



Chronic Disease Prevention and Management in Primary Health Care

August 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 food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the inquiry into Chronic Disease Prevention and Management in Primary Health Care for the House of Representatives Standing Committee on Health.

Contact Person: Erin McLean
Position: Professional Services Dietitian
Organisation: Dietitians Association of Australia
Address: 1/8 Phipps Close, Deakin ACT 2600
Telephone: 02 6163 5203
Facsimile: 02 6282 9888
Email: psdietitian@daa.asn.au

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Key messages

Dietary factors are a key contributor to chronic disease and greater investment at all levels of government is needed to support people to choose food consistent with the Australian Dietary Guidelines.

Accredited Practising Dietitians (APDs) and other allied health practitioners are essential to achieving better outcomes in chronic disease. Integrated models of care should include sufficient allied health resourcing and access to practitioners with the skills and knowledge relevant to meet the needs of people with chronic disease, from less complex to high end users.

People with chronic disease should have better access to allied health through Medicare including

- Increased number of allied health visits
- Case conferencing to support coordinated care
- Telehealth as a substitute for face to face consultation in rural and remote regions
- Additional items related to gestational diabetes, pre-diabetes and mental health.

Chronic disease prevention and management in primary care systems should be developed based on needs assessments of communities. Evidence-based care may be delivered by through various models by private health insurers, governments or Primary Health Networks. Governments and Primary Health Networks have a vital role in addressing service gaps in areas of market failure, especially in rural and remote regions.

Interpretation of Terms of Reference

DAA understands that the focus for this inquiry is primary health care. Consequently the Terms of Reference have been interpreted around chronic disease prevention in primary health care, and chronic disease management in primary health care.

Chronic disease

The Australian Institute of Health and Welfare characterises chronic disease conditions by their complex causality, multiple risk factors, prolonged course of illness, long latency periods and functional impairment or disability¹. The 12 chronic conditions identified in the National Public Health Partnership paper, 'Preventing chronic disease: a strategic framework² are:

- Ischaemic heart disease (also known as coronary heart disease)
- Stroke
- Lung cancer
- Colorectal cancer
- Depression
- Type 2 diabetes
- Arthritis
- Osteoporosis
- Asthma

- Chronic obstructive pulmonary disease (COPD)
- Chronic kidney disease
- Oral disease.

DAA considers that there are other chronic diseases, such as food intolerance and food allergy, which impact on individuals and the community. However the conditions listed above pose a significant burden on morbidity, mortality and Australian health care costs.

Approximately 70% of the Australian Health Budget (>\$70billion) is spent on chronic conditions (with cardiovascular disease costing the most at \$7.9billion). Of these chronic conditions, 70% are preventable through lifestyle behaviours³. Overall, the top two risk factors that account for the most disease burden in Australia are dietary risks and high body-mass index (Figure 1), both of which are preventable⁴.

Prevention

This submission considers primary and secondary prevention in the context of primary health care defined as ^{2,5}:

