE 1 @ GP1		CDE 2 @ GP4 APD @ GP3	
Week 4		CDE 1 @ GP2	CDE 2 @ GP3	APD @ GP1	APD @ GP4

Use of Clinical Software

Access to the practice clinical software was a topic of discussion during the co-design workshops. It was agreed by all providers involved in the pilot that the allied health professionals should have access to the practice's clinical software to support best patient care. The allied health professionals will be given permissions by the practice team that meet both the general practitioner's wishes and our requirements for data reporting. There will be a confidentiality agreement in place which allows allied health professionals to access patient information in the clinical software.

We arranged for the allied health professionals to receive training from Train IT Medical on the best use of the clinical software prior to service delivery.

Patient Journey

General practitioners will identify a list of potentially eligible patients in their practice who may benefit from the service. General practitioners will have a review appointment with all eligible patients to discuss the service with them. General practitioners will provide a formal referral into the service in the form of a letter that will be stored in the patient file in the clinical software. Patients who have had this initial review with their general practitioner will book in for the next available time for the credentialled diabetes educator and/or the accredited practising dietitian. The administrative team at the practice and the allied health professionals will work together to book follow up appointments with patients.

There is no formal limit to the number of sessions a patient may receive from the allied health professionals. Allied health professionals will work from the consumer enablement foundation stated above, to encourage effective self-management of diabetes over time. If a patient does not attend their appointment, without notification to the practice, allied health professionals will follow practice policies and attempt to rebook with that patient. It is at the discretion of the allied health

professionals and the practice to determine whether a recurring non-attending patient will be put back onto the waiting list to free up a session time for other patients.

Patient Consent & Confidentiality

All general practices involved in this pilot have a patient consent process that is in line with the Royal Australian College of General Practitioners' standards.

In addition to the above, all patients participating in this service will be asked in their initial consultation if they consent to their personal information being collected and de-identified information reported as part of this pilot. All patient information is collected and stored at the practice. Any patient information included in data collection for this pilot is done so in a de-identified and aggregated manner. All consenting patients will be coded with a unique statistical linkage key to track and link patient data across the duration of the project. The master list of statistical linkage keys will never be shared with our organisation and will be stored securely at the participating practices.

Patients who do not wish for their data to be used in this pilot are still able to access the service. The number of patients who do not consent for their data to be included in this pilot will be tracked and reported to us.

Roles & Responsibilities

For a multidisciplinary health care team to work effectively, all members must understand and accept their role(s) and responsibilities. The table below shows the main roles and responsibilities of each of the healthcare providers involved in this pilot:

General practices	Allied health professionals	Wentworth Healthcare
• Provide a private consulting room for the allied health professionals to use • Conduct orientation to the practice before service commencement • Identify, refer and book in eligible patients to the service • Provide allied health professionals with access to the clinical software • Provide administrative support, including reception services, on the days allied health professionals are in practice • Participate in team huddles when allied health professionals are delivering services in general practitioner practice • Maintain up to date clinical records in a secure place • Confer with allied health professionals regarding patient care, as needed • Attend all required workshops and meetings as set by our organisation	• Implement the agreed model of care • Provide monthly and quarterly reports to our organisation (including collection of PROMs) • Attend orientation(s) at the general practitioner practice(s) before services begin • Encourage the use of team huddles when delivering services at each general practitioner practice • Provide culturally appropriate, person-centred care • Operate within scope of practice to support patients with type 2 diabetes • Maintain up to date clinical records in a secure place • Confer with general practitioners regarding patient care, as needed • Attend all required workshops and meetings as set by our organisation	• Procure and manage service agreements with allied health professionals • Manage service agreements with general practitioner practices • Support the implementation of the Diabetes Multidisciplinary Team Pilot model of care • Provide dedicated contacts to general practitioners and allied health professionals • Provide participating providers with a Handbook that describes the agreed model of care • Support the general practitioner practices with systems and digital health improvements • Organise all co-design, upskilling, and review workshops • Organise practice-based pilot progress meetings

Scope of Practice

The allied health professionals involved in this pilot are uniquely skilled health professionals with their own set of standards and scopes of practice.

