

MONASH University



# **Simplifying the Mechanics of Patient Care Under Medicare for Dietitians in Private Practice**

*An Evaluation of Dietetics Medicare  
Services for Chronic Disease Management*

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## DECLARATION

The authors declare they have no conflict of interest in conducting this research. The research was conducted independently under staff salary arrangements provided by Monash University or costs met by the authors. Inducements of prize awards valued at less than AU\$120 were offered to participating dietitians and were funded by the authors.

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# Simplifying the mechanics of patient care under Medicare for dietitians in private practice: an evaluation of dietetics services for chronic disease management

## SYNOPSIS

Dietitians are the third most utilized allied health providers in the national insurance program Medicare (Strengthening Medicare; Chronic Disease Management).<sup>1</sup> Other than overall service statistics, there is no known evaluation of the program's implementation or the outcomes for patient care. In order to explore the practice of dietetics professionals, a questionnaire survey was developed by researchers from Monash University Institute of Health Services Research. This asked about GP referrals and methods of collaboration, patient education experiences, the fees charged and billing methods. It was administered to a national sample of dietitians working in private practice in March 2008. The main recommendations which arose from the survey results are given below.

## RESULTS

Three hundred and fifty-six Australian dietitians (47%) responded. Half the dietitians worked less than 12 hours per week in private practice. Many combined their private practices with roles in acute or community services.

### Utilization of Medicare

Most dietitians (83%) estimated they were referred 1-25 Chronic Disease Management (CDM) patients per month for individual consultations. Thirteen percent were referred more than this. Medicare CDM-referred patients made up more than 60% of clinic practice for one of every three dietitians.

Medicare Group Services for patients with diabetes type 2 were used by few dietitians (8%; n=28). As this item was introduced in 2007, professional education and support including development of a suitable program through a pilot project may be needed to assist uptake.

### The dietetic fee debate- individual consultations

The fee most dietitians charged patients for a first individual appointment was higher than the Medical Benefits Scheme (MBS) scheduled fee of \$56.25. Around 6% of dietitians reported their fee for the initial consultation was the scheduled fee of \$56.25, or less. However, this proportion is uncertain as only half the participants gave details of their initial scale of fees. Overall, 25% of dietitians charged a fee of up to \$70, 25% charged \$71-80 and 50% charged more than \$80. There were a number of different fee scales (for between 20 minutes to one hour), ranging from \$45.00 to \$150.00. Individual clinics selectively decided on discounts for healthcare or pension card-holders. There was little acceptance of bulk-billing due to the fee limits imposed by Medicare- as no gap could be charged if a patient was bulk-billed. Further, extra time taken to administer the billing process was viewed negatively. Forty-two percent of dietitians had never bulk-billed a patient. Dietitians preferred patients to pay for a consultation and then claim their fee rebate from Medicare.

- There is a need to overcome administrative and financial barriers to bulk-billing to enable improved access to dietetics services for all consumers- in particular, for those in low socio-economic groups.

Dietitians faced a dilemma about their scale of fees. They judged the current MBS rebate of \$47.85 only able to reimburse the direct cost of a consultation of up to 30 minutes. They felt a

counselling type consultation such as theirs which aimed to help patients to change their dietary behaviours required longer time. This was especially so for the first consultation. They suggested that the mandatory minimum of 20 minutes was inadequate and they required up to one hour, for example. Due to their professional responsibility to patients, they wanted to set an affordable fee structure. At the same time, however, their payment needed to meet the costs of running a practice. Many dietitians were providing this longer consultation (up to one hour) without an increase in payment, their business absorbing the extra cost.

There was greater consensus about the fee structure for review appointments. Two of every five dietitians bulk-billed or charged an identical fee (\$47.85; no fee gap). Forty-three percent of dietitians charged patients \$47.85-\$60 (a gap of up to \$12.15), and 25% charged more (a gap of up to \$44.15). The MBS fee structure has negative implications for the sustainability of dietetics services.

- The Medicare schedule should include both a long and a short consultation due to variations in time required for certain conditions and for initial versus follow-up dietetics consultations. Dietitians require at least 50 minutes for their first consultations.

### **Inability to meet patients' needs**

Dietitians did not think patient care needs were met. Up to five appointments annually were in actuality usually limited to 1 or 2. This, and the limited time allowed for each, did not give patients sufficient contact with a dietitian to provide optimum management.

- The number of dietetic consultations available per patient should be increased to a limit of at least five annually, with an option for more.

One in three dietitians thought patients were 'often' aware of the 'patient goals' as required on the form or plan, suggesting a need for more patient involvement during planning at medical clinics.

- There needs to be clarity about the roles of GPs, practice nurses and dietitians over setting of clinical goals, as dietitians should be delegated the task of collaboratively developing agreed dietary goals with CDM patients.

### **Lack of team planning**

There was little evidence that chronic care models' components were in place, as collaboration or active team care of patients was mostly lacking. There was written communication from doctors in referring patients to dietitians. Dietitians sent written reports to doctors after interventions. An offer for dietitians to be involved in team care planning (a collaboration required under Medicare TCA policy) was sometimes made and while welcomed, was regarded as an unpaid task.

- For collaborative planning to occur, dietitians should be financially compensated for time spent in patient care planning (as required for Team Care Arrangement (TCA), GP Management Plan (GPMP)).

Chronic care models in healthcare make use of tracking, reminders and prompts due to a patient's age or medical condition. These were applied in a limited way due to constraints of the Medicare referral process and remuneration level.

- There should be a policy for medical professionals on provision of patient reminders for those patients managed under Medicare (TCA/CDM). This is needed to guide practitioners about review, reinforcement, reminders and tracking methods to best support CDM patients. Automated reminders are possible using a tracking system.

There has been no published evaluation of whether allied health or dietetics interventions under Medicare CDM improve the healthcare status of referred patients or not.

- Research should be commenced to identify health care outcomes for allied health Medicare CDM referred patients.

### No remuneration for overhead costs

The current Medicare payment did not cover time taken to provide written reports to doctors. It did not cover business overheads such as administration (billing, appointment-making, reminders and so on), or room rent. There was no payment for case conferencing.

- Dietitians' MBS payment should include remuneration for proportional business costs and professionals' time in consulting with other professionals, such as case in conferencing.

### Better service integration needed

Results indicated a need for better service integration between dietetic services and that of GPs. This may assist management of many aspects of patient care. A need for better systems support including communication by electronic means, is recognised by the Australian government and planned for under the Australian Better Health Initiative.

- A method of E-referral and E-reporting is required to facilitate sharing of information between dietitian and GPs/PNs- both about administering the program and about patient management- to reduce dietitians' administrative costs.

Fast and direct communication using templates would reduce dietitians' costs. Further, a streamlined communication channel such as this might allow tracking of patient referrals and their uptake, and have many benefits.

### A need for program support

Half the dietitians worked alone in a sole practice and almost another third in a practice with a GP. Medicare dietetics providers may benefit from training in a business model for primary care for chronic disease management in the private sector. A community of practice could be developed through Divisions of General Practice to develop best care for chronic disease management. Such groups might instigate protocols best suited to local environments and their patient mix. Dietitians are unlikely to achieve this alone.

- Divisions of General Practice should broaden their role to include support for allied health Medicare providers such as dietitians through education and training to implement best care for patients with chronic disease or complex conditions.

### Conclusion

Dietitians perceived there were many barriers to their practice as a Medicare provider for chronic disease management. These involved all steps of the process, from referral, through to managing patients, record-keeping and billing.

Results showed that the tasks set for dietitians by doctors to assist patients to reach behaviour change goals within 1-2 consultations per year were unlikely to be achievable. Dietitian and GP/practice nurse education about optimum referral processes, practice integration and also evaluation to identify patient outcomes may further assist implementation. Detailed recommendations made in the body of this report may help advance the Chronic Disease Management dietetics program.

Dietitians' present views can best be summarised by this quotation from a sole practitioner working in a metropolitan area of Melbourne:

*...Private practice dietetics is a tremendously useful service, and one that's often valued by clients but no-one wants to pay adequately for it- not the government, private health insurers, or patients.*

## BACKGROUND

Strengthening Medicare Allied Health and Dental Care Program was introduced by the Australian Government under the Enhanced Primary Care policy in 2004 <sup>1</sup> to:

“provide more preventive care for older Australians and improve co-ordination of care for people with chronic conditions and complex care needs. The program provides a framework for a multi-disciplinary approach to health” <sup>2</sup>

In 2005, the MBS items were updated as Medicare Chronic Disease Management (CDM) items. <sup>2</sup> Dietitians are one of 14 health professions that were registered as providers for Medicare allied health CDM services as shown in Table 1.