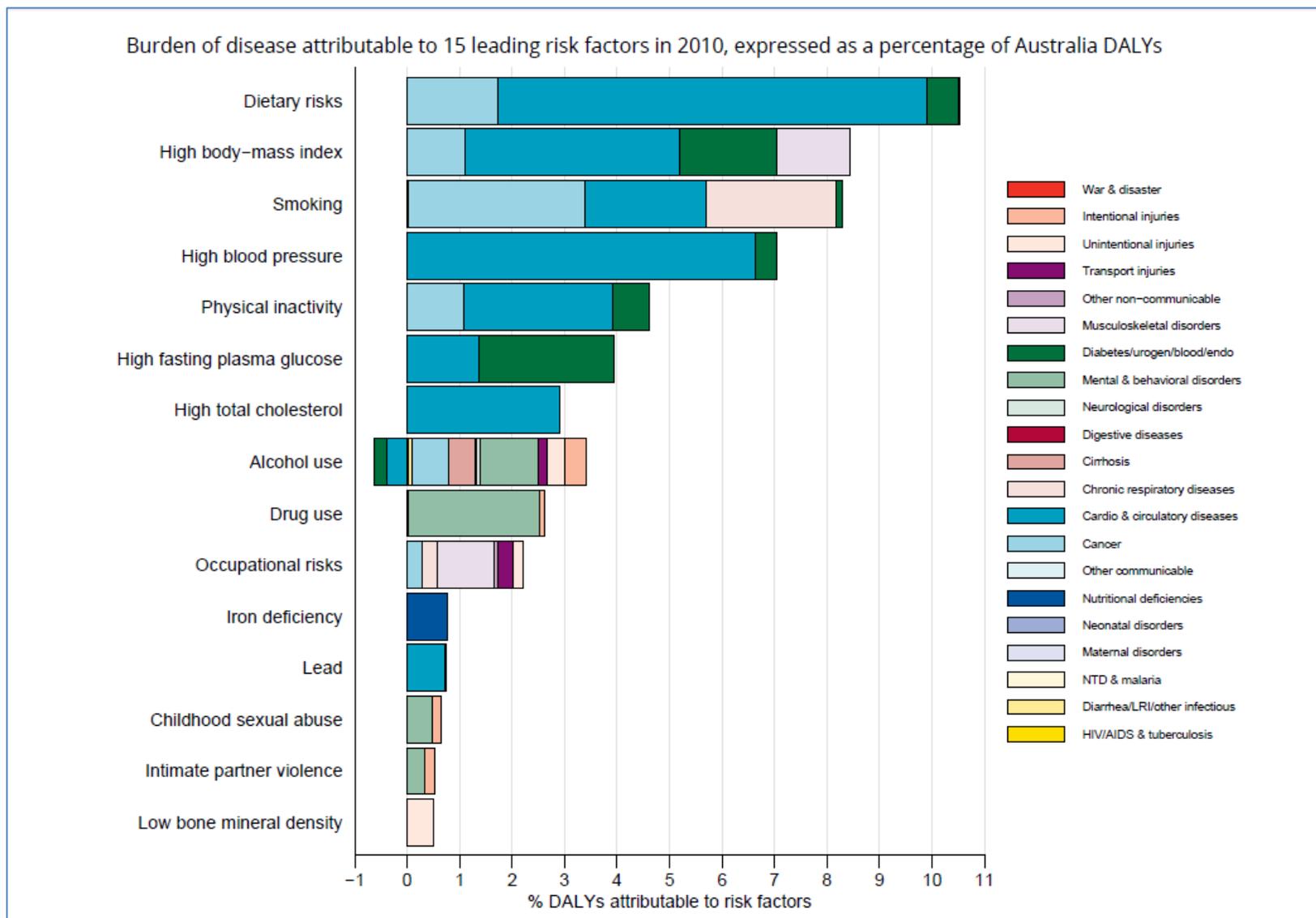
- Primary prevention is the protection of health by measures which eliminate causes and determinants of departures from good health and control exposure to risk; primary prevention decreases the number of new cases of a disorder, illness and premature death. Simply, it reduces the incidence.
- Secondary prevention is the measures available to individuals and populations for the early detection and prompt effective intervention to correct departures from good health; secondary prevention may lower the rate of established cases in the community.

Primary health care

It appears to DAA that government resourcing for primary health care in Australia is currently focused on health care delivered on a fee for service basis by general practitioners. DAA would like to see this focus broadened in keeping with definitions from the literature

“i.e. primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation^{6,7,8”}.

Figure 1: Burden of Disease - top 15 risk factors for Australia⁴



TOR 1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally.

Lifestyle interventions prevent diabetes

Lifestyle interventions such as diet and physical activity have been shown to be effective as single treatments for pre-diabetes when delivered by appropriately qualified and credentialed health professionals such as Accredited Practising Dietitians, Accredited Exercise Physiologists, and Credentialed Diabetes Educators.

A recent randomised controlled clinical trial in the United States demonstrated that individualised medical nutrition therapy delivered by dietitians was effective in decreasing blood glucose levels in patients diagnosed with pre-diabetes⁹. The Diabetes Prevention Project involving 3,234 participants with pre-diabetes showed a 58% reduction of IGT in the group undertaking 30 minutes daily moderate physical activity for 5 weeks compared with 31% in the pharmaceutical treated group. Physical activity also resulted in 5-10% reduction in body weight¹⁰.