Dietitians Australia, the peak body for nutrition and dietetic professionals, recognises accredited practising dietitians as professionals with the qualifications and skills to provide expert nutrition and dietary advice. Accredited practising dietitians are qualified to advise individuals, groups and organisations on nutrition related matters[24].

Dietitians:

- Guide patients to understand how food and nutrition affect the body and diabetes
- Support patients to create a food plan that helps manage blood sugar levels
- Give practical tips for managing daily challenges
- Help patients make choices to improve their long-term health

The Australian Diabetes Educators Association, the national peak body for diabetes education, management and care in Australia, recognises credentialled diabetes educators as multidisciplinary professionals with the qualifications and skills to provide diabetes self-management education[25]. Credentialled diabetes educators work closely with the National Diabetes Services Scheme and Diabetes Australia.

Diabetes Educators:

- Teach patients about diabetes and how it might be affecting them
- Guide patients on how to monitor and manage their blood glucose levels
- Show patients how and when to use medications
- Help patients set health goals and work towards them over time
- Help patients create a plan that fits their lifestyle
- Register newly diagnosed patients with National Diabetes Services Scheme

Practice Setup

After inductions are completed, allied health professionals are encouraged to spend time getting to know the practice team (administrators, practice managers, general practitioners, nurses, and other professionals working at the practice).

Consulting Resources

Allied health professionals should ensure that their consulting room has all the required tools and equipment. A computer system will be provided by the practice that provides access to the clinical software and the Microsoft Office suite.

Allied health professionals are encouraged to add any resources or templates to the clinical software and computer for ease of access when seeing patients. The allied health professionals may ask the main contact person at the practice for assistance with any technology or software related matters.

Allied health professionals may wish to bring their own printed patient resources or ask to use the printer at the practice. Each practice will have a different set up and may have different

requirements. Allied health professionals are expected to navigate these conversations on a per practice basis. Our staff (primary care engagement officers and project officer) are available to support these conversations.

Team Huddles

We expect that the practice teams engage in team huddles when allied health professionals are attending the practice. A team huddle is a short, stand-up meeting – 10 minutes or less – that is typically used once at the start of each workday in a clinical setting and gives teams a way to actively manage quality and safety, including a review of important standard work such as checklists[26]. For this pilot, a team huddle may occur at any time of day and should respond to the needs of the practice team members. See below for a sample huddle template[27]:

Sample huddle template [1]

Huddle date and time: ____________________________________

Huddle leader: ____

1. Ask how everyone in the team is feeling. Does anyone need any additional support?
2. Review patients scheduled for today. Communicate what you know about them.
3. Discuss any preventative and chronic health needs of patients.
4. Ask if the GP or nurse or other team members know of anything specific is required for the visit.
5. Ask if any anyone knows of a patient who is likely to be late.
6. Ask if anyone knows if a patient is likely to not attend.
7. Ask how many walk-ins can be added to the schedule for the day and where to fit them.
8. Ask if there are any other issues.

Communication Methods

Contact details of key personnel at each general practice will be provided to the allied health professionals that are attending those practices. Contact details of allied health professionals will be shared with the practices they are engaged with. Allied health professionals involved in the project will share their contact details with one another.

Allied health professionals are to contact the practice if they cannot attend their scheduled clinic day. Allied health professionals are responsible for re-scheduling their clinic session with the practice. The practice is responsible for re-scheduling patients. All communication with patients is to go through the practice. Allied health professionals will not have direct contact with patients outside of their hours at the practice.

Allied health professionals are to communicate with general practitioners and practice staff to determine the best method of triaging urgent patient needs/information to the general practitioners. Each general practitioner will have a preferred method for this. Allied health professionals will always utilise the clinical software to document observations and detail clinically relevant information in the patient's file. In some cases, the referring general practitioner may not be in practice when an allied health professional sees their patients. It is the responsibility of the practice and the allied health professionals to determine the best method for contacting the general practitioner should an urgent matter arise. In this case, the practice may nominate a general practitioner who is physically at the practice to assume the duty of care for another general practitioner's patients while allied health professionals are delivering services.

In addition to formal referrals through the clinical software, general practitioners are expected to provide "warm handovers" of patients to the allied health professionals. By doing this, the general practitioners give patients additional confidence in the referral because they have met the new healthcare provider.

