DAA Submission

Independent Hospital Pricing Authority

Teaching, training and research costing study

January 2015

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in dietetics and advocates for better food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the *Teaching, training and research costing study* by the Independent Hospital Pricing Authority (IHPA).

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DAA interest in this consultation

DAA supports excellence in teaching, training and research in healthcare. The Association has an interest in measures of quality and resource use which can be used to facilitate effective and efficient teaching, training and research which will ultimately contribute to better food, nutrition and healthcare in Australian hospitals.

Accredited Practising Dietitians (APDs) provide medical nutrition therapy in acute care, lead or contribute to inpatient food service systems, and contribute significantly to teaching, training and research in hospitals.

Recommendations

DAA strongly recommends that the consultants engage with dietetic and other allied health managers in the development of the costing methodology for the TTR Costing Study and in reviewing the data collected during the study.

Comments on IHPA TTR Costing Study Public Consultation Paper

Page/section	Comment
1.3.1 Definitions of TTR	DAA is pleased to see that allied health is in scope of the study. The constituency of allied health may vary between organisations. DAA recommends that the definition from Allied Health Professions Australia be used to ensure consistency in the capture of data in this Study[1]. *AHPA uses and builds on Professions Australia's definition of a profession with additional specifications:* *An allied health profession is one which has:* • *a direct health consumer care role and may have application to broader public health outcomes* • *a national professional organisation with a code of ethics/conduct and clearly defined membership* • *requirements* • *university health sciences courses (not medical, dental or nursing) at AQF Level 7 or higher,* • *accredited by their relevant national accreditation body* • *clearly articulated national entry level competency standards and assessment procedures a professionally defined and a publicly recognised core scope of practice* • *robust and enforceable regulatory mechanisms* *and has allied health professionals who:* • *are autonomous practitioners* • *practise in an evidence-based paradigm using an internationally recognised body of knowledge to* • *protect, restore and maintain optimal physical, sensory, psychological, cognitive, social and cultural function* • *may utilise or supervise assistants, technicians and support workers.*
1.3.1 Definitions of TTR	The scope of the Study relates to health professional teaching and training to attain entry level competency or post entry level competency. This is only a fraction of the teaching and training delivered and received by APDs and other hospital employees. Other teaching and training may occur in hospitals as continuing professional development. For example, health professionals such as APDs may provide continuing professional

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	development/clinical education/ training to doctors, nurses, allied health professionals, allied health assistants and food service staff. DAA supports a comprehensive approach to understanding teaching and training activities in hospitals. If the study continues with the narrow scope described in the consultation paper, then a brief explanation to data contributors about the scope of data collection is warranted.
1.3.1 Definitions of TTR	There has been an attempt at describing 'research'. However the definition given might also be interpreted as quality improvement. The formal approval by an ethics body can help to differentiate these two concepts, but not always. Some health professionals will seek approval from ethics bodies for projects which are quality improvement in order to publish their work. More work on the definition is needed to distinguish between quality improvement activities and research. For example, research methodologies generally have a hypothesis and quality improvement activities have a focus on consumer outcomes.
2.1 Project approach and deliverables	DAA supports the activities outlined in Stages 1- 6. Stage 2 describes selection of a representative sample of health services. DAA recommends that this sample also consider adequate representation of allied health, including dietitians. Stage 3 describes consultation with sites. This will be important for allied health to determine in which sites individual allied health disciplines already collect data and how, which sites bundle allied health activities (so that it is difficult to identify the contribution of disciplines) and which sites cost model only.
2.1.1 Key project deliverables	It is proposed that the study will include six months of costed data. Some large hospitals may have dietetic students on clinical placement for most of the year, while smaller hospitals, or regional/remote hospitals, may take one or two students on placement per year. Similarly the lecturing or tutorial load may vary through the year. DAA suggests considering how to capture activities which are not in the window of data collection as dietetic student placements, lectures or other clinical training activities may fall outside the data capture period. Failure to collect this data will lead to under representation of dietetic teaching and training. There have been staff cuts or freezes in some jurisdictions. It will be important to identify where TTR activities have been reduced as a result of reduced staffing if the data are to be used to represent usual or desirable levels of TTR. DAA also suggests that the costing data be linked to quality indicators for TTR activities at each site, so any association between costs and quality can be interrogated. For example, TTR activities that providers consider to meet only the bare minimum standards may produce different costing data from TTR activities considered to be excellent.
2.1.1 Key project deliverables	DAA suggests that the data collection methodology is checked with allied health managers in each site before collection begins to identify problems in data collection. DAA also suggests that the data be presented to allied health managers for review at the conclusion of data collection to interrogate and interpret results, especially unexpected results.
2.4.2 participating	Anticipated health service staff involvement identifies clinical education departments but these are

