

Re: Stakeholder feedback on Application 1385: Shared Medical Appointments for Type 2 Diabetes Management

To Whom It May Concern:

Thank you for the opportunity to submit feedback regarding the proposal on Shared Medical Appointments (SMAs) for Type 2 Diabetes (T2DM) management. As industry stakeholders, Exercise & Sports Science Australia (ESSA), Dietitians Association of Australia (DAA) and Australian Diabetes Educators Association (ADEA) have collaborated to present several issues of concern regarding this SMA proposal. Collectively, ESSA represents 4,734 members (including Accredited Exercise Physiologists - AEPs), DAA represents over 5,800 members (Accredited Practising Dietitians - APDs) and ADEA represents 2,000 members (Credentialled Diabetes Educators - CDEs).

The proposed SMA model does not currently reflect best practice service delivery, requiring several modifications to ensure optimised patient health outcomes and more efficient use of government resources. Whilst we do acknowledge that a SMA model has some merit, we strongly discourage replacement of existing T2DM group allied health services (Comparator 2) with SMA, rather, SMA could serve as an adjunct to these existing MBS item codes.

The proposed model may have some benefits for people with pre-diabetes but we suggest caution here also. People with pre-diabetes require good evidence based lifestyle intervention to prevent conversion to T2DM. The proposed SMA model does not demonstrate how this education based intervention will be delivered.

There appears to be confusion in the proposed model about the purpose of group education and the need to reduce Medicare costs for visits to General Practitioners (GPs) resulting in a hybrid model that may not achieve either objective. This will undoubtedly result in higher costs and poorer outcomes for people with T2 diabetes. Please refer to our specific concerns documented below.

- **Lack of relevant and high quality research supporting SMA implementation.**

As highlighted by the authors, the research and evidence base for SMAs in Australia is very limited, for example, *“No Australian trials were identified but an initial trial of patient and provider satisfaction has been completed [2]...”*(p.25), and, *“Outside of this research setting, SMA are currently not being widely used in Australia”* (p.5). Due to the limited evidence base, further research is required to determine if this health care model can be applied successfully within the Australian health care setting.

Most of the presented research within this proposal has no comparator of an Australian model, only demonstrating the benefits for GPs and neglecting impacts on allied health professionals (AHPs). For example, Australia is the only country that formally recognises the professional title of an AEP and inclusion within the medical model.

One of the cited research studies (Binns, 2014), outlined that *“the process should be trialled and evaluated in Australia before introduction”* and *“Cost-benefit analyses should be carried out to justify item payments”*. Evidently, widespread implementation of this model (through allocation of a MBS item code) would be premature and may not be effectively embraced by the health sector and Australian public, becoming a costly and ineffective treatment model.

- **Superiority of this model over other Comparators cannot be substantiated.**

The deficiency of specific Australian research on SMAs highlights that claims regarding superiority of the SMA model to other Comparators is not supported by evidence and cannot be entirely substantiated. For example, authors claimed that *“Studies from overseas suggest that SMAs have superior efficacy and lower costs than the comparators”* (p.22), however, the studies cited (23,30-33) compared the effects of a group intervention with traditional one-to-one care. **Therefore, this provides evidence of group session superiority against Comparator 1, but not Comparator 2.**

Furthermore, many of the proposed benefits (physiological, social support, integrated care and self-management) have been drawn from studies comparing the effects of group services versus conventional one-to-one medical appointments, **highlighting the benefits of group sessions, but not necessarily using the SMA model.** For example, authors state on p.23, *“Based on this literature, it is expected that implementation of SMAs will lead to improved self-management of T2DM through;*

- 1) *improved patient education;*
- 2) *increased peer support from fellow sufferers;*
- 3) *improved integration between GPs, nursing staff, and allied health;*
- 4) *reduced number of standard visits per annum;*
- 5) *appropriate management through pharmacotherapy; and*
- 6) *reduced costs to the health system of ~20-30%.”*

Proposed points 1, 2, 3 and 5, are currently being achieved by the existing group allied health services MBS items (81100 to 81125), supported by a substantial body of evidence identifying the benefits of group sessions administered by AHPs. In addition, a recent Deloitte Access Economics report (Pezzullo, 2014) clearly demonstrates that good quality education reduces the number of GP visits.