Secure Messaging

One of the aims of this pilot is to improve collaboration and communication between allied health professionals and general practitioners. For this reason, funding has been provided to allied health professionals for their use of secure messaging software for the duration of the pilot. It is at the discretion of the allied health professionals as to whether they wish to utilise secure messaging to send/receive information when they are not at the practice.

Medicare Benefits Schedule

It is imperative that providers involved in this pilot do not bill Medicare for patients seen during the clinic sessions delivered by the allied health professionals. Our organisation's funding cannot be used in combination with other government payments, including a co-payment for a Medicare-billable item.

General practitioners can bill in accordance with their practice billing policy for their time with their patients.

More information about the Medical Benefits Schedule can be found in the Medicare Provider Handbook[28].

Chronic Condition Management Plans

General practitioners are encouraged to prepare and review chronic condition management plans throughout the duration of this pilot. Our organisation-funded sessions with allied health professionals do not count towards a patient's chronic condition management plan sessions. The services available through this pilot can be provided on top of a patient's chronic condition management plan.

For an overview of the recent changes to the Chronic Condition Management Framework, please review the Medicare Benefits Schedule website[29].

Case Conferencing

General practitioners and allied health professionals involved in this pilot are encouraged to use case conferencing as a formal tool for care planning and review of patients with type 2 diabetes. It is imperative that allied health professionals do not bill Medicare if case conferences occur during our organisation's funded clinic time. General practitioners can bill in accordance with their practice billing policy for any case conferencing items. If any case conferences occur outside of our organisation's funded clinic time, allied health professionals are eligible to bill Medicare. Both allied health professionals and general practitioners are encouraged to use the Medicare website to determine their billing item numbers and eligibility[30].

Group Allied Health Services for People with Type 2 Diabetes

Under a general practitioner chronic condition management plan, patients with type 2 diabetes can access group allied health services[31]. General practitioners and allied health professionals should keep this in mind when considering consumer enablement, diabetes management and patient motivation. Both credentialled diabetes educators and accredited practising dietitians can deliver group services to patients with type 2 diabetes. If any Medicare-billable group services occur, it must occur outside of our organisation's funded clinic time.

Allied health professionals may recognise that a patient could benefit from an exercise class facilitated by an exercise physiologist. Allied health professionals should communicate this back to the general practitioner and the general practitioner will make the referral under the patient's chronic condition management plan.

Shared Medical Appointments

A shared medical appointment is where a group of patients have their medical appointments in each other's presence. Shared medical appointments provide opportunity to support patients in self-management education, health coaching and behaviour change conversations. Shared medical appointments have also been found to be well received by patients due to the peer support and connectedness they experience. Health providers have also reported favourable experiences, with better opportunities for patient education.

This pilot plans to test the use of shared medical appointments in practice. An allied health professional may act as the facilitator, while the general practitioner conducts a series of 1:1 consultations that are Medicare billable. Brisbane South Primary Health Network has created a Shared Medical Appointments Toolkit[32] that will be utilised as a guide during this pilot.

Data Collection and Reporting

Diabetes Multidisciplinary Team Pilot Measures

It is important to have clear measures that track progress towards achieving the aims set out by the Diabetes Multidisciplinary Team Pilot. This pilot will be implemented in a way that will build on the positive mindsets for improvement. Some of the measures for this pilot have been set by the Department of Health, Disability and Ageing, and some have been set by our organisation.

Activity Measures

Measures required by the Department

The following measures have been determined as a requirement by the Department of Health, Disability and Ageing. Only mean scores will be reported on.

Measure	Definition
Age of patient	Proportion of program participants in each of the following age categories: 0 – 4, 5 – 14, 15 – 24, 25 – 34, 35 – 44, 45 – 54, 55 – 64, 65 – 74, 75 years or older, not stated.
Gender of patient	Proportion of program participants in each of the following categories: Male, Female, Another term such as non-binary gender fluid gender queer etc., Prefer not to answer.
Patient's country of birth	Proportion of program participants in each of the country of birth category (as per the Standard Australian Classification of Countries Major Group[33].
Patient's post code	Proportion of participants in each of the following Modified Monash Model (MMM) categories: MM 1, MM 2, MM 3, MM 4, MM 5, MM 6, MM 7.
Aboriginal and Torres Strait Islander peoples origin	Proportion of participants in the following categories: Aboriginal and Torres Strait Islander peoples, Not Aboriginal or Torres Strait Islander peoples, Not stated
Culturally and Linguistically Diverse (CALD) identity	Proportion of participants who identify as culturally and linguistically diverse. Include language spoken at home if answer is yes.

