MBS Review – Report from the Allied Health Reference Group

June 2019

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 7000 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 communities. DAA appreciates the opportunity to respond to the *Report from the Allied Health Reference Group* as part of the Medicare Benefit Schedule Taskforce Review.

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DAA interest in this review

As the peak body for the dietetic profession, the Dietitians Association of Australia (DAA) has an interest in the health and wellbeing of all Australians. DAA recognise the significant burden that chronic disease has in Australia and that current programs are not fit for purpose as they are not effectively addressing the need across the community. Ensuring adequate access to evidence-based, allied health interventions under the Medicare Benefits Schedule (MBS) will help reduce the burden of chronic disease across Australia and improve the health and quality of life of individuals. DAA welcomes the review and recommendations from the Allied Health Reference Group and acknowledges the need to improve the allied health MBS items that are under review.

The Accredited Practising Dietitian program administered by DAA is the platform for self-regulation of the dietetic profession and provides an assurance of quality and safety to the public. Accredited Practising Dietitians are food and nutrition experts who translate the science of nutrition into practical solutions for healthy living. Accredited Practising Dietitians have an important role in providing medical nutrition therapy to those with chronic conditions. The number of services provided by Accredited Practising Dietitians under the MBS has increased from 124,111 in 2007/8 financial year to 445,193 in the 2017/18 financial year.

Key Messages

DAA welcomes the recommendation to provide a longer item for the initial assessment to improve quality of care. DAA recommend that appropriately remunerated long consultations should also be available for reviews. This is particularly pertinent for dietetics where the consultations are of a counselling nature.

DAA supports the recommendation to provide additional allied health sessions annually for people with complex and chronic needs.

DAA recognises the value group therapy can have in a range of conditions and support the recommendation to expand group therapy items beyond Type 2 Diabetes Mellitus. DAA however recommend that additional financial strategies be implemented to ensure viability of group therapy.

Dietitians play an integral role of the management of people living with a disability. As such, DAA recommends dietitians be included in teams for autism, pervasive developmental disorder and disability (M10). Dietitians should be provided with their own unique 800** number for dietary treatment for people with autism, pervasive developmental disorder and disability.

DAA supports the recommendation to allow allied health services to be delivered via telehealth to improve access and reach of services but recommends removal of the requirement for two face to face sessions, which will have the undesired effect of limiting access through these services.

DAA supports ongoing reviews of evidence on the effectiveness and the building of an evidence base around allied health to ensure ongoing quality services. This should include better analysis of allied health service statistics to inform future reviews.

DAA supports improving communication between the GP and allied health professionals to ensure individuals receive appropriate, coordinated care. Allied health need support from the Government to make allied health software conformant and to access low cost, secure messaging systems that enable communication with all medical software.

DAA supports initiatives for people at risk and currently not eligible for a team care management plan to reduce the likelihood of chronic illness developing. DAA recommends that the presence of dietary risk factors be added to list of eligible risk factors under recommendation 18.

Discussion

Recommendation 1. Encourage comprehensive initial assessments by allied health professionals.

DAA supports the recommendation for a longer initial assessment for allied health, available for each unique profession delivering care to a consumer with a chronic condition under the Chronic Disease Management program. This will bring practice in line with other MBS items and provide a more appropriate rebate for the type of care provided by allied health professionals, including dietitians. An Australian longitudinal study of 20 dietitians and 176 consults under the Medicare Chronic Disease Management program found that the mean time for an initial consultation was 42 minutes and for a review consult it was 28 minutes. When taking into consideration the time required per patient pre and post consult the total time for an initial was 55 minutes and review 36 minutes.[1] Increasing the time allocated for initial assessment consultations will help ensure that providers are able to undertake an effective assessment of the client and be remunerated for this time. The remuneration for this longer assessment needs to be appropriate and should be at minimum double the existing rate for a 20 minute consultation.

