Redesigning the Practice Incentives Program

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The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 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 Redesigning the Practice Incentives Program by the Australian Government Department of Health.

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DAA interest in this consultation

The Dietitians Association of Australia (DAA) recognises that General Practitioners (GPs) have an important role in supporting high quality holistic healthcare relevant to the needs of patients delivered in collaboration with other health professionals.

The Accredited Practising Dietitian (APD) credential administered by DAA is the basis of self-regulation of the dietetic profession. APDs work with GPs in multidisciplinary teams by providing medical nutrition therapy to improve the health and wellbeing of patients.

Data to drive improvement

DAA supports the principle that quality improvement processes use data to drive continual improvements in care provided, especially given the consultation report says

- ANAO found there is insufficient data to assess the effectiveness of the PIP
- Lack of data on outcomes of care from PIP places Australia in a position that is below other comparable countries.

Better data collection by GPs relevant to the needs of patients and the community as a whole could be rewarded, whether collected by GPs or by practice staff who operate within their scope of practice with training and supervision.

Refreshed PIP could be more relevant to allied health

Holistic healthcare requires the involvement of GPs and allied health practitioners.

- PIP could reward GP practices which connect with allied health practitioners and which collect data to measure this connection.
- DAA considers some practice improvement incentives for GPs are equally relevant to allied health i.e. rural loading, teaching payment, eHealth inventive, and diabetes. However allied health do not have access to these incentives. Allied health practitioners such as APDs face the same barriers to providing services in rural areas, and implementing technology for efficiency and better service delivery and so should be supported more to work with GPs and pharmacists in various care settings.

Quality

DAA suggests that PIP be a payment for demonstration of good universal practice in relation to key quality measures related to chronic disease prevention and management. This would include

- The use of a clinical audit tool (such as Canning Tool or PEN Clinical Audit Tool) potentially provided by PHN.
- Creation of a practice register of patients who are being managed for their chronic disease.
- Demonstrated use of recall systems for preventative health checks (in line with Royal Australian College of General Practitioners (RACGP Guidelines for preventive activities in general practice 8th edition, also known as 'the red book') recommended checks and screening across the lifetime continuum) and chronic disease management cycle of care.
- Monitoring of processes and demonstration of ongoing quality improvement activities to improve and enhance systems.
- Consideration should be given to reviewing the RACGP Accreditation Standards for General Practice to include targets for the capture of risk factor and chronic disease data such as blood pressure, height, weight etc. The RACGP red book could be used to guide the development of these criterion. The Quality Improvement PIP payment could trigger upon successfully passing accreditation.
- Collaboration with allied health practitioners would identify other areas which impact on health and wellbeing of patients. Malnutrition is one such example, where the prevalence in older Australians in the community has been estimated at 5 – 38% (1-3). GPs have an important role in screening for malnutrition and connecting patients to APDs and other services to facilitate wellness and reablement because an inability to prepare food and consume adequate nutrition is recognised as an accelerator to older people entering residential aged care. Consequently essential data fields for patients over 65 years of age could include unplanned weight loss, appetite changes, reduced oral intake and difficulty swallowing.
- Current PIPs are paid via MBS items. If all practices were using a clinical audit tool (has been provided free of charge by many Medicare Locals to general practices) this tool could be used to accurately review quality improvement. This could also allow for more accurate reporting against existing Criterion (i.e. 1.7.2).

Proposed options

DAA does not support Option 2 described in the consultation paper on page 15. This adds a layer of bureaucracy which does not add value and draws resources away from direct patient care.

Option 1 has greater potential., especially the ability to aggregate data at a national level. This would be very useful to drive PHN community needs assessment and planning.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander needs should be considered by involvement of Aboriginal Medical Services and other relevant bodies. Nutrition is a key factor in the physical and mental health of Aboriginal people and access to services should be monitored to inform service improvement.

References

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