Measures required by our organisation

The following measures have been determined by us as additional measures to track the impact of the pilot over time.

Measure	Definition
Diabetes management status	Proportion of program participants in each of the following categories: Optimised diabetes management, sub-optimal diabetes management
Medication adherence status	Proportion of program participants in each of the following categories: Adherence, non-adherence

Program Information

Measures required by the Department

The following measures have been determined as a requirement by the Department of Health, Disability and Ageing and will be reported to the Department annually.

Measure	Definition
Total number of participants in the program	Total number of consenting and non-consenting patients that have seen an allied health professional as part of this pilot
Number of referrals into the program by professional referred to	Total number of patients at all participating practices who have a referral from the general practitioner in their file
Number of referrals seen by professional type	Total number of patients at all participating practices who have been had an initial consultation by a credentialled diabetes educator and/or accredited practising dietitian (documented by allied health professional type)
Number of referrals unable to be seen	Number of patients who have not attended an initial consultation (i.e. did not attend, on waitlist, not ready to attend, etc.)

Measures required by our organisation

Measure	Definition
Clinic hours provided	Number of clinic hours delivered at each practice by each allied health professional that are payable under contract with us.
Number of group sessions held	Number of group sessions held at each practice, including the total number of participants who attended.
Number of team huddles held	Number of team huddles held on clinic days with practice staff (i.e. nurse, practice admin, general practitioner, allied health professional) that were not organised by us. Include key themes discussed in the huddles.
Number of participants referred to other allied health services	Number of patients who have been referred to other allied health professionals outside the pilot. Types will be listed.
Number of case conferences	Number of case conferences held per practice.

Patient Reported Outcome Measures (PROMs)

Patient reported outcome measures are more than just outcome measurement tools. For this pilot, patient reported outcome measures will be utilised as a clinical tool for clinicians to understand the patient better. These tools will be used by allied health professionals in a health coaching capacity.

EQ-5D-5L

The Department has selected the EQ-5D-5L as the patient reported outcome measure for use during this pilot.

The EQ-5D-5L is a well-validated instrument that measures a patient's response across five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each dimension has 5 levels: no problems, slight problems, moderate problems, severe problems and extreme problems. The patient is asked to indicate their health state by ticking the box next to the most appropriate statement in each of the five dimensions. This decision results in a 1-digit number

that expresses the level selected for that dimension. The digits for the five dimensions can be combined into a 5-digit number that describes the patient's health state[34].

A pre-treatment score and a post-treatment score must be collected. The pre-treatment scores will be collected once by an allied health professional in the initial consultation with a patient. The post-treatment score will be collected after a patient has been in the service for 3 months. Alternatively, allied health professionals can collect the post-treatment score at the time the patient exits the service. We acknowledge that it is challenging to know when a patient will exit the service. This is why the group has agreed that the post-treatment score will automatically be collected at the 3-month mark.

Problem Areas in Diabetes Questionnaire

We have implemented the use of the Problem Areas in Diabetes Questionnaire[35], in addition to the EQ-5D-5L, to more effectively measure participants' diabetes-related distress. The Problem Areas in Diabetes Questionnaire includes 20 items, each of which focuses on commonly experienced problems with diabetes.

A pre-treatment score and a post-treatment score must be collected. The pre-treatment scores will be collected once by an allied health professional in the initial consultation with a patient. The post-treatment score will be collected after a patient has been in the service for 3 months. Alternatively, allied health professionals can collect the post-treatment score at the time the patient exits the service. We acknowledge that it is challenging to know when a patient will exit the service. This is why the group has agreed that the post-treatment score will automatically be collected at the 3-month mark.

Provider Experience and Team Effectiveness Measures

It is important that this pilot understands the effect that it has on the providers involved. To understand provider experience and the effectiveness of the multidisciplinary team, we have chosen to implement regular touchpoints throughout the project to collect this information.

The 6-month and 12-month review meetings (as outlined on page 9 of this Handbook) will provide an opportunity for the providers to provide feedback to us on your experience.