DAA recommends that additional clarity is required in the proposed explanatory note in regard to what constitutes "where a significant change in the quality or severity of the complaint necessitates reassessment".

DAA wishes to highlight that consideration should be given to allowing following up review sessions to be eligible for long consultation items. This is particularly pertinent for treatments such as dietetics that are provided under a counselling approach to achieve behaviour change. The SMILES trial, an Australian randomised controlled trial exploring the use of diet to treat people with depression, found good outcomes for mental health that were achieved following a recommended seven longer duration sessions (~60 minutes).[2,3]

Analysis of Medicare statistics shows that over 90% of Better Access items used by psychology, social work and occupational therapy practitioners were long consults as required for counselling nature interventions. DAA recognises that not all review sessions will need to be provided as a long consultation, however complex cases could benefit from this option. The study of Australian dietitians and their implementation of Chronic Disease Management items found that reviews were on average 28 minutes, however the standard deviation was +/- 13minutes and overall there was no significant difference between the time for an initial and review.[1] Given this, providing options for long reviews, when clinically necessary, should be considered to ensure the best quality of care is provided to the client.

Recommendation 2. Expand allied health involvement under team acre arrangements.

Accredited Practising Dietitians play a critical role in the treatment of chronic illness, using medical nutrition therapy to manage chronic conditions such as diabetes, heart disease and arthritis. A 2017 systematic review of dietetic interventions in primary care found that there is fair evidence to support that dietetic interventions improve dietary intake, weight loss outcomes and diabetes clinical measures.[4] Furthermore, a systematic review and meta-analysis on the effectiveness of nutrition specialists (i.e. dietitians) on paediatric weight management outcomes, found that when a nutrition specialist was involved in the delivery of care, there appeared to be better weight management outcomes.[5]

Dietary interventions are not only effective but also low cost and safe. A European cost-benefit analysis measuring the role of dietitian interventions in treating obesity and comorbidities reported that for every one euro invested in dietetic treatment there was a four euro saving on health care costs over five years.[6] In Australia, two economic evaluations published in 2018 found that dietary interventions were cost effective when compared to social support as treatments for depression.[7,8]

DAA recognises that at present MBS services are often underutilised and highlight that this is potentially due to cost and limited awareness of out of pocket expense. The reasons for underutilisation must be urgently addressed in order to ensure the Australian population can access the care they require. The provision of five annual services shared across all eligible allied health provided under the current program does not align with guidelines for care for a range of chronic conditions and is not enough to meet the complex needs of people with chronic disease. This is due to the limited number of eligible services and insufficient time available to develop therapeutic relationships with clients to provide clinically effective nutrition counselling. Additionally, the five services are shared across allied health and thus access to effective, holistic, multi-disciplinary health care is limited. Given the effectiveness and low cost of dietary interventions in chronic disease, DAA is supportive of the recommendation to increase the number of allied health services annually for chronic and complex patients. This will help reduce the burden of chronic disease in Australia. To ensure individuals receive care tailored to their specific needs, a prescriptive number of sessions that is appropriate across all allied health professions and a range of chronic conditions is difficult to determine and is not in line with providing individualised care. DAA recommend further work be undertaken to guide implementation of how the additional sessions will be made available or explore options for patients to determine their own requirements, such as for other schemes in aged and social care. DAA welcomes this proposed change and is willing to engage in further discussions on how the process could be implemented.

Ongoing evaluation of the change is imperative, and this should include research on why services are at present underutilised, despite the increasing burden of chronic disease in Australia.

Recommendation 4 and 5: Allied Health Group Services under chronic disease management plans

DAA agrees that the high overhead costs of running group sessions outlined in the paper limits the uptake of group sessions, despite their potential effectiveness. An Australian study found that dietitians are not offering group services due to the high cost of room bookings and patient no shows.[9] DAA supports trialling appropriate incentives for allied health professionals to address issues with the existing model. It is imperative that this incentive is costed to ensure it will provide adequate reimbursement for the professional's time and expertise. The provision of practice incentives should be reviewed after a period of time to assess whether it is effective in addressing the challenges of group-based therapy.