**Table 1 Allied Health Service providers under Medicare (CDM)**

Service	MBS Item Number
Aboriginal Health Worker	10950
Audiologist	10952
Chiropractor,	10964
Chiropracist,	10962
Diabetes Educator	10951
Dietitian,	10954
Exercise Physiology	10953
Mental Health Worker (or Social Worker, Mental Health Nurse, etc)	10956
Occupational Therapist	10958
Osteopath	10966
Physiotherapist	10960
Podiatrist	10962
Psychologist	10968
Speech Pathologist	10970

Source: Enhanced Primary Care (EPC) Program Referral Form for Allied Health Services under Medicare (EPCAHS 0106); Department of Health and Aging at [www.health.gov.au/strengtheningmedicare](http://www.health.gov.au/strengtheningmedicare), 12 January 2008.

The program is based on referral decisions made by general medical practitioners (GPs) about desirable allied health interventions for patients with chronic or complex medical conditions. These chronic or complex medical conditions need to be present for at least six months. <sup>3</sup> This may relate, for example, to diabetes, a cardiac or gastroenterological condition, stroke, renal or other condition.

On order to be eligible for a rebated service, a patient should have a Team Care Arrangement (CDM Medical Benefits Scheme item 723) or an EPC Multidisciplinary Care Plan (CDM item 731) already in place and billed to Medicare (Fig 1). <sup>1</sup> A GP may use the item 721 (GP Management Plan) to assess a patient’s eligibility for allied health services.

This gate-keeping arrangement operates as an indicator that a patient has been assessed as eligible, and subsequently allows a fee rebate to be paid to the allied health provider (AHP). A choice of allied health services to which patients are referred is planned by a patient’s GP. Patients are eligible for up to five allied health services in total from any allied health providers per calendar year. <sup>1,3</sup> Details of these guidelines are given in the appendix.

**Fig 1: Strengthening Medicare: Enhanced Primary Care Summary**

<p>Australian government 2004:</p> <ul style="list-style-type: none"><li>■ <b>aimed to increase the public's access to multi-disciplinary health and dental services</b></li></ul> <p>Patient eligibility:</p> <ul style="list-style-type: none"><li>■ <b>chronic or complex conditions present for more than 6 months</b></li><li>■ <b>be registered: appropriate forms invoiced to Medicare by general medical practitioner</b></li></ul> <p>2005 review</p> <ul style="list-style-type: none"><li>■ <b>Re-named Chronic Disease Management (CDM) program, and dental services removed</b></li></ul>
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The referral process is as follows: a GP usually relies on computer software to populate the single page standard referral form<sup>4</sup> with their details and a patient's identity. They add the name and address of a chosen AHP and tick a box for which profession. They enter the number of consultations allocated to each, sign the form and then send it by facsimile to an allied health clinic. The task of preparing the form can also be delegated to a practice nurse, as can the GP Management Plan (GPMP), which is then signed by the GP.

Guidelines state that patients require both a GPMP and a TCA to be in place. A GP or practice nurse or AHP plans interventions in collaboration with the patient. TCA requires consultation with at least two professionals other than a doctor regarding identifying appropriate goals and likely outcomes for the patient- and if not face to face, this communication can be by mail or fax. The patient is required to sign the form, and the doctor is required to sign the form to confirm s/he has gained the agreement of the patient.

Relevant parts of the GP management plan or TCA need to accompany the referral form, as the plan gives some details of a patient's medical history. It also outlines the reason for a referral to an AHP in the goals which the patient has agreed to try and attain. The name and address of the AHP is placed on the TCA form (and whether they were provided with a copy). The patient is given a copy to keep as confirmation of the goals they are aiming to achieve, as well as the name of allied health professional/s they will consult. Samples of these forms are given in the appendix.

University-qualified dietitian practitioners in private clinics throughout Australia are able to register as service providers based on their professional accreditation status with the Dietitians Association of Australia (DAA).<sup>5</sup> Details of provider regulations are given in the appendix.

Whilst some evaluation has been undertaken of doctors' use of the Medicare program, there is no published evaluation of the allied health or dietetics' Medicare program. As the whole EPC/CDM program amounts to an approximate expenditure of AU\$57 million annually in fees to allied health professionals, this lack of evaluation is of concern. Medicare utilisation in 2007-2008 financial year by the six most referred professions is listed in Table 2.

**Table 2 Medicare CDM statistics by volume for top six allied health professions  
2007- 2008 financial year**

PROFESSION	ANNUAL NUMBER OF SERVICES July 2007-June 2008	ANNUAL COST 2007-8 (AUTHORS' ESTIMATION) AU\$m
1. Podiatry/Chiropody	491,257	\$23.5m
2. Physiotherapy	463,695	\$20.2m
3. Dietetics	124,111	\$5.9m
4. Chiropractic	62,915	\$3.0m
5. Speech Pathology	53,505	\$2.5m
6. Exercise physiologist	44,111	\$2.1m

Source: [http://www.medicareaustralia/cgi-bin/broker.exe\\_PROGRAM=sas.mbs\\_item\\_standard\\_report:m3 Allied Health Services](http://www.medicareaustralia/cgi-bin/broker.exe_PROGRAM=sas.mbs_item_standard_report:m3>Allied%20Health%20Services)

†Psychology use: 7,788 in 2008; some psychology services are billed under the Better Mental Health Initiative.

This evaluation is a follow-up to a study of Melbourne dietitians' experience of Medicare Policy on Allied Health Services in the first 12 months in 2005.<sup>6</sup> The earlier study explored 15 dietitians' experiences using qualitative methods of interview and focus group. Dr Robyn Cant and Dr Rosalie Aroni of Monash Institute of Health Services Research, Monash University, Victoria, designed a further study to evaluate dietitians' experience of the EPC/CDM policy. This aimed to determine progress in managing chronic illness using the EPC/CDM program three years after commencement. They received approval from the Monash University Ethics Committee for Research Involving Humans in November 2007. The DAA agreed to provide administrative assistance including access (anonymously) to their database of members and management of the survey process.

## RESEARCH METHODS

### Development of a questionnaire

Themes identified in the earlier dietetics research and literature were used to construct a questionnaire to evaluate dietitians' perceptions of the CDM program.<sup>7</sup> The questionnaire was also informed by questions in a survey undertaken of Queensland allied health and mental health EPC other than dietitians.<sup>1</sup> For the current questionnaire, 38 items were clustered into five questions using open and closed formats. Answers were based on either dichotomous (yes/no) responses or a multiple choice list, or on a five-point scale on agreement or otherwise (always/often/sometimes/rarely/never). Each question invited any further comments to be given in open-ended text. A summary of the questionnaire contents is given in the appendix. As all dietitians were known to have access to the Internet, a Web-based survey was administered. Formatting strategies known to encourage questionnaire completion were utilized.<sup>8</sup> The questions focussed on 1). personal demographic data, 2). referrals from medical practitioners, 3). the patient, 4). fees and billing, 5). Medicare Group Services. Face validity of the questionnaire was tested by two dietitians and by two other professionals. Four dietitians in private practice provided expert review when it was piloted as a web survey in January 2008.

<sup>1</sup> Dr M Foster, School of Social Work and Human Services, University of Queensland; personal communication 2007.

## Questionnaire administration

The questionnaire was administered by the DAA National Office using HostedSurvey software ([www.HostedSurvey.com](http://www.HostedSurvey.com)). In February 2008, the DAA National Office sent individually addressed e-mail invitations to 786 Australian dietitians on their database who had identified themselves as working in private practice in the 2007-2008 membership registration data. Each invitation included a link to the survey and an access code. Seven additional dietitians working in private practice subsequently requested access to the survey, and were sent invitations.<sup>ii</sup>

The population was reduced to 761 subsequently (as 15 dietitians ruled themselves ineligible due to not working in patient education, and 17 were not contactable). Two reminder invitations were also sent to the non-respondents. Subsequently, the data set was downloaded from the Internet for analysis by the two researchers.

## Analysis

SPSS Version 10<sup>9</sup> was used to analyse the data. Descriptive statistics and chi-square were used to examine responses and Spearman's rank correlation analysis was used for between-group analyses.<sup>10</sup> Content analysis was used to initially review the open-ended comments. They were subsequently clustered into themes as well as being grouped by state of employment. The themes identified were examined for deviant cases. After further analysis, these were incorporated into the interpretation of results.<sup>11</sup>

## Interviews with dietitian participants

Half the dietitians in the survey agreed to be interviewed by telephone, and 20 were selected for interview. These were purposively selected from various clinic categories as both high and low use providers for Medicare. The aim of the interviews was to explore topics which were insufficiently described in the questionnaire results, or to further clarify an issue identified in participants' questionnaire responses.