We will utilise the TeamSTEPPS Teamwork Perceptions Questionnaire (TPQ)[36] to measure providers' experience of team structure, leadership, support and communication. Providers will complete the questionnaire in the lead up to the workshops and the results will be discussed as a group.

Allied health professionals will be required to submit quarterly reports on the following:

- A patient experience case study on any of the topics below:
    - Experience and satisfaction with the service
    - Ability to self-manage their diabetes
    - Awareness of diabetes
    - Ability to achieve their goals
- A good news story

- Provider experience feedback on the topics below:
    - Successes
    - Challenges
    - Overall sense of satisfaction
    - Reflections on team effectiveness

Consumer Feedback

Patients who are accessing the service will have several mechanisms for providing feedback on their experience of their care:

1. Via the general practice feedback mechanism outlined in the practice policies and procedures
2. By speaking to the allied health professionals who are delivering the service in their general practice
3. Via the formal review workshops hosted by us
4. Anonymously via a Microsoft Form hosted by the general practice

Reporting Templates

Reporting templates will be created by us and provided to allied health professionals for their use during the pilot. There is a template for each of the following reporting requirements:

- Monthly Patient Report Template – for monthly tracking of consented patients in the pilot (per practice)
- Monthly Program Report Template– for monthly tracking of program data per provider (per practice)
- Quarterly Reporting Template – for quarterly tracking of patient case studies, good news stories, and provider experience

Reporting Frequencies

Allied Health Professional Reporting to Our Organisation

Allied health professionals will report the following to our organisation:

- Monthly patient reports will be submitted to us by allied health professionals on a per practice basis.
- The monthly program reports will be submitted to us by allied health professionals on a per provider basis.
- The quarterly reports will be submitted to us by allied health professionals on a per provider basis.

Our Organisation Reporting to the Department of Health, Disability and Ageing

We will report the following to the Department on an annual basis:

- The mean scores for all required activity measures
- The program information measures
- The mean pre-treatment and post-treatment scores for the EQ-5D-5L
- The mean pre-treatment and mean post-treatment overall health scores for the EQ-5D-5L

How Our Organisation Will Support You

Throughout the Diabetes Multidisciplinary Team Pilot, you will receive proactive and practical support from us.

The following representatives will support you throughout the duration of the Diabetes Multidisciplinary Team Pilot:

For general practices:

- Your **primary care engagement officer** will be the first point of call for all matters related to the pilot. This will include assisting with clinic set up, administrative issues, clinical software and Primary Sense.
- Your **primary care engagement officer** will liaise with the **Diabetes Multidisciplinary Team Pilot program development officer** about any concerns regarding the model of care.
- The **Diabetes Multidisciplinary Team Pilot program development officer** will be the first point of call for any contract-related concerns (i.e. payments, workshop dates, etc.).

For Allied Health Providers:

- The **Diabetes Multidisciplinary Team Pilot program development officer** will be the first point of call for all matters related to the pilot.

We also have an Aboriginal health lead, a digital health program officer, a disaster and emergency coordinator and a workforce team who can assist on related matters.

Please reach out via the **Diabetes Multidisciplinary Team Pilot program development officer** and they will liaise with the appropriate team.

Continuing Professional Development

General practices participating in the Diabetes Multidisciplinary Team Pilot will be eligible for Continuing Professional Development hours for the 2023-2025 and the 2026-2028 triennia.

Allied health professionals participating in the Diabetes Multidisciplinary Team Pilot will be eligible for Continuing Professional Development hours/points for the years 2025-2028.

Templates

Talking Points for Admin Staff Template

This document provides guidance for administrative staff when discussing the details of the diabetes support services available through the Diabetes Multidisciplinary Team Pilot.

About the Project

- "This practice is participating in a project funded by the Nepean Blue Mountains Primary Health Network."
- "The practice has been funded to have a diabetes educator and a dietitian in the clinic fortnightly to help patients with type 2 diabetes management. If you choose to participate, you will have access to this service at no cost."
- "The great thing about this service is that it won't use up any of your sessions through your chronic condition management plan. You can still use those sessions for other services."

What Does a Diabetes Educator Do?

"A diabetes educator will support you to manage your diabetes with confidence."