- **SMAs do not serve as a replacement for the specialised allied health advice required by this patient population.**

We acknowledge that SMAs warrant some merit in certain contexts which may include medical assessment, but strongly discourage replacement of existing T2DM group services (Comparator 2) with SMA for specific educational requirements. SMAs would be an effective adjunct intervention for this patient cohort, if structured properly and the content of the sessions were clearly articulated, but should not be a replacement for the valuable and specialised education provided by AHPs (AEPs, CDEs, APDs). It is important to recognise that not all patients are suited to this style of intervention.

The existing group allied health services enable the provision of specific and individualised advice by qualified AHPs to patients with T2DM. Simply relying on SMAs will neglect this level of intervention as GPs and practice nurses are generally not skilled nor confident to provide this specialised education. This is supported by the 2015 RACGP SNAP guidelines

which advocate for patient referral to expert allied health interventions.

Interventions must account for the frequent presence of comorbidities in this patient population, whereby 75% of adults with diabetes have at least one comorbid chronic disease (Druss, 2001) and up to 40% have at least three (Wolff 2002, Maddigan 2005). The subsequent increased clinical complexity associated with comorbid conditions is unlikely to be effectively accounted for through provision of generic lifestyle advice (as provided by a GP or Practice Nurse). For example, some GPs are able to give general exercise advice (i.e. “do more walking”) but the majority do not have the skills, training and confidence to design programs for those who have specific needs.

The authors purport no safety concerns nor evidence of a risk assessment with this SMA model, however, without the specialised input of AHPs, patients are exposed to increased risk of adverse outcomes due to inappropriate and/or lack of specific medical nutrition therapy, exercise prescription and diabetes self-care education that meet their needs, risk factors and comorbidities. Furthermore, this gap will reduce the likelihood of successful interventions, reducing patient motivation and compliance and increasing financial costs to the government and medical practices as identified in the Deloitte Access Economic report (Pezzullo, 2014). This also exposes potential medico-legal responsibility implications as RACGP guidelines advise GPs to refer to an appropriate AHP with the skills and training to provide specialised and individualised intervention.

This SMA model emphasises measurement taking, general education and discussion within the consultation, removing focus on intervention time. General advice and education within a group setting cannot replace actual intervention and specific education on an individual basis. The provision of generic advice and recommendations will not yield the successful results that are currently identified through the provision of group allied health services. For example, several barriers have been identified as restricting the uptake of physical activity behaviour change in primary health care, including, lack of specific knowledge and skills necessary to assess and prescribe physical activity behaviour change, time limitations, lack of confidence in skills necessary to support physical activity interventions, and lack of patient interest (Briffa 2006, RACGP 2009, Jansink 2009, Hetteema 2005). Further, evidence demonstrates generic nutrition advice is less effective than the provision of medical nutrition therapy in diabetes outcomes (Franz, 1995) and a multidisciplinary diabetes program provided by an Endocrinologist, a CDE and other AHPs achieved improvements in glycaemic control and quality of life at 12 months in people with T2DM (Rasekaba, 2012).

This SMA model does not provide evidence that quality education will be a focus of the SMA or who might deliver it. Quality education would meet many of the needs of the people who might attend and SMA and it is unclear how an AHP will deliver quality education in the model as proposed given that the model funds a facilitator to take vital signs, bloods as required and record the session. Nor does the model support a quality educational environment as there is no real educational structure proposed. Quality diabetes education has been found to improve patient outcomes and reduce costs to the health system (Pezzullo, 2014).

- **Practice nurses cannot ‘replace’ AHP: mandatory inclusion of AHP is required.**

The model proposed includes “a GP and at least a trained Facilitator (practice nurse or other allied health)” (p.13). Given that ~60% of general practices employ a practice nurse, it can be reasonably expected that most medical practices would **not** seek input from AHPs as a ‘Facilitator’. Also, this would reduce the fee payable to the medical practice as the AHP would be taking a portion of the MBS fee payable.