Nine dietitians were interviewed by telephone in the major dietetic provider states (NSW, Victoria, Queensland, South Australia) over 25 to 30 minutes each. The interviews were audio-recorded with the participant's consent. A interview schedule was used to initiated discussion, asking about matters such as referral process, time given to consultations, detail of reporting methods, how patients' needs could be better met, or other personal comments made earlier. The interviewing stage of the study was subsequently ceased after completion of the analysis of nine interviews as no new topics were raised. It was thought that 'saturation' was evident.<sup>12</sup> The interview tapes were studied and notes made about the narrative themes and these were subsequently compared with questionnaire results. Extracts of four interviews are given as case studies in the appendix to illustrate both the meanings attached to the practices that were discussed in interview, and the interview process itself. Each is reproduced with the participant's consent.

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<sup>ii</sup> Many dietitians in private practice in each Australian state are listed on a public access website of the Dietitians Association of Australia: Find an APD (accredited practicing dietitian)- <http://daa.asn.au/index>

# RESULTS

## CHARACTERISTICS OF PARTICIPANTS

There were 356 dietitians who participated. This is estimated to be 47% of all those who were contactable and working in private practice in patient education in Australia within the DAA membership enrolment data in 2007-2008.

Half the dietitians (161) had first qualified in the last 12 years (since 1995) and one-quarter (88) since 2002. The median year of qualifying was 1995 ( $\pm 10.506$ ), and the range was 1960 to 2007. There was a significant association between year of qualifying and practice category in which dietitians worked. However, as the effect size was negligible (<3%) the impact of this association was thought to be nil.

Ninety-four percent of dietitians (n=330) were Medicare providers. Most (75%) commenced in 2006 or earlier, suggesting they had experience of the Medicare program.

### Representative of Dietitians Association of Australia working membership

Ninety-three percent of dietitians (331) were female and 7% (21) were male. They worked in private practice in every state. The proportion of respondents by state correlated with the states of employment for working dietitians in the DAA membership (Table 3).

**Table 3 Dietitians' state of employment**

In what Australian state or territory are you currently employed? (n=355)	RESPONSE		DAA 2006*† %
	Frequency	%	
Australian Capital Territory	6	1.7	2.9
New South Wales	125	35.1	33.1
Northern Territory	1	0.3	0.9
Queensland	83	23.3	18.6
South Australia	25	7.0	7.0
Tasmania	2	0.6	1.4
Victoria	86	24.2	27.2
Western Australia	24	6.7	7.8
None of the above	3	0.	
TOTAL	355	100%	100%

\*No significant difference: participants and all working dietitians by state ( $r=0.984$ ; CI 95%)

†DAA Canberra: Annual Report 2007

### Private practice is mostly a part-time occupation

One-quarter of dietitians (n=88) worked in private practice less than 6 hrs per week. Half worked in private practice less than 12 hours per week, and one quarter worked in private practice more than 20 hours per week. Many combined private practice work with other employment such as in hospitals or community services and so were unavailable for fulltime private practice. Thirty-four (10%) reported they worked 35-40 hours per week.

There was no significant association between hours of work and category of practice, time elapsed since qualifying for dietetics (seniority), or satisfaction with the Medicare EPC program.

## Practice environment of dietitians in private practice

Most dietitians (176; 49.4%) worked in a sole practice and 41% worked in a multi-disciplinary practice with or without a GP. One hundred and two (29%) worked in a practice with a GP. Twelve percent (44) were employed in a group dietetics practice, however they may or may not be co-located with others. Forty-four worked in other various practice types such as in a medical specialists' rooms, details of which are given later. As dietitians were often employed in more than one clinic, the proportions given in the following table may relate to more than one workplace per participant.

**Table 4 Proportion of dietitians employed in each practice category by state**

State of employment	Sole practice Freq/%	Group practice-dietitians Freq/%	Multidisciplinary group with GP Freq/%	Multidisciplinary group without GP Freq/%	Other Freq/%
ACT	3(50%)	0(0%)	2(33%)	1(16%)	1(16%)
NSW	62(50%)	12(10%)	43(34%)	19(15%)	20(15%)
Qld	47(58%)	13(16%)	19(23%)	11(14%)	7(9%)
NT	1(33%)	0	1(33%)	1(33%)	0
Tas	1(50%)	0	1(50%)	0	0
SA	12(48%)	4(16%)	6(24%)	1(4%)	2(8%)
Vic	38(44%)	5(6%)	28(32%)	18(21%)	(10%)

## DIETITIANS' ESTIMATED UTILISATION OF MEDICARE SERVICES

Dietitians' estimated utilisation of Medicare services was as follows:

1. Number of new EPC referrals per month per dietitian:

<u>Number:</u>	
none:	4%
1- 10:	43%
11-25:	40%
26-50:	9%
51-100:	4%
>100:	0.6%.

2. Proportion of Medicare patients per dietitian's practice:

<u>Proportion:</u>	
<20% in	35% of practices
21-40% in	16%
41-60% in	14%
> 60% in	35%.

There were 53 dietitians (16%) who said that Medicare CDM patients made up 81-100% of their patients.

## TYPES OF CHRONIC OR COMPLEX CONDITIONS REFERRED AND PRACTICE SPECIALITIES

### KEY RESULT

- The most commonly referred diagnosis types were (in descending order)
  - Diabetes Mellitus Type2
  - Obesity
  - Cardiac
  - Gastroenterology
  - Diabetes Mellitus Type1
  - Under-nutrition.

Respiratory, stroke and renal patients were not commonly referred (<3% said they were common). There were a wide range of other diagnosis types- including paediatrics and aged care cases- for which patients were referred.

Two of every five dietitians (143; 40%) reported they worked in a practice that specialised. However, this detail was difficult to determine because many also said that they would see other referred patient types, or they worked at more than one clinic.

Other practice environments included

- 'with specialist', 'with paediatrician'
- 'with surgeon'
- 'sole practitioner at medical centre, and nursing home with one other dietitian'
- 'health and fitness centre - massage therapist plus dietitian and personal training studio'
- 'cardiology practice'
- 'consulting to specialist clinic'
- 'I am in private practice, but also consult for indigenous corporation and private hospital'
- 'endocrinologist/physician'
- 'dietitian, podiatry, osteopath multidisciplinary sports clinic with specialist sports physicians'
- 'physio, podiatry' etc.

### KEY RESULT

- The range of conditions treated was not perceived to have changed in a way which was attributable to the Medicare program in the last 12 months (64%; 226 said it had not, 17%: 56 said it had, and 14%; 46 were unsure)

There were five ways in which practice was perceived to have changed:

1. Increase in diabetes referrals for diabetes type 2 or diabetes with obesity
2. Increase in referrals for weight reduction
3. Both greater variety of diagnoses in referrals or more limited types of referrals
4. An Increase in client numbers attributed to Medicare referrals
5. Better access to dietetic advice for patients (attributed to lower cost)

Seventy-five dietitians commented about how practice had changed and 12 commented about how practice had not changed. Quotations selected as representative of the themes which were raised are given below.

**Table 5 Examples of participants' comments which explain the themes of practice change**

Increase in referrals for diabetes	Increase in referrals for weight reduction
<p>Lots more diabetes due to rebates available and long waiting list at local hospital</p> <p>More newly diagnosed Type 2 diabetics are referred than previously</p> <p>Probably now see more low income obese, diabetic clients who would otherwise not visit dietitian</p>	<p>I have seen a rapid increase in overweight patients</p> <p>Obesity, overweight and depression is on the rise</p> <p>More obesity cases where primary diabetes and/or cardiac issues are under-reported</p>
Wider variety of diagnoses in referrals or more limited types of referrals	
<p>Rather than having a large % as weight/obesity issues, more medically related conditions are appearing</p> <p>Most of the patients come for advice for lowering cholesterol, diabetes and obesity</p> <p>Has become more limited - doctors seem to think we are only capable for weight loss/diabetes</p> <p>Our skill set seems to be untapped by GPs who refer for NIDDM, O/wt and cardiac</p>	
Increased patient access to dietitians	Increase in clients attributed to Medicare referrals
<p>Absolutely! [has changed] All these patients were either not accessing dietitians or on very long waiting lists for community</p> <p>We still treat the same range. All that has changed is more people having access to dietitians</p> <p>Seeing some individuals that would not have attended in the past, due to cost. Accessible for pensioners, young parents</p>	<p>Many more general clients.</p> <p>Range of conditions unchanged but attendance rates are higher due to minimal costs</p> <p>Not so much the range of conditions [has changed] , but the frequency of referrals &amp; the number of repeat visits by the clients</p>

Alternatively, practice had not changed with regard to referral types, but several dietitians reported that attendance rates were higher. This was said to be so particularly for review attendances, which they proposed was due to increase in affordability.