Examples of what a diabetes educator can do:

- "Teach you about diabetes and how it might be affecting you"
- "Guide you on how to monitor and manage your blood glucose levels"
- "Show you how and when to use medications (if you need them)"
- "Help you set health goals and work towards them over time"
- "Help you create a plan that fits your lifestyle"

What Does a Dietitian Do?

"A dietitian can help you manage your type 2 diabetes through food and lifestyle choices."

Examples of what a dietitian can do:

- "Guide you to understand how food and nutrition affect your body and diabetes"
- "Support you to create a food plan that helps you manage your blood sugar levels"
- "Give you practical tips for managing your daily challenges"
- "Help you make choices to improve your long-term health"

New Clinician Induction Checklist Template

Welcome to our practice team for the Diabetes Multidisciplinary Team Pilot.

Our induction will provide you with the information you need to work effectively and safely in our practice.

We have developed an induction checklist to ensure you have a comprehensive understanding of relevant areas and ask that you countersign each section with your direct report or nominated person once each step has been completed. When your induction is complete, we will provide you with a copy of this document for your records.

We encourage you to ask questions or request assistance at any time.

Best regards,

Insert Principal Name

Insert Practice Name

SECTION 1 – THE PRACTICE

Welcome to our practice	AHP	Practice	Date
Introduction to staff members			
Tour of our practice (bathroom, tearoom, consulting room)			
Collection of required documentation - Peak Body registration, insurance, CPR certificate - Allied health professionals to sign a Confidentiality Agreement as set out by the Practice (or as outlined as part of this template)			
Overview of the organisation chart			
About the culture of our practice			
The importance of asking questions			
How/where to access policies and procedures			
Information about available resources			
Exchange mobile numbers			

About our practice	AHP	Practice	Date
The background/history of our practice			
The practice profile - special interests, patient demographic, cultural backgrounds of patients			
Practice operating hours and services			

About our practice – our organisation	AHP	WHL	Date
Diabetes Multidisciplinary Team Pilot – Allied health professional clinic hours/roster			

SECTION 2 – PRACTICE ADMINISTRATION

Practice administration	AHP	Practice	Date
An introduction to the front desk			
How to handle incoming and outgoing correspondence			
Procedures for using printer and practice software			
Information about billing arrangements			
Practice administration – our organisation	**AHP**	**WHL**	**Date**
Role of the admin team for Diabetes Multidisciplinary Team Pilot – new pt bookings, phone calls to pts, scanning and uploading documents to pt file, etc.			
Information about case conferencing – provisions for the Diabetes Multidisciplinary Team Pilot			

Telephone procedures	AHP	Practice	Date
Instances where allied health professionals would be using the telephone			
When to transfer telephone calls to the other clinical and non-clinical staff			
General practice policy on receiving and returning patient telephone calls			

Appointment management	AHP	Practice	Date
Information about the appointment system			
Instructions and regulations regarding telehealth appointments			
Instructions on how to use telehealth platform at the practice			
The role of admin staff in booking appointments and how appointments are typically booked			
The process for 'did not attend' and cancelled appointments			

Appointment management – our organisation	AHP	WHL	Date
The types of appointments allied health professionals will be delivering at the practice: Initial consultation – 1 hour Follow up consultation – 30 mins			
Appointment types in the clinical software for Diabetes Multidisciplinary Team Pilot: MDT Initial MDT Fup MDT GP Review			
Decision on who will book follow up appointments for patients of Diabetes Multidisciplinary Team Pilot			

SECTION 3 – PATIENT MANAGEMENT

Triage and medical emergencies	AHP	Practice	Date
How to handle a medical emergency - on the telephone or in person and with or without a general practitioner in attendance			
How to identify and care for patients in distress			