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costing study sites	more likely to service nursing and/or medical education, and may not service allied health. DAA recommends that consultations include dietetic and other allied health managers for each of the Engagement Activities detailed in Table 2: Site stakeholder involvement.
3.4 High level costing methodology for teaching and training	Figure 5 identifies Embedded T&T with examples such as procedures. This is appropriate and relevant to dietetic training. Dietetic examples might be dietetic students interacting with patients, families, or carers, in the course of patient assessment, patient counselling, patient education, setting up special diet or oral nutrition support, or managing enteral nutrition. Dietetic students are also required to undertake clinical placements related to food service as part of accreditation requirements. This also requires direct, indirect and embedded T&T. Training in this area is essential and might be viewed as an non-individual patient attributable activity using the National Allied Health Casemix Committee Health Activity Hierarchy[2]. The briefing and debriefing of a dietetic student with their supervising dietitian before and after various interventions would require logging of the supervising dietitian time. Instructions to study participants should be given on how to allocate this time. DAA considers it is very important to capture embedded T&T that occurs in conjunction with patient care (Question 3 and 8) because supervised clinical placements are an essential part of the training of dietetic students, i.e. they are required for accreditation purposes. Alignment is unlikely between embedded T&T and the amount of direct and indirect T&T, DAA recommends collection of sufficient data to examine this question (Question 4). Dietetic students are not paid while on placement. They generally have to meet their own expenses when travelling across cities or to regional or remote centres. In some cases their travel and/or accommodation costs are reimbursed or subsidised by universities or hospitals, or accommodation provided as happens in some University Departments of Rural Health. The methodology should address travel and accommodation expenses for the hospital site in question, and should describe how the 'free' labour source or accommodation subsidy is to be handled where the university or student pays the cost. In some locations, the university partly or wholly funds clinical tutors/placement program supervisors who work in the hospital with the dietetic student. The methodology would need to identify situations where the salary is not paid by the hospital. However that cost should still be considered because without that input the teaching and training could not proceed. Site consultations should determine if there are any travel costs which should be applied. These might be incurred if a supervisor or student travelled between hospital sites, or if there are hospital in the home programs etc.
3.5 Approach to capturing embedded costs	The statement that data relating to T&T has not been previously collected on a systematic basis is inaccurate. The Australian Allied Health Service Weights Study 2005[3] showed variability in the data collection in allied health departments. No doubt this is still the case but some allied health departments will have a capacity to report actual data on T&T. The consultants are advised to do site checks with managers of allied health departments to establish what capability there is to report T&T. They are likely to find that in some hospitals it is practical and feasible to capture embedded T&T using existing systems without additional data collection.(relates to question 5 and 7)
Appendix B: Proposed TTR data items	B.1 Allied Health refers to 'Other allied health professionals undertaking postgraduate qualifications'. Care should be taken to distinguish between dietetic students who are undertaking entry level training (four year undergraduate programs or two year Masters program) and post

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	entry level training (e.g. doctor of philosophy). B.2 Clinical school expenditure may be relevant for nursing and/or medical training but may not capture allied health training.

References

1. Allied Health Professions Australia, Definition of Allied Health, 2012. Available at http://www.ahpa.com.au/Home/AboutAlliedHealth.aspx Accessed 28 January 2015

2. National Allied Health Casemix Committee. Health Activity Hierarchy.2001. Available at http://www.nahcc.org.au/hierarchy.htm Accessed 29 January 2015.

3. The Australian Allied Health Service Weights Study. Final Report August 2005. RMIT University.

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