## LOW SATISFACTION WITH CURRENT MEDICARE CDM POLICY

### KEY RESULT

- Dietitians were ambivalent about their satisfaction with patient management under the current Medicare program for patients with chronic conditions. Forty percent were 'very satisfied/satisfied' and 33% 'dissatisfied/very dissatisfied'.

Dietitians were asked: **In general, how satisfied are you with the current Medicare program for patients with chronic conditions who are referred for dietetics interventions?**

There was a low level of satisfaction with the CDM program. Seven of every ten dietitians did not believe that up to five appointments annually for each patient as currently allowable gave sufficient contact with a dietitian to provide optimum care. It should be noted that this number includes all types of allied health professional referrals under current policy. A dietitian may see a patient only once or twice in a year.

### Satisfaction by state

There was no significant association between state of employment and satisfaction with the program ( $r=-.042$ ; ns;  $n=324$ ). However, trends were noted. Victoria reported the highest satisfaction rate. There was a trend of increased satisfaction from 41-44% (in WA, Qld and NSW) to 53% in Victoria. WA and NSW had the highest dissatisfaction rates (46% and 41%), while Qld, Vic and SA had dissatisfaction rates of 33-34% (the lowest). States with less than seven respondents were excluded from this calculation.

### Satisfaction by practice type

A group practice comprising either a group of dietitians or including other disciplines without a GP were both associated with increased satisfaction with the program. There was no significant association between satisfaction and working in a GP practice where referrers (GPs) may be located with concurrent ability to share patient records and/or have facilitated access to referrals or plans.

There was no significant association between year of qualifying (and hence assumptions of practice experience) and satisfaction with the program ( $p=-.025$ ; ns;  $n=324$ ), nor weekly hours of work (for instance, whether working part-time or fulltime)( $r=.018$ ; ns).

Most dietitians (61%;  $n=216$ ) were not actively trying to increase the number of EPC/CDM referrals.

## PLANNING FOR DIETETIC CDM REFERRALS: LITTLE TRUE GP-DIETITIAN COLLABORATION

### KEY RESULT

- Dietitians rarely took part in team planning. They regarded being sent a GPMP plan by the GP inviting input to the patient care plan as welcome, although questioned this process as it is not time which is funded in the fees.

GPs are funded under the Medical Benefits Scheme (MBS) for a Medicare GP Management Plan (GPMP) and Team Care Arrangements (TCA) to coordinate care of chronic disease management in collaboration with a patient and relevant allied health professionals. TCA requires consultation with at least two professionals other than a doctor, and replaces the former Enhanced Primary Care referral form. They may be administered together with a standard consultation with a patient.

The current results indicated that few dietitians took part in team care planning. From the comments given, this collaboration seemed likely to occur when the professional groups were co-located and already worked in multidisciplinary teams (for example, in a diabetes team). However, the frequency with which TCA's were prepared without face to face GP-dietitian communication was unclear, as some dietitians stated they were faxed the TCA and asked to comment on the plan. Perceived barriers to direct GP-dietitian communication (location, time, available communication method), or perceived willingness of GP to collaborate or consult during planning, were raised as matters of concern. A particular barrier to team communication voiced by dietitians was a lack of any payment for a dietitian's consulting time. However, as more practice nurses are delegated to undertake care planning, the focus of this task may alter for dietitians. Many dietitians reported communicating with practice nurses and it was unclear how often practice nurse-dietitian communication was utilised in care planning.

A small number of dietitians reported that they received the care plan prior to the referral being made (thus might have some input into the pre-prepared 'patient goals'), and/or were asked to agree to participate in the plan for a patient.

*The GP generally sends the initial Care Plan asking for input/possible changes. Once I have seen the patient I prepare reports for the GP to give them updates on their patient's progress. If anything needs to be discussed in detail about the patient's care I will contact the GP by phone.*

Case conferencing was rarely attended (11 dietitians: 3% ever took part in case conferencing). A GP MBS item for a Case Conference (items 734 to 779) is paid to a doctor for organising and attending a case planning conference of at least 15 minutes for a complex care patient in various environments, including outside of GP clinics. (See [medicareaustralia.gov.au](http://medicareaustralia.gov.au) and [www.health.gov.au](http://www.health.gov.au)- index for chronic disease management for these details; or section on remuneration in this report). Although some dietitians reported they had been involved in a case conference, or had attended team planning, it was unclear how this time was funded:

*I have not been asked to attend a case conference, My understanding is that there is no rebate for allied health for case conferences so I would be unlikely to attend. Some GP's send EPC plans asking for comments.*

*Would like to see rebates for participating in case conferences. The true spirit of the EPC won't be realised until case conferencing occurs regularly and is remunerated for all, not just the GP.*

The current results indicate that care planning guidelines for Medicare CDM TCA are not adhered to with regard to chronic care patients who require dietetic referrals. Relevant guidelines are not working due to the various constraints voiced by dietitian practitioners. A principle barrier is that dietitian providers are not remunerated for other than face to face consultation time with the patient.

Although Medicare policy clearly enunciates a guideline that care planning should be multidisciplinary, recent Australian research suggests that doctors do not view this collaboration as either necessary, or a part of their role in the care of these complex patients. In a study of the use of multidisciplinary care plans for diabetes care in 2006, Shortus et al <sup>13</sup> reported that doctors rarely collaborated with others in preparing these plans. They did not recognise that a patient's health condition/s might be sufficiently complex as to be assisted by the interventions of other professionals. However, the preparation of the care plans often prompted them to educate patients and to make allied health referrals. Thus, before the Medicare CDM guideline about collaborative care planning can be fully operational, stakeholders need to agree to particular work practices.

**RECOMMENDATION:**

1. For collaborative planning to occur, dietitians should be financially compensated for time spent in patient care planning (as required for TCA, GPMP).
2. Agreed protocols should be developed to guide GPs/practice nurses/AHP to standardize practice of collaborative care planning, regarding which professions should receive referrals.

### The stated goals are appropriate for dietitians' intervention

**KEY RESULT**

- Most dietitians were satisfied that the stated goals on the EPC/CDM form were appropriate for the intervention ('always/often' appropriate 72% versus 'rarely/never' 1%).

Accepted models of care for chronic illness suggest that self-management strategies adopted by patients enhance health outcomes. This model of management is said to depend on patients being informed about their condition, and participating in the planning of their own care. <sup>14</sup>

However, even though advance knowledge through preparation of a patient is required according to the CDM plan, few dietitians (32%) thought that patients were adequately informed about their health goals. Although one complicating factor may be a patient's memory recall, it was unclear whether patients had active involvement in preparing the care plan goals. This involvement and agreement might be crucial for dietary changes to be achieved by patients in the long term (as much of a patient's nutrition education in a consultation focuses on negotiating dietary change and activating behaviour change towards goal achievement). This focus is explained in Case Study 3 in the appendix, when a dietitian explains her education and reporting methods.

Results of the questionnaire indicated that dietitians were satisfied with the goals stated on the EPC/CDM plan. Nevertheless, the goals were said to be generalised (rather than specific measurable goals) so that many thought they were derived from a computer template. Of 49 dietitians who commented, many stated they themselves developed more specific goals in conjunction with the patient. Comments grouped by themes are given as examples in Table 6.

**Table 6 Dietitians' comments on suitability of GP/PN-led goals for EPC/CDM plan**

Goals are suitable	Goals are not suitable
Goals set realistic and achievable	GPS just print off a standard template without going into a specific reason for referral.
Only a small number of GP's don't provide adequate goals	Sometimes the main reason(s) for dietary consult is not included in the referral.
The goals are always clear and appropriate.	Tend to be very general (eg "diet advice"), not always appropriate eg weight loss to meet HWR when obese.
I usually wrote the goals and the EPC.	Some GPs only send a Medicare referral form with no attached documentation.
Goals typically very general, I usually create more specific recommendations.	My role involves teaching insulin adjustment to carbohydrate intake and GP often doesn't realise the specifics of what I do. Often my role is stated as 'healthy eating advice'.
I rarely need to add anything.	I tend to start from the beginning with my patient - I don't spend a lot of time reading the EPC paperwork as often is generic or done in a hurry
All GPs state the goals clearly in their referral.	