Registered nurses “do not provide care ‘for and on behalf of’ any other health care professional” (Australian Practice Nurse Association, 2014). As stated by APNA, “Chronic disease management (CDM) is a core component of the nurse’s role in general practice. This role may incorporate: health promotion, identifying patients with risk factors for chronic disease, planning, coordinating and implementing systems to organise care, care planning/coordination, patient education and self-management support”. Evidently, whilst registered nurses certainly have an important role to play within CDM, they are not able to provide the specialised intervention and advice which can be delivered by AHPs (including that provided by CDE registered nurses, unless the practice nurse is also a CDE) to influence lifestyle change and improve diabetes outcomes. Additionally, “access to, and care delivery by different healthcare providers allows the patient to benefit from a broad perspective on their health and wellbeing” (RACGP guidelines on T2DM, 2014). Therefore, if a supplementary model of care were to be introduced, we propose that an appropriate AHP (AEP, APD and/or CDE) lead/facilitate the group with GP participation for medical input.

- **Better integration and coordination of services, including access to AHP**

Current evidence suggests that multidisciplinary and integrated care teams are best practice in the management of T2DM, preventing and decreasing the impact of complications and comorbidities, resulting in health care cost savings (Hollern 2011, Diabetes UK 2010). The risk of SMAs is that all diabetes care may be perceived to have been provided during the SMA appointment and multidisciplinary integrated health care will be missed, particularly if the SMA is facilitated by the primary health network without any AHP involvement.

If SMAs are implemented, there should be a pathway facilitating the direct referral of a patient to an AHP (within their scope of practice) for the delivery of CDM and T2DM group allied health service items, removing the need for a patient to return to a one-to-one GP appointment for referral. This proposal does not currently facilitate direct referral of patients to AHPs, creating an inefficient and costly process for Medicare and consumers, delaying patient access to treatment, increasing GP administrative burden, and is not practised in the private health sector.

- **Potential barriers to physician and patient support and participation.**

Physicians:

Litigation cases and accusations related to health care service delivery have increased dramatically in recent years, whereby the documentation of clinical notes play an important role during any audit or investigation into the provision of medical advice or care. The authors propose that “The documenter or Facilitator will detail medical records in real time” (p.7). We anticipate that the significant cultural shift required from GPs (sharing the responsibility of clinical note taking with a third party) may preclude successful implementation of SMAs. This will require GPs to release control and share the

responsibility of clinical note taking, or, increase duplication and administrative burden due to GPs 'checking' the patient notes recorded.

Additionally, the capacity for many AHPs to undertake clinical documentation effectively on behalf of a GP is limited due to restricted medical knowledge (beyond professional scope of practice) and given the group size (8-12 patients), rendering this an ineffective and time consuming process.

We anticipate the need for considerable time and effort invested into driving substantial cultural and professional practice changes amongst GPs to support the uptake and successful implementation of SMAs. Considerations such as, the willingness and readiness of GPs to offer their services in front of an audience and openly sharing medical information must also be accounted for.

Patients:

Authors purport that a signed confidentiality agreement will overcome issues of sharing medical information. However, this needs to be extended to the signing of an informed consent so that patients are aware of the potential risks (and mitigation strategies) to sharing medical information. Regardless, the question remains as to whether most people will truly feel comfortable and trusting to openly participate and share their medical information in SMAs. Current group allied health sessions leverage off group dynamics to facilitate social support and self-management of participants, without the need for such explicit sharing of personal information (e.g. blood glucose readings). Authors propose that the SMA model provides medical input currently lacking in the AHP group session, but sharing medical information within these sessions will completely alter the group dynamic.

We are aware of the many patient, health provider and organisational difficulties and implications resulting from patients failing to attend scheduled medical appointments. Continued investment of time, effort and resources is needed to attract and retain patients within a group intervention. Therefore, if the patient is the subject of the discussion, this may further increase likelihood of 'no show' and difficulties experienced with group dynamics and business operations. Many patients may perceive a 90-120 minute group session as time consuming, inconvenient and cost prohibitive. Particularly given that *"Patients who require more specific or personalised attention can then be advised to come back for a personalised assessment outside the SMA if necessary"* (p7).