Combination lifestyle interventions

Lifestyle interventions have been most powerful when delivered in combination¹¹. The Diabetes Prevention Project, the Finnish Diabetes Prevention Study, and the Da Qing Impaired Glucose tolerance and Diabetes Study are evidence that lifestyle changes can prevent or delay the onset of Type 2 diabetes mellitus.¹²⁻¹⁵ In the Diabetes Prevention Project people with pre-diabetes responded more favourably to lifestyle modification programs compared to people with Type 2 diabetes mellitus.⁹

The benefits of lifestyle intervention programs apply over significant periods. In one meta-analysis, people with pre-diabetes who made lifestyle changes were 40% less likely to progress to diabetes after one year, and 37% less likely to progress after three years, compared to those who did not make lifestyle changes. In another study the benefits persisted for up to 10 years.¹³

TOR 2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

Multidisciplinary care

Individuals with chronic disease experience better outcomes when they have access to primary health care provided by a multidisciplinary team, including a GP and one or more allied health practitioners¹⁶⁻¹⁹. Currently there is a limit of five services rebated annually under the MBS for allied health (including APDs), services must be delivered face to face and there is no incentive to participate in multidisciplinary case conferencing.

The limit of five services per annum in total for allied health is insufficient for allied health professionals to deliver multidisciplinary care to individuals with complex health care needs to achieve behaviour change. The pilot of the Diabetes Care Project demonstrated that greater investment in allied health resulted in better outcomes measured by mean glycated haemoglobin

levels (HbA1c), systolic blood pressure, total cholesterol, LDL, waist circumference and depression.²⁰ This is supported by Diabetes Australia evidence which identified that 10 services are needed to achieve acceptable outcomes in Type 1 diabetes.²¹ DAA considers that an increase in the number of allied health visits allowed under the MBS would improve chronic disease management.

Case conferencing

Multidisciplinary case conferencing has the potential to improve the effectiveness of health care and reduce hospital admissions²². Although GPs have incentives through Medicare items 735 - 758 to participate, they do not do so because others in the health care team cannot afford to attend a conference, which compromises the quality of patient care. An additional item for allied health professionals under the MBS as an incentive for participation in multidisciplinary case conferencing, would improve the quality of care for Australians with chronic disease.

Telehealth

People living in rural areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities.²³ They also have less access to health care.²⁴

In recognition of this the Australian Government has permitted medical specialists, general practitioners, midwives and nurse practitioners to deliver specialist video consultations without the time and expense for individuals to travel to major cities .

Dietetic services are well suited to the medium of telehealth, and there is evidence that telephone counselling by a dietitian achieves dietary behaviour change^{25,26} and improves metabolic parameters in individuals with metabolic syndrome²⁷. DAA would like to see telehealth services as an alternative to face-to-face allied health services, such as Accredited Practising Dietitians (APDs), under MBS Dietetics Item 10954 to improve access to allied health services and thus improve chronic disease management in rural and remote areas.

Maternal nutrition

The foetal origins hypothesis of obesity and non-communicable diseases risk is supported by growing evidence²⁸ of the critical influence of the perinatal environment in predisposing the foetus to future chronic disease risk. DAA would like to see more work in primary health care to manage excessive gestational weight gain²⁹ because maternal overweight and obesity have consistently been associated with a greater incidence of overweight or obese children and adolescents.²⁸

This could be facilitated by the use of clinical pathways and the provision of MBS items for lifestyle intervention, including medical nutrition therapy, for pregnant women with gestational diabetes or obesity during the prenatal period and during the early developmental years of a child. Similarly, extending access to Allied Health items under the Chronic Disease Management program to pre-diabetes based on the presence of agreed criteria has the potential to delay or prevent onset of type 2 diabetes.³⁰

Mental health

In the mental health sector, APDs are the health professionals with the skills and knowledge to provide medical nutrition therapy for individuals experiencing untoward metabolic side effects related to medication for mental illness, for example weight gain and diabetes are common in people treated for schizophrenia³¹. At present many people with mental health are unable to access the help they need with nutrition. DAA would like to see dietitians funded to work alongside psychologists, social workers and occupational therapists under the Better Access Initiative mental health items, to support early dietary interventions when medication is commenced to minimise risk of adverse metabolic consequences of medication.