As highlighted in the paper there is evidence to support the use of group sessions including those provided by a dietitian in chronic conditions beyond Type 2 Diabetes Mellitus such as heart failure and cancer. The *My health for life* Program in Queensland offers small group sessions, run by a range of health professionals (dietetics, physiotherapy, exercise physiology and nursing), aimed at reducing the risk of developing type 2 diabetes, heart disease, high cholesterol, high blood pressure and stroke.[10] DAA understand that there is evaluation work underway, which could be of benefit for this review of group services. Given the potential benefits of group therapy beyond Type 2 Diabetes, DAA support the expansion of group therapy to other chronic diseases.

DAA recommend that a rapid review of group allied health interventions be undertaken prior to implementing changes to ensure timely, effective system improvement. This should include research on barriers to group treatment to ensure these are minimised when implementing changes to group services.

Recommendations 6-12: Allied Health Services for autism, pervasive developmental disorder and disability.

Dietitians are not listed as allied health providers for the Medicare eligible allied health services (M10) for children with autism, pervasive developmental disorder and disability (82000, 82005, 82010, 82015, 82020, 82025, 82030, 82035). Dietitians play a role in the management of people living with a disability as outlined in the DAA Disability Role Statement.[11] There is a growing body of evidence on the nutrition issues experienced in people with a disability and dietitians play an integral role in managing these. A 2013 review and meta-analysis found that children with Autism Spectrum Disorder have significantly more feeding disorders than their peers.[12] There are a range of nutrition issues experienced in children with autism spectrum disorder and other intellectual and development disabilities such as restricted and repetitive food behaviours, gastrointestinal problems, nutritional inadequacies, feeding difficulties including issues with chewing and swallowing, weight management concerns and food allergies and intolerances.[13,14] Accredited Practising Dietitians can assist those with a disability manage nutrition related factors such as weight, food behaviours, malnutrition, nutrition imbalances, gastrointestinal issues, food preparation skills and much more.

The position statement from the Academy of Nutrition and Dietetics, *Nutrition services for individuals with intellectual and development disabilities and special health care needs* (2015), highlights that dietitians are essential in the multidisciplinary team for the care of these individuals.[13] Accredited Practising Dietitians assist people with disability to make positive lifestyle

changes tailored to their unique needs**.** Accredited Practising Dietitians are recognised as allied health providers of care under the National Disability Insurance Scheme and other Medicare items. DAA recommend consideration of the inclusion of disability specific dietetic Medicare items, with a separate number, to help those with a disability manage their condition and comorbidities by providing access to evidence-based and effective nutrition interventions delivered by an Accredited Practising Dietitian.

DAA supports that case conferencing included under Recommendation 8 offers potential to improve multidisciplinary care across all MBS categories. An item should also be included for other allied health MBS items where one does not exist, such as those for chronic disease.

Recommendation 13: Support the codifying of allied health research and evidence.

DAA supports the investment and development of an allied health research base. There are a number of structural barriers that exist for primary care research such as the limited time and resources available for professionals. At present, there is an inability to capture data and service utilisation across allied health professions in a systematic way. Clear deliverables should be set for this recommendation to build on the evidence base. Chief allied health researchers, across multiple professions could form a team to undertake this direct research and report to the Government. Greater investment should also be made in analysis of the use of allied health items to understand the profile of use across sociodemographic and geographic areas.

Recommendation 14: Improve access to allied health services via telehealth.

DAA supports the recommendation to allow allied health items to be used for telehealth services, consistent with the provision of telehealth items for medical professionals. This should be implemented by expanding the criteria for existing Medicare items. Allowing allied health to deliver services using telehealth will help improve access, particularly in rural and remote areas. It will also enable individuals to receive care from allied health practitioners that work in specific areas of practice and enable individuals who are unable to travel due to their health to access services.