The proposal identifies patients with low levels of health literacy, including the aged, migrant groups, the Indigenous and lower socioeconomic groups as likely participants in SMAs. Justification should be provided as to why this model would be a more successful intervention for these patients, as no evidence is presented in the proposed model. Through our experiences in administering health services to indigenous populations, cultural issues render delivery of group interventions highly challenging and problematic. Group interventions (particularly administered by 'outsiders' or professionals not embedded within the local community) often pose an intimidating and anxiety-provoking environment for this population, prompting non-involvement or patient 'no shows'. This population generally needs individualised care and attention due to the aforementioned reasons and the typical poor health literacy of this cohort. Individual requirements for diabetes tend to become

more unique as people age, which again requires greater individual attention by health practitioners.

- **Considerations and operational logistics for AHPs have been neglected.**

We are concerned about the open-ended and loosely termed reference to AHPs. Only select AHPs are equipped with the appropriate knowledge and skills to contribute effectively within this type of patient intervention.

A workforce already exists (consisting of AEPs, APDs and CDEs) to deliver group allied health services to patients with T2DM. Whilst these aforementioned professionals may undertake and coordinate many of the tasks this model is proposing - it is not clear how they will be utilised in this model or remunerated, for example, *“The proposed item fee cannot be designated for payment of AHPs, if these are used as the Group Facilitator”* (p.14).

Authors recommend ‘Facilitator training’ to ensure successful management and facilitation of group sessions. Given the relevant skills of AHPs (particularly AEPs, APDs and CDEs) in promoting patient self-management and behavioural change, and experience in the delivery of group services, we do not support the need for Facilitator training to be completed by these three AHPs. Exemptions on required training for other AHPs (dependent on their relevant skills and experience) must also be considered. There may also be a need for ongoing certification for facilitators to remain up to date and continue to provide a service of relevance to this patient groups in this setting. This has not been addressed by the paper.

- **Support for extending interventions to include patients with pre-diabetes.**

Australia is facing a health crisis, where 3.3 million Australians are expected to have T2DM by 2031 (Speight, 2011) and health expenditure for T2DM is projected to increase by 520% between 2003-2033 (Lee, 2013). Current eligibility criteria for the ‘Medicare Allied Health Group Services for T2DM’ require disease diagnosis. However, by this stage individuals are reliant on pharmaceutical intervention and often have associated comorbidities.

Over 1 million Australians have pre-diabetes, with a 5-10% annual incidence of developing T2DM compared to ~1% in the general population (Gerstein, 2007). Lifestyle interventions are largely effective in preventing progression of pre-diabetes to T2DM and reducing associated comorbidities and risk factors (Dunstan 2001, Huang 2014, Parker 2014). We support the expansion of the eligibility criteria for MBS items 81100 to 81125 to allow access for people diagnosed with pre-diabetes and help slow and prevent the progression to T2DM. Our associations have previously advocated this position as part of a 2015 federal government pre-budget submission and the National Diabetes Strategy Advisory group consultation (Appendix 1), this model should be considered in lieu of the proposed SMAs.

- **Application and implementation of findings from previously funded trials.**

We seek clarification on the Diabetes Care Project (DCP) and MBS support of the findings identified in this research. We are aware that the DCP was trialling other models of primary care with potential for directing the allocation of MBS funding for patients with T2DM. We view that allocating additional funding (MBS item number allocation to SMAs) to a separate project is not capitalising off previous government financial investment into this area, and could be perceived as inefficient and wasteful by the Australian community.

- **Anticipated logistical difficulties.**

We foresee several logistical challenges that may prohibit the successful implementation of SMAs in the context of group diabetes interventions, including:

- achieving multidisciplinary participation and coordination (with the typically restricted availability and time limitations of GPs) may be frustrating and difficult for all parties.
- coordinating the availability and funding for facilities to accommodate the group.
- It is unclear how funding will be allocated in the event of patient ‘no shows’ and divided between practitioners to ensure fair reimbursement for AHP involvement.