The idea of generic rather than specific goals being given in plans was confirmed by a participant dietitian working in private practice who was interviewed for the study by telephone (see Case Study 2, appendix):

*I think a lot of the time its just sort of whatever electronic program they have...I don't always see the care plan, either, I mean, I'll often just be presented with the one-page EPC referral. But, quite often, its just the generic EPC sort of- the generic care plan and its- er weight loss, glycaemic control, whatever, [they ask for] its- you know, its very- its not patient specific at all. So what I end up discussing with the patient can be quite different.*

GPs have templates available from the clinical management software programs such as Medical Director and MedTech32 from which they can import details based on best clinical evidence for health outcomes targets for common chronic conditions.<sup>15</sup> However, in a study of 230 patients' care plans prepared by 26 GPs for patients with type 2 diabetes in New South Wales, most GPs applied a template and the audit showed that little information was recorded in the plan.<sup>16</sup>

This has implications for both the time spent on planning and the training of those who prepare plans. Practice nurses (PN) were stated to often be the primary or key member of staff who managed referrals, while a GP was the signatory, or else plans were prepared by a GP. Dietitians also mentioned that they would be greatly assisted if patients had formed expectations of required dietary interventions prior to their arrival for a first consultation. This would assist both the education process by starting with informed patients, and also save valuable consultation time.

The current results suggest that there appears to be room for improvement in clarifying issues for those who develop individualized patient goals within EPC/CDM plans. GPs/PN can identify patients' risk reduction outcomes as clinical aims, rather than dietary goals. It seems likely that there should be an increase in time spent with a patient whilst developing the plan. On the other hand, dietitians may be the key persons who need to collaborate with patients in planning goals. This would allow dietitians the planning of patients' detailed nutrition goals. The agreed goals are then used as the basis for reporting progress- conveyed to the treating GP to enable them to reinforce the education process and to review a patient's progress. Further work is needed to determine how patients can become engaged with their healthcare plan and understand their dietary risk reduction aims, and become informed about the helping roles of the multi-disciplinary care team.

**RECOMMENDATION:**

3. There needs to be clarity about the roles of GPs, practice nurses and dietitians over setting of clinical goals, as dietitians should be delegated the task of collaboratively developing agreed dietary goals with CDM patients.

## COMMUNICATION BETWEEN DIETITIAN & GP OR PRACTICE NURSE REGARDING PATIENT INTERVENTIONS

### KEY RESULT

- When asked how they collaborated with other members of the healthcare team, most dietitians reported that they did not truly collaborate, but communicated by writing the prescribed initial and final reports to doctors, and telephoning them when they perceived key issues of concern.

Team collaboration in management of patients with chronic disease has been found beneficial because delegation of care to other professionals (by doctors) results in proven clinical benefit and better support, and “critical elements of care that doctors may not have training in or the time to do well are competently performed.”<sup>17</sup> However, two-way communication and sharing of patient information is thought to be essential for each health professional to perform these tasks effectively. Dietitians thought that the main communication re EPC/CDM patient care was written and that there was little true collaboration between provider members of a care ‘team’. Dietitians’ comments illustrated the usual communication process:

*They send the request to participate with client X. The GP sends the EPC form and hopefully a more detailed referral. We send the GP the letters. Rarely is any more communication established - certainly never from the GP's end.*

*There is usually little direct contact with the referring doctors as they mostly seem to use practice nurses to administer the EPC program. We have more contact with these nurses (usually from large medical centres) or the notes the doctor may write (from small GP practices)*

Face to face discussions might take place in the corridor or in the tea-room if a doctor and a dietitian were located in the same building. Responses showed that teams involved in diabetes care shared patient information through discussion. Other responses outlined various methods of communication to share information on patients (Table 7).

**Table 7 Dietitians’ comments about communication methods used for reporting on CDM patients**

Verbal communication	Written communication
Discussion re patient and mutual goals.	No contact, see pt, write letter to doctor.
Referral forms only, and often talking to the practice nurse regarding the treatment of these patients.	I do not provide any services from a GP practice and therefore collaborate through correspondence including preparation of a care plan, letters to summarise progress towards treatment goals and requests for measures to assess progress e.g. blood test results.
Discuss what would be the most appropriate referrals.	Limited access, practise nurse prepares the plans. Doctor does the referral for EPC and just forwards the paper work.
Informal discussions, written reports.	I provide very good written correspondence with clear goals including strategies that GP can help keep patient accountable too.
Team planning or 1:1 discussions with GPs.	Send letter only, GPs too busy for chats.
The manager of the clinic I work in regularly meets with referring GPs and we have in-house case conferencing regularly.	

More than one dietitian reviewed her attendance records and reported this potentially useful information to referring doctors.

*I don't collaborate with them prior to the patient coming to the actual visit. I have 2 doctors who actually ask me what my intentions are for the visits , but other than those 2 people , I don't have any input until I actually see the patient . I always write a report and send back after the first visit and then do this again at the end of the nominated visits. A couple of times a year, I do some filing and notify doctors of patients who never completed their allocated visits. It is good feedback for the doctor to know that his/her patient hasn't utilized the visits and made the most of it.*

Many others stated there was no collaboration in managing chronic care patients. Thus, the main method of communication was written reports sent from dietitian to medical clinic as a result of referred patients' consultations. Where professional staff were co-located, there was greater opportunity to share patient information with GPs/nurses and collaborate both in the planning stage and in the intervention period for particular patients (not as a routine). The key contact person in GP practices was often the practice nurse, and any verbal communication about patients' referrals or intervention was then between the practice nurse and dietitian.

## BILLING PROCEDURES

The experiences of dietitians who worked in a wide variety of clinic environments prompted many comments about fees and patient billing procedures. Medicare policy decrees that dietitians may charge patients the scheduled fee of \$56.25 for each consultation. If this is direct-billed by Medicare form and signed agreement of the patient, then a practitioner agrees to accept 85% of this fee (\$47.85) as full payment which is paid directly into their business account from national health insurance (Medicare) under bulk-billing arrangements. (Details and guidelines are available at [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)) Alternatively, patients pay the provider the required total fee themselves, and claim the rebate from Medicare.

### KEY RESULT

- Most dietitians (59%) did not have administrative assistance to help with the billing of patients and thus needed to carry out this process themselves.

Hence, fees and patient billing procedures were highly contentious and were regarded negatively by dietitians. Half of the respondent dietitians worked less than 12 hours each week in private practice, and less working hours meant they were significantly less likely to have administrative assistance than those working a greater number of hours ( $p = -0.200$ , CI 95% ( $p < 0.01$ )).

A high cost of purchasing administrative assistance versus profitability was stated as a barrier to instituting billing help, even in practices which were co-located with a GP or another clinic. The cost of administrative assistance was often shared in co-located clinics and was thus seen to be affordable. Whether they had administrative assistance seemed to influence dietitians' positive and/or negative views about bulk-billing. Dietitians who received assistance from secretaries or receptionists valued their handling of a time-consuming and sometimes difficult billing procedure, as inadvertent errors on forms could be handled by these persons and followed up effectively.

A dietetic workforce that has a small number of working hours in private practice clinics and/or sole practices appears vulnerable to fitting into a category of not being able to afford administrative assistance to decrease the administrative load required by the program. It appears that improvement of this process is dependant on dietitians' either increasing working hours to achieve adequate income, and/or attempting to organise co-location to cost-share the desired administrative assistance.

## Referred patient's eligibility for a dietetics EPC/CDM consultation

### KEY RESULT

- Encountering difficulty in ascertaining a patient's eligibility to receive a rebated consultation was common (for 42% of dietitians), although the majority (58%) had not had a problem.

Two of every five dietitians encountered difficulty in ascertaining a patient's eligibility to receive a rebated consultation, and some had not been paid for services as a result of a patient having used up all their available consultations for a calendar year. This strongly influenced some not to bulk-bill, saying:

*Too much hassle to get money back from Medicare. Now billing client for first visit and they then claim back.*

Several dietitians who bulk-billed invoices reported they would telephone Medicare prior to a patient's arrival to confirm their eligibility for a rebated consultation. This process was viewed as costly in terms of their time and might be more easily resolved if more uniform billing practices were in place. Participants' responses indicated that the implications of the Medicare funding policy only operating for a patient for a 12 month period was the introduction of an unnecessary barrier to service provision. Practitioners were then required to somehow overcome this in their provision of care.

Conversely, as un-used CDM referrals received by dietitians yet never implemented were discussed elsewhere in this report. Given these data one would expect that this situation could be rectified by the implementation of a referral tracking system, as suggested in another part of this report.

## The direct-billing process has low acceptance

### KEY RESULT

- The direct billing process was not accepted by the majority of dietitians. Around half the dietitians (58%) had ever bulk-billed a patient. When those that had not yet done so were asked whether they would bulk-bill in future, 66% said they would not and 23% were unsure.

