Australian National Diabetes Strategy

May 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 nutrition and advocates for better food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on *Consultation paper for the development of the Australian National Diabetes Strategy* by the National Diabetes Strategy Advisory Group.

Contact Person:	Annette Byron
Position:	Senior Policy Officer
Organisation:	Dietitians Association of Australia
Address:	1/8 Phipps Close, Deakin ACT 2600
Telephone:	02 6163 5202
Facsimile:	02 6282 9888
Email:	abyron@daa.asn.au

DAA interest in this consultation

As the peak professional and regulatory body for dietitians, DAA is concerned about the increasing prevalence of type 2 diabetes in Australia. DAA supports policies that aim to prevent the development of diabetes and that ensure people with diabetes have access to safe high quality care.

Accredited Practising Dietitians (APDs) provide medical nutrition therapy to assist in the self management of diabetes. APDs are the nutrition experts in client centred multi-disciplinary teams that work with individuals and communities to improve quality of life, physical and financial outcomes. APDs provide evidence based nutrition interventions in programs which delay or prevent the onset of type 2 diabetes in at risk individuals.

Key messages

DAA commends the Australian Government on identifying the need to prioritise Australia's response to diabetes and to identify approaches to reduce the impact of diabetes in the community. DAA is concerned however that the process of development of the National Diabetes Strategy has not included dietitians as major stakeholders and that the draft Strategic Framework lacks the structure and content to meet the challenges presented by diabetes in Australia in 2015 and beyond.

Particular concerns relate to the limited detail provided in the Strategic Framework and lack of supporting evidence for recommendations. Given the fiscally constrained environment in which the Strategic Framework has been developed and in which it will be implemented it is surprising that not more use has been made of current international diabetes policy documents from other countries e.g. Canada, United States.

DAA would like to see that the final Strategic Framework reflects the evidence from major international trials in diabetes care that people with diabetes should receive individualised medical nutrition therapy from a qualified professional to assist in achieving treatment goals, e.g. glycaemic, blood pressure, and lipid and weight goals, and to prevent or delay complications of diabetes.[1,2] In Australia Accredited Practising Dietitians are the nutrition professionals who are qualified and credentialed to support individuals and communities to realise better health outcomes through food and nutrition.

Recommendations

The National Diabetes Strategy Advisory Group (the Advisory Group) were asked to provide expert policy advice that prioritises the national response to diabetes within the broader context of prevention and primary healthcare, supports patients with complex health conditions and recognises the burden of chronic disease on our health system.

It is regrettable that a dietitian was not included on the Advisory Group, given the central role that diet plays in the management of diabetes, and that "It's been known for years that diabetes requires a multidisciplinary team approach because there are so many components to its management."[3] It is especially surprising given the Strategic Framework notes "care delivery should be transformed to become more consumer-focused, team-based and proactive" (page 5).

DAA considers that the terms of reference of the Advisory Group are very relevant to the current and future management of diabetes in Australia. Our comments are presented in relation to these terms.

The scale and extent of diabetes in Australia, and key clinical and policy challenges

- DAA would like to see further exploration of key clinical and policy challenges. For example a significant proportion of primary care is delivered through Medicare chronic disease items but there is no suggestion that increases to the current limit of five allied health visits per annum be considered. This is despite the fact that the recent Diabetes Care Project demonstrated that more than five visits on average are required to achieve satisfactory outcomes for all patients, and that greater investment in allied health consultations achieved better outcomes for patients, particularly for those with complex needs.

Australian diabetes outcomes compared with international evidence

- It seems that little use has been made of relevant international evidence. Key documents such as the American Diabetes Association Nutrition Therapy for the Management of Adults with Diabetes should be referenced. The Canadian Diabetes Association Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada are also relevant. Consideration of the international evidence in the Australian context would be valuable given the resource constraints placed on the National Diabetes Strategy.