- **Proposed cost savings attributed to SMAs.**

Authors propose significant cost-savings attributed to SMAs, however there is a lack of data to support this claim. Potential challenges with this model (outlined herein) such as patient non-compliance, limited GP support, logistical/operational barriers and reduced intervention effectiveness (i.e. general discussions dominating consultation time as opposed to specific intervention/advice) may exacerbate costs in the long term.

- **This SMA model lacks structure, promoting inefficiencies.**

Authors propose that individuals may attend any session within a given 12month period. This poses administrative tracking difficulties to ensure that appropriate advice is provided which is sequential, systematic and builds upon previous recommendations, avoiding duplication of recommendations. The RACGP recommend that patients with T2DM “receive structured care programs that are easy to implement, are well supported and meet the needs of the individual”. Further, “whatever the composition of the team, care needs to be organised and delivered systematically” (RACGP, 2014-15).

Summary point

ESSA, DAA and ADEA welcome ongoing consultation to ensure the delivery of the most effective services that achieve the best health outcomes for Australians with pre diabetes and T2DM. Please contact Katie.lyndon@essa.org.au for further information.

Kind Regards,



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Exercise & Sports Science Australia (ESSA) is a professional organisation which is committed to establishing, promoting and defending the career paths of university trained exercise and sports science practitioners. ESSA's vision is to achieve member excellence in exercise and sports science that will enrich the health and performance of every Australian. As the peak professional body for exercise and sports science in Australia, ESSA's mission is to empower our members by providing strategic leadership in exercise and sports science through advocacy, support of professional networks and the promotion of excellence in education, research and professional practice.

Accredited Exercise Physiologist (AEP)

AEPs are federally recognised allied health professionals that specialise in clinical exercise interventions for patients with existing chronic and complex medical conditions or injuries, or those at high-risk of developing these. These interventions are provided by exercise delivery including health and physical activity education, advice and support, and lifestyle modification with a strong focus on achieving behaviour change with the aim of optimising physical function, health and wellness. As part of a multidisciplinary team, AEPs work with clients with a range of medical conditions including cancer, diabetes, cardiovascular disease, mental illness, pulmonary disease, osteoarthritis and obesity.



Dietitians Association of Australia (DAA) www.daa.asn.au

DAA is the national association of the dietetic profession with over 5800 members. The interests of dietitians are broad and derive from training in three dominant areas of practice i.e. individual case management (clinical care), community and public health nutrition, and food service management. Dietitians work in diverse settings including hospitals, private practice, public health, community health, food service, food industry, research and teaching.

Accredited Practising Dietitian (APD)

The APD program is the foundation of DAA as a self-regulated profession. The APD credential is recognised by Medicare, the Department of Veterans Affairs, private health funds and for access to the Healthcare Identifiers Service.



Australian Diabetes Educators Association (ADEA) www.adea.com.au

ADEA has become the leading organisation for healthcare professionals with a special interest in diabetes education. ADEA's mission is to lead and advocate for best practice

diabetes education and care. The ADEA is committed to support its members' efforts to provide evidenced – based best practice diabetes education and care to people with or at risk of diabetes, their carers and families.

ADEA has a strong focus on:

- Actively promoting evidence-based diabetes education to ensure optimal health and wellbeing for those affected by, or at risk of diabetes
- Setting standards and developing guidelines for the practice of diabetes education
- Offering professional development programs and accrediting those developed by other organisations.

Credentialed Diabetes Educators (CDE)

Credentialed Diabetes Educators (CDEs) are qualified to provide a client-centred approach to diabetes education and care, empower patients and assist them in dealing with daily self-management. A CDE supports people with diabetes and their carers, communities and populations at risk of, or affected by diabetes to achieve their maximum health potential. They integrate diabetes self-management education with clinical care as part of a therapeutic intervention to promote physical, social and psychological wellbeing.

CDEs are health professionals qualified to practise in a range of health disciplines including nursing, dietetics, podiatry, pharmacy, medicine, exercise physiology and physiotherapy. An ADEA CDE is a full member of the ADEA, has completed an ADEA accredited post-graduate diabetes education university course and a period of supervised clinical practice and activities that fulfil the continuing education and professional development requirements of the ADEA Credentialing Program.

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