Fifty-eight percent of dietitians had ever bulk-billed a patient and only two in five had administrative assistance to do so. They were strongly influenced by the personal time taken to invoice and bill, and to 'trouble-shoot' errors or omissions on forms which prevented payment to themselves or to clients -for which they did not receive any administration fee.

*Have missed out on payment of some bulk billed patients. Because of this I do not bulk bill in all my rooms - only one where the GP's bulk bill*

*This is why we don't bulk bill. We get the cash up-front and it is up to the patient to decide which health professional they want to claim from. Usually if physio involved, all claims are used up before we see them.*

Further, dietitians were negatively influenced by a need to accept the fee rebate as the sole payment if they bulk-billed for the initial consultation. Details of these issues are discussed later in the section on remuneration for Medicare services. All these issues appear to be of greater

importance if dietitians' employment is sessional and administrative assistance nonexistent, compared to better resourced fulltime clinic practice.

There is a recognition by Medicare that direct-billing has a cost, as GPs are eligible for an MBS incentive payment for bulk-billing for certain categories of patients such as Commonwealth concession card holders and children (MBS 10990-1).<sup>15</sup> If a dietitian's payment was higher, then report-writing and administrative help might be purchased and dietitians may be more amenable to bulk-billing and thus provide a fee-free service to patients. Current efforts to improve the billing process by instituting electronic payment may also be uneconomic due to the same issues, and proportional cost.

**RECOMMENDATION:**

4. There is a need to overcome administrative and financial barriers to bulk-billing to enable improved access to dietetics services for all consumers- in particular, for those in low socio-economic groups.

## UPTAKE OF CDM REFERRALS (ATTENDANCE) AND REMINDERS

**KEY RESULT**

- Over half the dietitians (53%) reported there was no tracking of attendance if a patient did not make a first appointment after an EPC/CDM referral.

**KEY RESULT**

- Most dietitians (60%) reminded patients to attend appointments by telephone, and re-contacted patients if they did not attend a planned appointment.

Chronic disease management protocols suggest that prompts, reminders and jointly planned care assists patients to make healthful changes. The results indicated that dietitians or their clinics made efforts to remind patients to attend planned appointments by telephoning them prior to the day of attendance (Table 8). However, dietitians stated there were redundant plans made and paid for, as not all patients implemented their referral. Many dietitians also did not receive these forms prior to them being brought in by a patient. It was uncertain whether doctors tracked these non-attendances or not. It may be important to people with chronic illness for dietitians to facilitate these issues.

**Table 8 Whether reminders are given to patients re their attendance**

Yes, patient is contacted	Not contacted and reason
We contact them to make appointment. If no show we inform the GP.	I used to but it is a big unpaid job, so not any more.
When they miss their appointment, they are contacted to see if they still want to attend.	Too many referrals, not enough time to follow them up. I assume the pt is not interested.
I have 2 doctors who send me paper work beforehand. I let them know if patient doesn't make contact.	It is only occasionally paperwork arrives before the patient and it is not often they fail to attend.
I receive referral from Dr, then contact patient to make appointment	I screen for 3 months [if] nil consult and pass onto clinic to follow up.

While it was apparent that many dietitians did contact patients either to make appointments or to remind them, many of the views suggested that it was up to a patient to make a first contact and then attend as arranged- as an indicator of their keenness, or level of interest.

*It is up to the patient to do this. If they can't be bothered making appointment, then won't be motivated.*

*No time because the people who are interested in helping themselves will access the services.*

This is an outdated theory, as the literature clearly shows that people are assisted by professionals who help them plan and also offer prompts and timely reminders in order that these patients are assisted to comply with management plans.<sup>18</sup> Accessible patient information systems are necessary to providers, however, to successfully administer chronic disease management programs<sup>19</sup> The results indicate that the expectations of some dietitians are too high and it would help practice if they were to more actively manage chronically ill patients. Although whether these factors apply to other allied health professions' providers is unknown, patients may benefit from a uniform policy across Medicare CDM providers about tracking and reminders. Further, this process would be facilitated by electronic records, through e-referral and shared access to databases. Electronic tracking is already in use by some GP clinics.

**RECOMMENDATION:**

5. There should be an electronic mechanism for tracking patients' attendance at allied health services when referred under EPC/CDM. This requires shared software access to track which professions referrals were generated for and their number, services received and whether they were ever completed.

6. There should be a policy for medical professionals on provision of patient reminders for those patients managed under Medicare (TCA/CDM). This is needed to guide practitioners about review, reinforcement, reminders and tracking methods to best support CDM patients. Automated reminders are possible using a tracking system.

7. Research should be initiated to determine a number of dietetics consultations consistent with best practice for common chronic conditions.

## DIETITIANS' MANAGEMENT OF PATIENTS

### KEY RESULT

- One or two half-hour consultations per year were not regarded as adequate to change a patients' lifestyle and dietary behaviours. Dietitians were ambivalent about their satisfaction with patient management under the current Medicare program. Forty percent were satisfied and 33% dissatisfied (n=356).

### Consultation time available is inadequate

It should be noted that nutrition education and counseling by dietitians is conducted not only by the giving of information or advice, but by a best practice of 'patient centredness' and a "dietetic process' of assessment, education, goal setting and monitoring of outcomes.<sup>20</sup> This requires revision, reinforcement of new information and review of outcomes whilst face to face with a patient.<sup>21</sup> Furthermore, the referred patients have *chronic disease or complex conditions* with/without dietary risk factors which makes lifestyle interventions more complex, and so dietetic change is not achieved instantaneously.

Dietitians in this study felt their professional practice was undermined by being asked to help patients achieve dietary goals (which had been set out by a doctor or clinic nurse) and yet they had insufficient time to build a relationship with a patient and to help them to make the required depth of change over a period of time. This could make their service appear ineffective both to a patient and to other professional staff. Dietitians were also well aware that the EPC/CDM process did not fit with their expectations of self-management models of best practice for chronic disease due to the constraints of the program.

*An initial half-hour consultation was universally regarded as not adequate to assess, educate and plan dietary goals with a patient and yet this was what was funded under current arrangements of a \$47.85 payment per visit to a provider. Many dietitians reported giving patients greater consultation time (such as 40-60 minutes) and said that they were not compensated for this extra time if they did not charge a fee gap. Two dietitians working in private practice who were interviewed for the study gave more detailed accounts of these issues- see Case Study 1 and Case Study 3 in the appendix.*

To address this issue, should a model of briefer counselling be developed which might assist dietitians in their quest to deliver effective nutrition education within particularly limited timelines such as 30-minute consultations? There is no known precedent for this process, and no outcomes of patient care for the current program (which could potentially assist) have been evaluated. Alternatively, Medicare rebates for a short and a longer consultation should be funded.

### Consultation frequency is often inadequate

### KEY RESULT

- Seven of every ten dietitians did not believe that the current program which allowed them *up to five* appointments annually for each patient gave sufficient contact with a dietitian to provide optimum care. In practice, they reported they may see a patient once or twice.

Dietitians' degree of satisfaction may relate to their principal patient type. For instance, one dietitian stated: "*Very difficult to provide comprehensive dietary education on diabetes, for example, in one short consultation*". Alternatively, another who may prescribe high protein

supplements or teach patients about lowering their cholesterol might achieve this in basic form in a shorter time because it is less comprehensive lifestyle change. Some comments on various patient diagnosis types are given in Table 9 below.

**Table 9 Dietitians' comments about consultation allocation and perceptions of patients' needs**

<b>Low frequency of allocated dietetic visits makes program inadequate</b>	<b>Frequency is adequate</b>
<p>If had 5 appointments yes but most are 1,2 or 3 if lucky. Often complex and 5 inadequate.</p> <p>Need at least 5 for just dietitian only. It is ineffective and inefficient only getting 1 or 2 EPC.</p> <p>Particularly when it is shared with other allied health professionals.</p>	<p>5 appointments is kind of a jump start for a short period of time but not sufficient for management.</p> <p>In GI disorders 5 is rarely necessary. I only see them once or twice depending on the condition.</p> <p>5 a good start but most clients need more then 5 to make a lifestyle change, but unwilling to pay.</p>
<b>Not meeting the needs for some patients</b>	<b>How many visits are needed?</b>
<p>Some patients, especially overweight or obese, may need regular support - far more than 5 visits. Definitely not for type 2 diabetes who require podiatrist and other allied health appointment. Suitable for simple intervention, but not for most chronic conditions.</p> <p>For wt loss impossible. Newly diagnosed diabetes really pushing it. 20 mins too short for initial appointment.</p> <p>Chronic disease is complicated. In 5 sessions you just skim the surface.</p> <p>Most of the patients have long term/multiple health issues not easily fixed in 5 sessions.</p>	<p>Many patients would have better long term outcomes if this was increased to at least 8. Should be a min of 6/yr</p> <p>It needs to be min. 5 contacts with dietitian and not 5 with allied health.</p> <p>Some require monthly reviews to stay on track, some patients call me between appointments to talk.</p> <p>5 yes, under 5 no.</p> <p>Need at least 12 sessions (one a month) especially for combined chronic disease and weight loss.</p>

Thus, 1-3 patient consultations was widely regarded as inadequate to address referred patients' goals and also to help them achieve these. There seemed to be a consensus that if patients were able to attend five dietetic consultations per year, then this would close the gap between an ideal situation and the current practice which did not meet most patients' needs for nutrition education and support.