Gaps in diabetes prevention and care, including service coordination and integration, research and monitoring

- More detail would be helpful to show how services might be better planned and coordinated with multidisciplinary governance models, especially taking into account models that already exist, the limited funding that is available for new initiatives and barriers that need to be overcome. The document includes mention of multidisciplinary care, but does not address how this care is currently being delivered or could be done better.
- The Strategic Framework identifies that people living in remote regions may have difficulty accessing services, including dietitians. Telemedicine is mentioned as one approach to this issue, but this could be strengthened by promoting telehealth for all members of the multidisciplinary team. At present Medicare is only available to allied health providers for chronic disease items when delivered face to face, even though rural and remote residents face a greater burden of disease and stand to benefit greatly from innovative service delivery.

Improve early identification of diabetes and those at future risk of diabetes

- The document discusses the need for educating primary healthcare practitioners about who should be screened for diabetes. APDs should participate in such education.
- Education should identify APDs as the referral destination for individuals who have diabetes or are at risk of developing diabetes for advice on nutrition and self management of diabetes.

Enable optimal management of patients by general practice and the primary health care sector

- There is a lack of depth around nutrition issues and how to address these in the primary health care sector. Diet and weight have been identified in the document as the top two risk factors for diabetes in Australia, but no reference is made to medical nutrition therapy delivered by an APD to address these risk factors. The document should at least refer to the American Diabetes Association Standards of Medical Care in Diabetes which provides evidence for the role of medical nutrition therapy in managing the complications associated with diabetes including hypertension/blood Pressure control, cholesterol levels, hyperglycaemia, gastroparesis.[4]
- The Professional Practice Committee for the development of the American Diabetes Association's "Standards of Medical Care in Diabetes" included physicians, diabetes educators, registered dietitians, and a range of other health professionals with relevant backgrounds. The committee for a National strategy in Australia should be modelled from this committee.[4]
- It should be noted that even moderate weight loss will achieve significant improvements to risk factors for type 2 diabetes.

Improve health literacy and support for patient self-care, including applications to enhance monitoring of an individual's condition

- The Strategic Framework needs to provide more details on who should be involved in improving health literacy and support for patient self-care.
- The HEAL program is an example of a current program that aims to achieve improve health literacy with multidisciplinary involvement. [5]

Ensure timely responses to prevent and manage complications caused by diabetes e.g. kidney and heart health, eye and foot complications

- Diabetic Ketoacidosis (DKA) is referred to a number of times throughout the document as a complication of type 1 diabetes. Diabetes related distress, cost of care issues, and timely access to integrated, quality, specialist diabetes care are other issues in type 1 diabetes that need to be considered in this population group.

Focus on those most at risk e.g. Aboriginal and Torres Strait Islander people, pregnant women;

- Goal 4 is focussed on reducing the incidence of diabetes in at risk groups, but there is no exploration of the unique difficulties of securing a healthy food supply in rural and remote communities which is important for prevention of diabetes and to support self management of those who are diagnosed with diabetes. Food insecurity is not addressed and is a key dietary problem for these groups.
- It is appropriate to identify pregnant women as a key group requiring optimal care, however advice on diet for pregnant women should be provided by an APD, working with a diabetes educator and exercise physiologist in a multidisciplinary team. Aboriginal Health Workers are also essential members of the team in Aboriginal and Torres Strait Islander Communities.

Approaches to strengthening the evidence base through research and translation of research into practice, including enhanced use of clinical practice guidelines, standards and pathways

- Goal 5 discusses a nationally co-ordinated research agenda. We understand that there will be very limited funding for this initiative. A plan for how this will be achieved within the known limitations is required.

References

1. Evert, Boucher, Cypress, Dunbar, Franz, Mayer-Davis, Neumiller, Nwankwo, Verdi, Urbanski. Nutrition Therapy Recommendations for the Management of Adults With Diabetes. Position statement of American Diabetes Association. *Diabetes Care.* 2014; **37:** supplement 1.
2. Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. *Can J Diabetes.* 2013; **37**:S1-S212
3. Building an Effective Diabetes Care Team http://www.joslin.org/info/building-an-effective-diabetes-care-team.html Accessed 15 May 2015
4. American Diabetes Association. Standards of Medical Care in Diabetes – 2015. *Diabetes Care*. 2015: **38**, supplement 1.
5. The Healthy Eating Activity and Lifestyle program. https://www.essa.org.au/for-gps/heal-program/ Accessed 15 May 2015