TOR 3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care

Nutrition programs

Primary Health Networks have the potential to improve chronic disease outcomes through the engagement of dietitians and other allied health professionals in governance, planning, and implementation of services against assessed needs. Respondents to a DAA survey of dietitians employed in Medicare Locals in 2014 indicated that dietitians were addressing nutrition as a contributor to chronic disease prevention and management through

- Medical nutrition therapy for chronic diseases, including diabetes, cardiovascular disease, renal disease, obesity, gastrointestinal disorders, cancer, food allergy and food intolerance.
- Education and training for health professionals, community support workers, food service workers and students.
- Preventive health programs Development of clinical pathways between acute health services and community services.³²

Gaps in services

The services in Medicare Locals were particularly valued in rural and remote areas where there had been long standing gaps in service delivery.

“The work that our program carries out (chronic disease risk reduction) fills a major gap in the current health care system, especially with the significant funding cuts to public health and community nutrition and dietetics. Preventive health and early intervention for chronic disease programs are somewhat hard to come by now; and with the telephone based program, we are able to deliver cost-effective dietetic services to large geographic areas and increase accessibility of a dietetic service for remote participants where services are extremely limited. “

DAA considers that Primary Health Networks will have a vital role in filling service gaps, particularly in areas of market failure. This can be expected in rural and remote areas where there is a lack of private practitioners and where individuals cannot afford to see private practitioners where they do

exist. Unfortunately it appears that cracks in continuity of services are already appearing with one member reporting she had been made redundant.

“Interesting a very well respected Aboriginal community member’s explanation that resonated with me....., was that just when the community get use to, respect and have that rapport with people and successful programs and groups are up and running and well attended, the powers at be change things for no good reason. There will be no one in the position or run groups for a while, then something will start again, it will take another long time to get back to this level again and boom change will happen again.”

Continuum of care

DAA considers that both Primary Health Networks and State and Territory Governments have roles in supporting a continuum of health care for individuals, communities and populations, particularly where individuals and communities are not able to meet the costs of programs.

Examples of interventions for the primary health care sector, for which there is promising evidence of effectiveness and cost-effectiveness, include³³

- community-based mother’s groups promoting breastfeeding and healthy infant feeding practices
- family-focused weight management programs for 5-12 year olds and 13-18 year olds
- guidelines for weight management during pregnancy
- routine weighing and discussion of weight management at all ante-natal visits
- individual/group lifestyle interventions with high risk women during pregnancy
- brief advice on physical activity, nutrition and weight management (adults)
- moderate intensity lifestyle behaviour change programs for people with chronic disease and high risks for chronic disease (adults).

TOR 4. The role of private health insurers in chronic disease prevention and management

Saturation of private health insurance

At June 2013, 10.8 million Australians (47% of the population) had some form of private hospital cover and 12.7 million (55%) had some form of general treatment cover.³⁴ This means about half of the population have no private health insurance and either completely self fund their health care, or are reliant on Medicare. Even when individuals can claim a rebate for health services through private health insurance or Medicare, there may be significant out of pocket expenses because of the gap between fees charged and rebates. Those least able to pay for health insurance or health care treatment are most likely to be impacted by chronic disease.

Evidence based services

DAA understands that the products offered by health insurers are determined by a number of factors including actuarial considerations and consumer demand.³⁵ Concerns about the efficacy of some services led to the review of the Australian Government rebate on private health insurance for

natural therapies.³⁶ DAA suggests that private health insurers have an important role to play in primary health care by covering services for which there is a strong evidence base.

Chronic disease management programs

Chronic disease management programs aim to help patients reduce risk factors, facilitate better management and reduce associated disease risks.³⁷ Such programs include health assessments, action plans, education and health behaviour tracking, often with additional telephone support (Table 1).

DAA is aware that some health insurers offer chronic disease management programs with health coaches from various professional backgrounds, including Accredited Practising Dietitians, and that evaluation by insurers of such programs has demonstrated fewer hospital admissions for participants. Private health insurers have an important role in evaluating outcomes of programs which they fund, and disseminating the results of programs.

Table 1: Examples of Australian private health insurers with CDMPs

Private health insurers	Strategies
HBF Health Support Plan and Health Coaches ³⁸	Face-to-face visits, phone support, educational information, review of existing health conditions and services.
CBHS Health Fund Health Management Programs ³⁹	Telephone-based support, self-education, goal setting.
GMHBA Health Insurance CDMP ⁴⁰	Phone based and home based support and health advice, goal setting and monitoring, hospital admission reduction strategies

The complexity of the health system requires multiple approaches to funding of chronic disease prevention and treatment. As diet is an essential component of prevention and treatment, DAA considers that private health insurers have a role in supporting their members to access the services of Accredited Practising Dietitians on a fee for service basis or through chronic disease management programs.