Chronic care management as currently delivered has a focus on short-term and limited interventions that emphasize the planning and referral stages to initiate care. This is in contrast to more effective programs such as those in the UK which focus on outcomes, allowing access according to assessments of patients' need for ongoing chronic care and support.<sup>22</sup> The consultation time limits under CDM may be overcome to some extent if patients were able to attend group education programs where they are able to develop self-management skills and have ongoing education and also support. This relates to many of the chronic disease diagnoses that are involved in dietetic referrals, although the availability of such groups is unknown. These issues need to be explored.

**RECOMMENDATION:**

8. There should be recognition of a dietitians' important counselling role in management of chronic disease patients through a longer time allocation of at least 50 minutes for the first consultation.
9. The Medicare schedule should include both a long and a short consultation due to variations in time required for certain conditions and for initial versus follow-up dietetics consultations.
10. The number of dietetic consultations per patient should be increased to a limit of at least five annually, with an option for more.

## LEVELS OF REMUNERATION

### KEY RESULT

- Most dietitians felt they were being underpaid if they charged the scheduled fee of \$56.25 or accepted \$47.85 per visit if they bulk-billed.

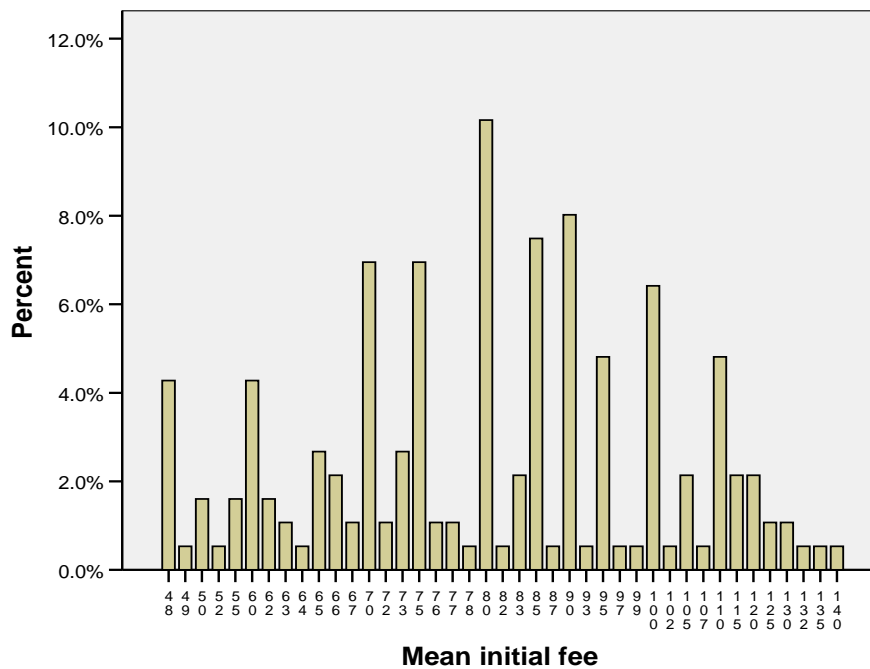
### KEY RESULT

- Around 6% of dietitians charged the scheduled fee of \$56.25. The most common fee for the initial consultation was \$80. Twenty-five percent of dietitians charged up to \$70, 25% charged \$71-80, and 50% charged more than \$80.

Fees charged for first patient attendance seemed to relate to time given- whether a dietitian provided a first brief consultation based on the scheduled fee, or provided a longer assessment/education and then charged a patient a fee gap. It should be noted that only half the survey respondents chose to reveal their initial fee, and that the figures are based on the mean of each dietitian's fee range (if a range was given).

Dietitians' fees charged to patients were usually greater than the scheduled Medicare fee for the first appointment based on time spent with a patient. Around 6% of dietitians reported their mean total fee for the initial consultation was the scheduled fee of \$56.25, or less. However, this proportion is uncertain as many selectively discount rates for concession-card holders alone. Overall, 25% of dietitians charged a fee of up to \$70, 25% charged \$71-80 and 50% charged more than \$80 as shown in the figure below.

**Dietitians' mean fee for initial consultations (\$) (n=187; 52%)**



There were a great number of different fee scales given for consultations lasting from 20 minutes to one hour, which ranged from \$47.85 to \$150.00. Dietitians faced a dilemma in trying to set the most appropriate fee structure for patients and for their practice relative to the scheduled fee. Few dietitians reported they allocated patients 20-minute appointments at the first consultation and bulk-billed. They felt an ethical responsibility to patients to set an affordable fee. Many dietitians were providing a longer consultation (40 minutes to one hour) which they thought necessary-though they did not charge a higher fee. Their business bore the extra cost. For the review appointment, two of every five dietitians (42%) bulk-billed or charged an equivalent fee (\$47.85)-no fee gap payment. Many comments were given about fees and the majority were negative comments about a low level of payment for their provision of services.

*There must be a higher initial rebate for a first dietetic appointment we cannot give a 20 minute appointment like a physio or a podiatrist*

*Very difficult to provide comprehensive dietary education on diabetes, for example, in one short consultation (ie if bulk billing).*

Many others had decided that education of patients could not be achieved a short consultation in a counselling type setting, and decided to provide a longer consultation. For example:

*... I refuse to do a 30-min initial (ie, the time given to do a bulk-billing appointment) so I charge my normal amount and give a decent service and let them get a rebate.*

*Unlike other allied health (who can see 3+ patients an hour) my consultations are 1 hour initial and 30 min follow-up. Thus cannot afford to bulk-bill.*

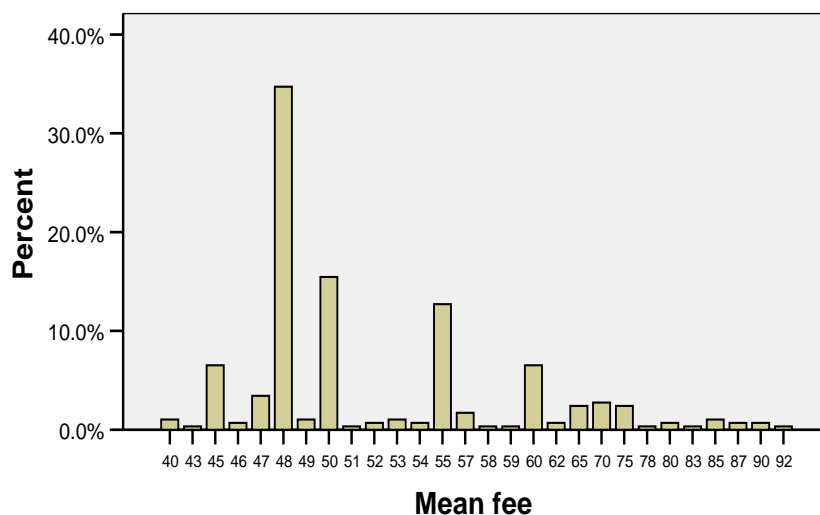
There were multiple fee arrangements including discounts for pensioners, who were more commonly charged the scheduled fee. There was no significant association between the initial or review visit fee and the state of employment, nor the length of practice experience and the fees charged.

#### KEY RESULT

- Fees charged for review attendances were more commonly the scheduled fee rebate of \$47.85. Two of every five dietitians (42%) bulk-billed or charged the identical fee (with no fee gap payment). Others charged patients a gap of up to \$12.15 (43% of dietitians), or more (25% of dietitians).

The mean fee for follow-up visits (of a range if a range was given by each dietitian) was \$53.30 and the median fee was \$50.00. The range is shown in the figure below.

**Mean fee charged by dietitians for review consultations (\$)  
(N=291; 81%)**



There were multiple fee arrangements for the review visits, including fee discounts for pensioners. Again, many comments were made which gave details of practitioners' various fee policies and experiences. There was agreement that the initial consultation with a CDM-referred patient was given longer than a review visit.

