29/01/2016

Medical Services Advisory Committee
msac.secretariat@health.gov.au

RE: Application 1385 – Shared Medical Appointments for Type 2 Diabetes Management.

To Whom It May Concern,

On behalf of the Dietitians Association of Australia, I wish to highlight several issues of concern with Application 1385 for consideration of the Medical Services Advisory Committee (MSAC) at the Evaluation Sub-Committee (ESC) meeting scheduled for 11-12 February.

Our concerns have previously been raised in the form of a joint submission to MSAC filed 20 March 2015. The Dietitians Association of Australia (DAA), Exercise & Sports Science Australia (ESSA) and the Australian Diabetes Educators Association (ADEA) collaborated to review Application 1385 and submit feedback on the management of Type 2 Diabetes using Shared Medical Appointments (SMAs). In essence, we do not support the replacement of existing Type 2 Diabetes Management (T2DM) group allied health services (Comparator 2) with SMAs for the following reasons:

Lack of relevant and high quality research supporting SMA implementation.

Much of the research and evidence base presented in the SMA proposal draws on overseas trials. As highlighted by the authors, no Australian trials were identified – only an initial trial of patient and provider satisfaction has been completed. The limited evidence base suggests further research is warranted to determine if this health care model is successful within the Australian health care system. Widespread implementation of this model (through allocation of an MBS item code) would be premature ahead of an Australian trial. There is little evidence to suggest the SMA model will be effectively embraced by the health sector and the Australian public, which may potentially become a costly and ineffective treatment model.

Unsubstantiated superiority of the SMA model over existing T2DM group services.

The studies cited by the authors (23, 30-33) compare the effects of a group intervention with traditional one-to-one care (Comparator 1), yet the authors claim *"Studies from overseas suggest that SMAs have superior efficiency and lower costs than the comparators"* (p. 22). Whilst the evidence for group session superiority against one-to-one care (Comparator 1) may be valid, the authors fail to provide evidence that SMAs are superior against existing T2DM group services (Comparator 2). The evidence for benefits of group sessions administered by allied health professionals (AHPS), (such as Accredited Practising Dietitians, Accredited Exercise Physiologists and Credentialled Diabetes Educators), is well substantiated. Superiority of the SMA model over existing T2DM group services is unsubstantiated by the authors in the Application.

Issues with replacement of specialised Allied Health Professional advice with generic advice.

The SMA proposal includes a GP and at least one trained Facilitator (practice nurse or other allied health). It is unlikely that a medical practice would engage the services of an AHP to be the Facilitator, given around 60 per cent of medical practices employ a practice nurse. Evidence demonstrates generic nutrition advice is less effective than the provision of medical nutrition therapy in diabetes outcomes (Franz, 1995). DAA does not support SMAs for T2DM as a replacement for the valuable and specialised education provided by AHPs (Comparator 2). If a supplementary model of care were to be introduced, we propose that a qualified AHP (AEP, APD and/or CDE) lead/facilitate the group with GP participation for medical input.

Neglect of considerations and operational logistics for AHPs.

A skilled workforce already exists (consisting of APDs, AEP's, CDEs) to deliver group allied health services to patients with T2DM. Despite this, the SMA model gives little or no consideration as to how AHPs may be utilised, or renumerated, as indicated on p. 14: *"The proposed item fee cannot be designated for payment of AHPs, if these are used as the Group Facilitator".* Neglect of this consideration needs to be addressed.

Given the relevant skills of the aforementioned AHPs in promoting patient self-management and behavioural change, and their experience in the delivery of group services, we do not support the need for 'Facilitator Training' to be completed by these three AHP groups.

Lack of data supporting cost savings attributed to SMAs.

The SMA model authors outline proposed cost-savings attributed to SMAs, yet there is little data to back this up.

Summary

DAA is concerned that the proposed SMA model (Application 1385) lacks evidence in its ability to achieve better health outcomes for people with Type 2 Diabetes Mellitus and it shows very little evidence of cost savings to the Australian health care system. Furthermore, it is of great concern to DAA that the proposed model fails to acknowledge the achievements already being made in the management of Type 2 Diabetes using group allied health services (Comparator 2). The proposed SMA model lacks consideration of AHPs or group allied health services involved in the facilitation of the SMAs. In fact, the model does not deliver on the 2015 RACGP SNAP guidelines, which advocate for patient referral to expert allied health interventions.

DAA welcomes ongoing consultation with MSAC to ensure the most effective health services are delivered and the best health outcomes are achieved for all Australians with T2DM.

Kind regards,

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