TOR 5. The role of State and Territory Governments in chronic disease prevention and management

Continuum of care

State and Territory Governments have an important role in ensuring that the spectrum of health care is comprehensive. The needs of individuals and the populations should be addressed by services and programs for the prevention of chronic disease and treatment in primary to tertiary care settings. Where there are service gaps, Governments should take the lead on responses to such gaps. Where individuals are not able to pay for the health care they need to prevent or manage chronic disease, governments should ensure there are options in place to support access to services for self management and better health outcomes.

Nutrition programs

Given diet is recognized as a factor in most chronic diseases in terms of prevention and/or treatment it is important that governments at each level develop policies to implement population health and primary health care measures which go beyond reliance on programs that focus on individual behaviour change.^{41, 42} DAA would like to see more investment in this area given various States, including South Australia, Queensland and Tasmania have reduced their community and population health workforce in the last decade.

The WHO NOURISHING Framework categorises policy under three broad domains of activity (Table 2)⁴³;

- the food environment;
- the food system; and
- behaviour-change communication.

The WHO recommends healthy eating policies and strategies that focus on breastfeeding; food and beverage marketing; food production, supply and retail; food provision within institutions; pricing and agricultural incentives; public information campaigns; supportive healthy eating environments; and nutrition labelling for pre-packaged foods.⁴⁴

Examples of primary health care activities in behaviour change communication in the Australian context for which there is evidence of effectiveness and cost-effectiveness are given in Table 3.

Table 2: The NOURISHING Framework⁴³

Domain		Policy area	Examples of potential policy actions
Food environment	N	Nutrition label standards and regulations on the use of claims and implied claims on foods	eg, nutrient lists on food packages; clearly visible “interpretive” and calorie labels; menu, shelf labels; rules on nutrient and health claims
	O	Offer healthy foods and set standards in public institutions and other specific settings	eg, fruit and vegetable programmes; standards in education, work, health facilities; award schemes; choice architecture
	U	Use economic tools to address food affordability and purchase incentives	eg, targeted subsidies; price promotions at point of sale; unit pricing; health-related food taxes
	R	Restrict food advertising and other forms of commercial promotion	eg, restrict advertising to children that promotes unhealthy diets in all forms of media; sales promotions; packaging; sponsorship
	I	Improve the nutritional quality of the whole food supply	eg, reformulation to reduce salt and fats; elimination of trans fats; reduce energy density of processed foods; portion size limits
	S	Set incentives and rules to create a healthy retail and food service environment	eg, incentives for shops to locate in underserved areas; planning restrictions on food outlets; in-store promotions
Food system	H	Harness the food supply chain and actions across sectors to ensure coherence with health	eg, supply-chain incentives for production; public procurement through “short” chains; health-in-all policies; governance structures for multi-sectoral engagement
Behaviour-change communication	I	Inform people about food and nutrition through public awareness	eg, education about food-based dietary guidelines, mass media, social marketing; community and public information campaigns
	N	Nutrition advice and counselling in health-care settings	eg, nutrition advice for at-risk individuals; telephone advice and support; clinical guidelines for health professionals on effective interventions for nutrition
	G	Give nutrition education and skills	eg, nutrition, cooking/food production skills on education curricula; workplace health schemes; health literacy programmes