Patient management	AHP	Practice	Date
The importance of respecting patient rights			
The practice's policies and guidelines on open disclosure			
Obtaining patient consent for the presence of a third party during their consultation			
Obtaining patient consent for accessing My Health Record			
The importance of treating patients with courtesy and respect			
How to provide important information to patients			
How to handle difficult or angry patients			
How incoming and outgoing Pathology is handled			
Information about each general practice's policy on receiving and returning patient emails			
How to access services to help communicate with patients who speak a language other than that of the general practitioners and/or those with a disability (allied health			

professionals have access to Translating and Interpreter Service)			
Information about local health, disability and community services			
Patient management – our organisation	**AHP**	**WHL**	**Date**
Obtaining and recording patient consent for the purpose of the Diabetes Multidisciplinary Team Pilot			
Role of general practitioners in referring patients into the Diabetes Multidisciplinary Team Pilot (warm handovers, introduction to allied health professionals, formal referral letters)			
How allied health professionals will share newly disclosed health details with general practitioners			

SECTION 4 – PATIENT HEALTH RECORDS AND CONFIDENTIALITY

Patient health records and confidentiality	AHP	Practice	Date
The importance of privacy, confidentiality and security of patient health information (verbal, written and electronic information)			
The process for handling results, reports and clinical correspondence			
Information about the practice recall and reminder system			
Information on key public health regulations (such as reporting requirements for communicable diseases)			
The practice policy on retention of records and archiving			
The process for transferring patient health records			

SECTION 5 – COMPUTER ADMINISTRATION

Computer administration	AHP	Practice	Date
Information about privacy, confidentiality and security issues			
Allocating the appropriate passwords and permissions			
How to lock the computer and activate screensavers			
Our email policy			
Our social media policy			
Computer security procedures - firewall, anti-virus, disaster recovery			

Computer administration	AHP	Practice	Date
Computer administration – our organisation	**AHP**	**WHL**	**Date**
The sharing of patient information between allied health professionals and general practitioners in Clinical Information System (secure messaging, formal letter, notification/alert, verbal conversation if urgent)			
Confirmation that the practice has Microsoft 365			

SECTION 6 – HUMAN RESOURCE MANAGEMENT

Human resource management	AHP	Practice	Date
Code of conduct			
Requirements for continuing professional development			
Policy on equal opportunity and sexual harassment			
What to do in the event of an incident or injury			
Practice policy on lifting heavy objects			
Practice policy on smoking, drugs and alcohol in our practice			
How to handle violent situations in the workplace			
Ways to maintain health and wellbeing			
Current immunisation status known, documented and immunisation appropriate to the duties identified and arranged (by consent)			
How to handle non-medical emergencies - fire, bomb threats			
Human resource management – our organisation	**AHP**	**WHL**	**Date**
Creating trust in the clinical team (understanding scope of practice, sharing information, being punctual, follow through)			
Team huddles on allied health professional's clinic days			
Practice-based pilot progress meetings 2 times per year, coordinated by our organisation			
Whole group multidisciplinary team review meetings (November 2025 & April 2026)			

SECTIONS 7 – TREATMENT ROOM and FACILITIES

Treatment room	AHP	Practice	Date
The process for using and maintaining practice equipment			

Treatment room	AHP	Practice	Date
The process for reporting any issues with equipment, medical supplies, consulting room etc.			
Practice cleanliness procedures			

SECTION 8 – CONTINUOUS QUALITY IMPROVEMENT

Risk management and continuous quality improvement	AHP	Practice	Date
Information about practice accreditation and what that means			
The name of the staff member with primary responsibility for infection prevention and control			
The name of the staff member responsible for managing patient feedback			
The name of the staff member responsible for the investigation and resolution of complaints			
The name of the staff member responsible for leading clinical improvements			
The name of the staff member responsible for leading risk management			
Risk management and continuous quality improvement – our organisation	**AHP**	**WHL**	**Date**
Information about how to provide input and feedback for improving the Diabetes Multidisciplinary Team Pilot			
Allied health professional reporting on patient feedback from the Diabetes Multidisciplinary Team Pilot			
Allied health professionals reporting on measures throughout the pilot			
Problem Areas In Diabetes (PAID) scale – determine at what score allied health professionals need to escalate back to the general practitioner for further care			

SECTION 9 – MULTIDISCIPLINARY TEAM CARE

Team-Based Care	AHP	WHL	Date
Maintain shared purpose of Diabetes Multidisciplinary Team Pilot: Improving collaboration between health care professionals Provide equity of access to allied health services			