Dietetic services are well suited to the medium of telehealth. There is evidence that that telephone counselling by a dietitian achieves dietary behaviour change and improves metabolic parameters in individuals with metabolic syndrome.[15-17] An Australian review of allied health video consultation services found clinical outcomes have generally been similar to outcomes of face-to-face consultations, with relatively high levels of patient satisfaction.[18]

DAA is concerned that the requirement to have two face to face sessions will be a barrier to providing services via telehealth. It may not be possible for some providers to see the individual for two sessions prior to starting telehealth due to issues with access and also the limited number of sessions the individual has access to under the MBS. As such, DAA recommends that this requirement be reconsidered to ensure that telehealth can be used effectively to provide care to those in need in rural and remote areas and those who may need to access allied health working in specific conditions. DAA note this barrier was removed from Better Access items and does not exist in other MBS telehealth items such as those for medical specialists.

To facilitate uptake of telehealth and to enable it to be effective, funding support should be provided for activities to support its delivery. This is proposed in the MBS review of specialist items and should be consistent across all areas where telehealth is covered through the MBS.

Recommendation 15: Pilot non- fee- for- service allied health payment models.

DAA supports that it is appropriate to trial alternative approaches to fee-for-service funding for allied health. DAA recommend allied health representatives, including a dietitian, be included in the development of any pilots.

Recommendation 16. Enhance communication between patients, allied health professionals and GPs.

DAA supports improving communication between health professionals including providing incentives for secure messaging. My Health Record and secure messaging provides opportunities for enhancing communication, but allied health professionals have limited access to these systems. A primary barrier is the limited availability of allied health conformant software. Consequently, as a result of this barrier, allied health providers can often only view and not upload to My Health Records. Additionally, for self-regulated health professionals there are a number of barriers to registering for a Health Provider Identifier. Allied health professionals should be involved in any digital health projects to improve communication pathways.

There are currently several secure messaging services that are used by medical practices and it is not feasible for allied health professionals to have several services to address this. Allied health professionals need a secure messaging service that is low cost and facilitates communication across many secure messaging systems.

In addition to improved communication, increased education for medical professionals on the use of allied health items is required. DAA recommends that GP's receive adequate education on the role of allied health professionals to ensure that referrals are appropriately made to enable patients to get access to the most appropriate, evidence-based care. Enhanced education and awareness of the likeliness of a gap payment and benefit of services is required to prevent ongoing under utilisation of MBS items.

Recommendation 18: Expand the role of allied health in the Australian public health care system.

DAA supports the establishment of systems that enable access to Medicare items for preventive care. The Academy of Nutrition and Dietetics position statement on the role of nutrition in health promotion and chronic disease prevention, highlights that the most effective and affordable method to prevent chronic disease is through primary prevention including nutrition interventions.[19] DAA agrees that primary prevention of chronic disease is important to reduce the burden of these illnesses in Australia and welcomes the recommendation to expand programs to include prevention and at-risk groups. Allied health professionals are well placed to deliver preventative health programs.

DAA highlights that under recommendation 18, the list of risk factors should also include poor diet. Poor diet currently contributes 8.5% of the burden of disease.[20] Poor diet is a risk factor for many chronic conditions and those with poor diet should be referred to Accredited Practising Dietitians to receive nutrition interventions.

General comment

DAA has identified a high priority issue that was not addressed by the current report however should be considered in this review. DAA wishes to raise concerns with the existing limitations with Medicare services and workforce development. Specifically, DAA is concerned about the current ineligibility for delivery of services by students supervised by an appropriate, qualified supervisor on student placement experiences. Allied health students undertake placements as part of their university training program and must demonstrate competence prior to graduation. To demonstrate competence, observation of their supervisor is inadequate. Healthcare in Australia is shifting, with an increased focus on primary health care. Additionally, many allied health graduates will start work in private practice as opposed to hospital roles. It is therefore critical that there are student placement opportunities that will help build capacity amongst the future health workforce.

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