Table 3: Examples of nutrition programs addressing chronic disease

Strategies	Examples
Food environment changes	
Front of pack interpretative food labelling (mandatory)	Australian Health Star Rating system (voluntary) ⁴⁵
Fast food menu and energy (kJ) labelling	NSW Fast Food Initiative ⁴⁶
Targeted subsidies and health-related food taxes	Taxation on sugar-sweetened beverages ⁴⁷
Restricted advertising to children that promotes unhealthy food and drinks in media, promotions and sponsorship	Australian Obesity Policy Coalition "A comprehensive approach to protecting children from unhealthy food advertising & promotion" ⁴⁸
Government regulatory policies supporting a healthier composition of staple foods (reformulation)	Australian Food and Health Dialogue voluntary reformulation program ⁴⁹
Restrictions on fast food outlet density in the vicinity of schools, parks or services for young people	UK Health Prevention First Forum – Healthy Places ⁵⁰
Healthy choices and set standards in food provision for public institutions, schools and workplaces	Victoria's School Canteens and Other School Food Services Policy ⁵¹
Pricing strategies, prompts and promotions at point-of-purchase, and store layout redesign to support healthier choices	Combination of shelf labels, promotion or price reductions ⁵²
Food system changes	
A dynamic multi-sectoral approach	Australian Healthy Together Victoria initiative ⁵³
Health-in-all policies approach	SA 'Healthy Weight Project' ⁵⁴ ; ACT 'Towards Zero Growth Healthy Weight Action Plan' ⁵⁵ ; NSW 'Healthy Eating and Active Living Strategy' ⁵⁶
Behaviour-change communication	
Social marketing campaigns	"Live Lighter" in WA, ACT and Victoria ⁵⁷
Communication about healthy lunchboxes, reducing intakes of energy-dense nutrient poor foods/drinks at and away from home, promoting family meal times	Australian Dietary Guidelines ⁵⁸ & Infant Feeding Guidelines ⁵⁹ ; "Get Up & Grow" ⁶⁰
Nutrition, cooking and food preparation skills	Stephanie Alexander Kitchen Garden Program ⁶¹ (8–12year old school children); Back to Basics Cooking Club & Healthy Lifestyle Program ^{62,63} (primary school children), The Healthy Dads, Healthy Kids Program ^{64,66} , Jamie Oliver Ministry of Food ⁶⁷ (adults)
Telephone and web-based lifestyle behaviour change programs.	Get Healthy Information and Coaching Service ^{68,69} in SA, NSW & QLD, Health Navigator in Wheatbelt and Great Southern regions of WA ⁷⁰
Culturally appropriate healthy lifestyle/weight management programs	PEACH (Parenting, Eating and Activity for Child Health) ⁷¹ in SA & QLD
Access to information and support to promote breastfeeding and healthy infant feeding practices	Australian National Breastfeeding Strategy (2010-2015) ⁷²

TOR 6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management

Models built on needs assessments

The models which are implemented for chronic disease prevention and management should be based on needs assessments of care recipients, and knowledge of barriers and enablers to implementation of models of care.

Fee for service model

At present the fee for service model does not meet the complex needs of people with chronic disease, particularly those who have a number of co-morbidities. The Medicare Chronic Disease Items for allied health are insufficient to provide adequate care for the least complex clients, let alone those with greater complexity. The Diabetes Care Project was innovative in making available more allied health visits for trial participants and demonstrated that greater investment for lower and higher complexity cases resulted in better outcomes. This experience suggests that the fee for service model could work, if increased allied health visits were allowed under Medicare Chronic Disease Items and if case conferencing arrangements were extended to allied health.

Capitation model

A capitation model where people with chronic disease sign up for a package of care has the potential to work, provided funding of the package allows for team conferencing and sufficient time with all relevant allied health practitioners. Also, this model needs to ensure that care recipients with complex high level needs can access allied health practitioners with the requisite advanced practice skills and knowledge for specific cases.

Technology will enhance models of care

Some government health agencies have been using telehealth in their models of care for some time. DAA recognises the potential for telehealth to deliver health services to people residing in less populated areas where there is a lack of practitioners such as Accredited Practising Dietitians. For rural communities, telehealth can overcome geographical barriers and weather concerns, improve access to health care professionals and services, provide access to education and ongoing monitoring, and reduce stress, travel time and expenses. It can also reduce time away from support networks, and loss of income⁷³.

The Department of Health in Western Australia has implemented Health Navigator as a free multidisciplinary service which supports people living the Wheatbelt and Great Southern regions to manage their chronic conditions. It is available for those with diabetes, heart disease, heart failure, and long term lung conditions such as chronic obstructive pulmonary disease (COPD). Support is provided over the phone, and includes the development of a 'My Plan' with steps, information and advice to achieve health improvement⁷⁴. Evaluation of the program has demonstrated cost savings.