Team-Based Care	AHP	WHL	Date
Enhance patient experience of care Improve health outcomes Improve provider experience Achieve best value for resources invested			
Understanding allied health professionals' role in the team (unique scope of practice) Reporting to our organisation Gather patient consent required for collection and reporting of de-identified pt information for this project Share details about this project to patients			
General practitioner referrals into the service must have clear reason indicated			
Effective communication – honest, timely, respectful			
Entire multidisciplinary team at the practice is educating patients on evidence-based care			
Practice huddles on clinic days (themes captured by allied health professionals)			
Practice-based pilot progress meetings will be held 2 times/year at the practice – facilitated by our organisation Reviewing team effectiveness			

Service Integration	AHP	WHL	Date
Understanding your role in the team			
Importance of patient consent for data collection			
Importance of understanding patient eligibility for the service: T2DM, 18 years or above, regular patient of the practice, not currently seeing a Dietitian or Diabetes Educator			
Allied health professionals require certain permissions in the software. They must be able to: View patient record, start visit; start visit of other health professional; add category in pt education materials; add file to pt education materials; record reason for visit; My Health Record; create autofill entries (allied health professionals); autofill templates for accreditation; notification area			

Confidentiality Agreement Example Template

I ________________________________ have received explanation in all the areas listed in this induction program. I acknowledge and understand the content of the items above, and I agree to abide by the processes detailed in the policy and procedure manual.

I understand that in performing the responsibilities of my role in the Diabetes Multidisciplinary Team Pilot, I will have access to confidential information relating to patients' health and the practice's business. I agree that I will not disclose any confidential information during the period of my contractual arrangement for the Diabetes Multidisciplinary Team Pilot, or after its termination (however caused), to any person not authorised to receive such confidential information.

I undertake not to access, use, disclose, copy, reproduce or retain confidential information for any purposes other than required to perform my role in the Diabetes Multidisciplinary Team Pilot. I acknowledge that to do so would be in breach of the *Privacy Act 1988*.

I have read and understood the practice's privacy policy and agree to abide by the procedures used by this practice in ensuring there are no breaches of privacy.

Allied health professional's name in full: ____

Signature of allied health professional: _____________________ **Date:**__________________

Practice principal name in full: ____

Signature of practice principal: ____________________________ **Date:** __________________

Clinical Software Autofill Shortcut Template for Dietitian Initial Consultation

Session attendance (support worker/family):

Patient-centred goal:

Hba1c (%):

BSL:

Weight (kg)

Height (m)

Waist circumference (cm)

Dietary Assessment

Food allergy:

Shopping and cooking:

Cooking and food storage facilities:

Supplements

Diet History

BF:

L:

D:

Snacks:

Beverages (etoh/SD/tea/coffee):

Meal completion:

Skip meals:

Eat out:

Non-hungry eating:

Other:

Goal setting:

Model for Improvement Template

The Model for Improvement is a tool for developing, testing and implementing change, and consists of two parts.

The Model for Improvement

Date: ________________________

STEP 1:	The ***'Thinking Part'*** Consists of three **Fundamental Questions** that are essential for guiding improvement work

Fundamental Question 1: What are we trying to accomplish?

*By answering this question, you will develop your **S.M.A.R.T. (Specific, Measurable, Achievable, Realistic and Time bound) GOAL** for improvement*

Fundamental Question 2: How will we know that a change is an improvement?

*By answering this question, you will develop your **MEASURES** for tracking your goal*

Fundamental Question 3: What changes can we make that will lead to an improvement?

*By answering this question, you will develop **CHANGE IDEAS** you can test to achieve your goal*

IDEA 1: ....

IDEA 2: ....

IDEA 3: ....

Plan-Do-Study-Act Cycle

PDSA #: ________________________ Date: ______________________

STEP 2: The ***'Doing/Testing Part'***

Consists of **Plan-Do-Study-Act (PDSA) Cycles** that will help you test and implement the change ideas identified in Step 1

IDEA: Choose an idea from **Fundamental Question 3**

PLAN: What exactly will you do? Include who, what, when, where, predictions & data to be collected

*By answering this question, you will further develop the **IDEAS** you can test to achieve your goal*

Who:

What:

When:

Where:

Predictions:

Data to be collected:

DO: Was the plan executed? Document what happened (expected or unexpected events)

STUDY: Record, analyse and reflect on results

ACT: What will you take forward from this cycle? What is your next step or PDSA Cycle?

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