Unfortunately recent Australian Governments have not wished to invest in allied health services to achieve better outcomes for people with chronic disease by allowing telehealth consultations under Medicare Chronic Disease items because it might drive demand in the short term, and drive up

costs. This is despite the evidence from Australia and other countries e.g. Canada and The Ontario Telemedicine Network (OTN). In 2012/13 the use of the OTN saved the government an estimated \$60million, and saved patients 238 million kilometres of travel.⁷⁵

Addressing access issues

Workforce shortages in some areas, particularly in rural and remote regions have prompted various proposals for health practitioners to take on other practitioners roles. DAA would like to see more innovative approaches to recruitment and maintenance of staff in rural and remote regions, and opportunities for allied health professionals to maximise their scope of practice when contributing to multidisciplinary care. Operating outside of the scope of practice presents various risks which must be managed carefully both for client safety and health system efficiency.

TOR 7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals;

Better outcomes

Individuals with chronic disease experience better outcomes when they have access to primary health care provided by a multidisciplinary team, including a GP and one or more allied health practitioners.^{76,77}

Clinical healthcare pathways

Having well defined clinical healthcare pathways is helpful in linking primary health care and acute care.

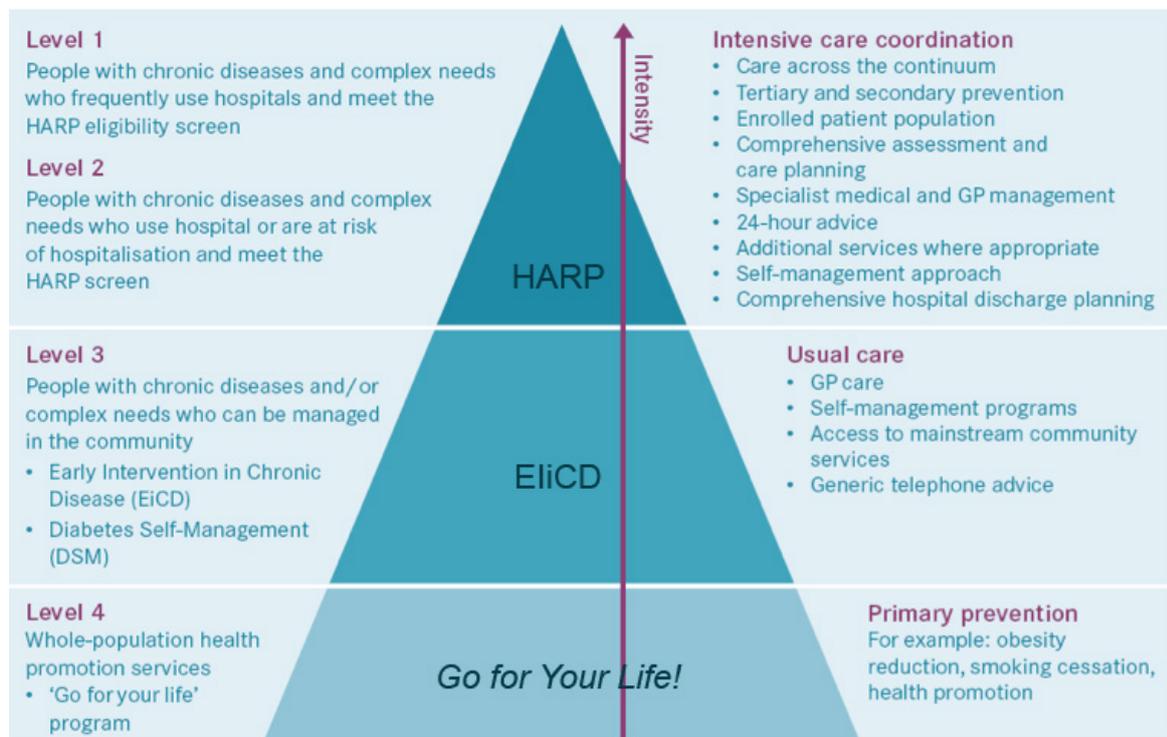
Coordinated care

DAA considers that best practice is characterised by an model of care which incorporate multidisciplinary, community based, integrated primary-secondary care.⁷⁸ In Victoria, the Hospital Admission Risk Program (HARP) provides specialised client-centred medical and allied health care and care coordination in the community and ambulatory setting through an integrated response of hospital and community services.⁷⁹ The project was formally evaluated in 2004-05, and in that 12 month period, HARP clients' experienced.⁸⁰

- 35% fewer emergency department attendances;
- 52% fewer emergency admissions; and
- 41% fewer days in hospital.

The service delivery model used is based on the Kaiser Permanente Chronic Care framework (see Figure 2 below) and the Wagner Chronic Care Model.

Figure 2: Kaiser Permanente Pyramid⁸⁰



TOR 8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

Invest early

DAA considers investment in less complex users of medical and health services is necessary to delay or prevent the progression of chronic disease. The literature suggests that in order to effectively manage chronic diseases, the following components must be considered⁸¹

- Collaboration
- Personalised care plans
- Self-management education
- Adherence to treatment
- Follow-up and monitoring.

The literature also suggests that programs which are successful improving the self-management of participants have targeting, goal setting and planning.⁸¹

Support less complex and high end users

The Diabetes Care Trial included testing of five new care components alongside the current models of care at the time²⁰

- An integrated information platform for general practitioners, allied health professionals and patients.
- Continuous quality improvement processes informed by data-driven feedback.
- Flexible funding, allocated based on patient risk stratification.
- Quality improvement support payments linked with a range of patient population outcomes.
- Funding for care facilitation, provided by dedicated Care Facilitators.

The intervention group received all five components, while the control group received the first two only. Over the 18 month trial period, less complex and high end users in the intervention group showed significant improvements in HbA1c, blood pressure, blood lipids, waist circumference, depression, and diabetes-related stress. Also, high cost items assigned to the MBS, PBS, NDSS and hospital costs were reduced.²⁰

Similar results were seen in the LOADD project which demonstrated a reduction in the cost of medications with greater utilisation of dietitians. With new and emerging medications used for Type 2 diabetes, medication costs will rise further and dietitians have a role in helping to control this cost.⁸²

Another Australian model, Health Navigator triages clients with chronic disease into level 1, 2 and 3. Level 3 clients are deemed to have low health service needs, low risk of disease progression and sufficient self management skills whereas level 1 clients have high health service needs, high risk disease progression and limited self management ability.

DAA would like to see models of care which adequately fund allied health services to support self management by both less complex and high end users.

Self management

Qualified and credentialed allied health practitioners, including APDs, have an important role in working with individuals to self manage chronic disease. One approach which has been widely used is the Flinders Program, a chronic care philosophy and tool set containing an assessment, planning and motivational process which applies to chronic medical or mental conditions and co-morbidities⁸³. The program has been applied in Australia, New Zealand, USA, Canada, Hong Kong, Scotland and Sweden and to population groups such as Aboriginal and Torres Strait Islanders, children, mental health, disability and rural and remote⁸³. A pilot study with an Aboriginal population showed an approach of targeted self-management support and goal setting, led to significant improvements in self-management behaviour, and clinical measures such as HbA1c.⁸⁴

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About the Dietitians Association of Australia

- The Dietitians Association of Australia (DAA) is the leading body for nutrition professionals. DAA has been the national association of the dietetic profession since 1976.
- DAA has over 5800 members constituting approximately 80 percent of the dietetic workforce in Australia.
- DAA has accredited training courses for dietitians in Australian universities since 1984.
- Prior to 1999 DAA advised the Australian Government about recognition of dietitians trained overseas. Since that time DAA has been specified as the assessing authority for the recognition of the education and skills of overseas trained dietitians. DAA has achieved mutual recognition with New Zealand and Canada.
- The interests of dietitians are broad and derive from training in three dominant areas of dietetic and nutrition practice i.e. individual case management of medical nutrition therapy (clinical care), community and public health nutrition, and food service management.
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About Accredited Practising Dietitians

- The Accredited Practising Dietitian (APD) program is the foundation of DAA as a self regulated profession with 98 percent of eligible members participating in the program.
- The APD credential is recognised by Medicare, the Department of Veterans Affairs, private health funds and for access to the Healthcare Identifiers Service.
- The APD program recognises the continuum of professional development and career progression of dietitians through the credentials of Provisional APD, APD, Advanced APD and Fellow.
- APDs apply their skills and knowledge of nutrition and dietetics in diverse settings including hospitals, private practice, public health, community health, aged care, disability, food service, food industry, research and teaching.