However, CDM patients were often seen as more complex than other patients and may require extra time, and therefore cost more. Some of these issues are stated elsewhere in this report and recommendations are made under 'remuneration' and under 'patient management'.

## Impact on dietitians' business model

### KEY RESULT

- Dietitians were ambivalent about their ability to provide a dietetics service for EPC/CDM-referred patients in a manner which might allow them adequate remuneration. Forty-three percent agreed they could, 37% thought they could not, and 20% were unsure (N=347).

These views about ability to provide an adequate service within the remuneration offered by Medicare may centre on whether the patient is charged a fee gap or not, or what proportion of a practice Medicare patients made up.

*Because costs are not covered with the Medicare rebate. Need to charge a gap payment as initial session 1 hour.*

The view of dietitians that the current CDM policy should be changed was centred both on level of payment and also perceptions of a need for more adequate (increased) counselling time in consultations, and also greater number of reviews to support patients throughout an intended period of dietary change. Differences may be due to variations in the types of patients dietitians were referred- for instance, a patient with diabetes who sees a dietitian once or twice can have additional food-related education from other professionals such as a diabetes educator in the team, who shares consultations. For other patients that a dietitian sees once, goal achievement may be completely unachievable. All these dilemmas illustrate the complex nature of chronic care management and limitations enforced by a single policy for all patients.

Issues of the Medicare rebate not meeting the financial needs of a clinical practice were prominent in the results. It was apparent from dietitians' comments that the payment did not cover administrative costs of room rental, reception, bookings, patient reminder calls, liaison with GPs or practice nurses, case conferences nor time to prepare patient progress reports as well as provide the patient with a consultation of at least 20 minutes.

*[Fee] doesn't cover practice costs of an admin supported practice. We offer high quality service - do body composition assessment, use educational models, confirm appointments, [run] own rooms.*

*Couldn't afford to run a professional business this way! The rebates are too low for the length of time invested and the overheads.*

Dietitians were thus stating that if they had to rely on the income from Medicare fees for their business then this would not cover their costs resulting in a negative impact on their business. Several dietitians stated that they depended on concessions from doctors to survive- for example, by providing very low room rental or providing a salary rather than depending on income from fees. Despite this, dietitians were keen to maintain a standard of professional practice and endeavoured to provide Medicare patients with the same service as other privately paying clients, though they often did not want to increase the number of Medicare clients.

*[I] give same time to Medicare and private patients although fee received is almost only half of my actual fee.*

Dietitians' views can best be summarised by this quotation from a sole practitioner working in a metropolitan area of Melbourne:

*...Private practice dietetics is a tremendously useful service, and one that's often valued by clients but no-one wants to pay adequately for it- not the government, private health insurers, or patients.*

The fee structure should be revised and level of payment increased commensurate with work done.

**RECOMMENDATION:**

11. The dietetics Medical Benefit Scheme scheduled fee payment should be increased.
12. Dietitians' MBS payment should include remuneration for proportional business costs and professionals' time spent consulting with other professionals.

The business model utilised by dietitians needs to be improved. Two-way communication between team members (particularly between GP/PN and dietitian) should be better integrated in order to facilitate reporting. E-referral and e-reporting offers a potential for reduction in time and cost of accessing information and reporting by dietitians. Further, it has the potential to assist care planning and sharing patient information and track patients' referral and attendance. This could be achieved by electronic means by sharing of patient records. Further, it may offer GPs more timely and efficient patient reports. Some GP Divisions are already well advanced in implementing this process between GPs, but it has not been introduced in the allied health professions so far as is known.

**RECOMMENDATION:**

13. A method of E-referral and E-reporting is required to facilitate sharing of information between dietitian and GPs/PNs- both about administering the program and about patient management- to reduce dietitians' overhead costs.

## Comparison with remuneration of other Medicare providers

Dietitians in the study were perceptive about the differences between their provider rebate and the scheduled fee compared with other providers within the same scheme, and therefore it was necessary to make comparisons. Dietitians' comments about provider roles and remuneration focused on the time spent versus an equal or greater remuneration of others (Table 10).

**Table 10 Dietitians' open-ended comments on the theme of remuneration comparison**

Allied health roles	Doctor roles
<p>A need for the rebate to reflect the consultative and educative nature of dietetic practice. It takes time to assess and provide relevant and appropriate information for clients. I see our work practice more akin to a psychologists consultation than that of a podiatrist or perhaps a physio where treatment is provided rather than negotiated.</p> <p>As dietitians we also see patients with complex psychological issues that need time to explore and develop rapport with. Anything less than a 45 minute consult is ineffective and inefficient. Anything less than at least 5 visits a year is the same</p> <p>Medicare needs to revise its rebates for counselling type services and significantly increase these.</p> <p>A different rebate schedule should operate for dietitians and others that include lengthy counselling. Physio's may be able to provide quick hands-on treatment (and in fact, treat several patients at the same time), but the time investment is much greater for dietitians for the same rebate - explain that?!</p>	<p>I would also like to see people have a minimum of 5 visits to each of the required allied health professionals in a calendar year. This could potentially be funded by reducing the money paid to doctors who often are having practice nurses do the care plans anyway</p> <p>...I am then pressured to bulk bill and lose money. An initial appt. takes at least 50mins, \$47.85 is not adequate for this. Especially when compared to a 5 minute doctors appointment.</p> <p>[Need] Automatic rebate without having to get the GP to fill in their form. If this was the case perhaps the patients could obtain 10 sessions for the same cost. It doesn't seem appropriate that a GP gets a significantly larger fee for filling in a standard form (that is often incorrectly completed or not useful in patient assessment) than the dietitian/patient gets.</p> <p>...They should add extra claimable items for dietitians e.g. for report writing and liaison with other health care providers - similar to the extra items GP's can claim.</p> <p>Drs get too many \$\$</p>

The points made by dietitians were

- *Doctors receive a significantly larger Medicare payment than themselves for what was seen as less time per task ('filling in a form')*
- *Doctors are paid for administrative and planning tasks and billing tasks; dietitians are not*
- *Dietetics is a counselling role requiring more time than 'hands-on' professions such as podiatry or physiotherapy, therefore a higher fee should be paid in recognition of this more time-consuming role.*

Improving the quality of care for patients with chronic disease is a major burden for the health care system given that one third of problems encountered in general practice are chronic in nature.<sup>23</sup> Efforts to provide support for GPs to plan and co-ordinate patient management have resulted in a number of MBS items in this chain of decision-making.<sup>15</sup> However, it should be noted that any advice, planning or reporting undertaken by an allied health professional such as a dietitian is not remunerated by Medicare and is thus not part of a private practice business model, and is therefore loss-making. Alternatively, GPs are remunerated for their planning time. This process has been summarised by Harris and Zwar<sup>24</sup> and by Foster et al.<sup>25</sup> Some details of Medicare remuneration for GPs and dietitians are given in the table below.

**Table 11 GP and dietetic Medical Benefits Scheme items; Medicare Chronic Disease Management (CDM)**

GP/PN service	GP task	AHP service: dietetics
Item 721 GP Management Plan† (rebate \$127.70)	Prepares an individual plan for a patient with a chronic medical condition (once every 2 years): assesses, agrees goals, identifies actions to be taken by patient, identifies treatment/ongoing services to be provided, documents in plan.	
Item 723 Team Care Arrangement(TCA) (Rebate \$101.55)	Coordination of a team-based care for patient with a chronic condition and complex, multi-disciplinary care needs (once every 2 years; involves at least three professionals in planning).	Refers to dietitian as option for up to five consultations and to other AHP as appropriate (No fee for a dietitian if asked to consult about TCA as required under 723).
		Item 10954 dietetics AHP provides individual consultation of at least 20 minutes face to face. (Rebate \$47.85 per visit)
Item 725 Review of GPMP (Rebate \$63.85)	Review of a patient's progress against the GMMP, documents changes and sets next review date.	Written report required to GP on first and last consultation –not rebated.
Item 727 Review of TCA (Rebate \$63.85)	Review of a patient's progress against the TCA- documents changes and sets next review date.	
Item 10990-1 Additional bulkbilling payment for general medical services (rebate \$5.40; \$8.20)	Rebate for bulk-billing -Only for commonwealth concession card holders or those under age 16.	
Item 10997: PN or AHW providing chronic disease support and monitoring (rebate \$10.85)		

Source: <http://www.health.gov.au/internet/wcms/publishing.nsf/Conyt=tentpcd-programs-epc-chronic> accessed 12 April 2008 and [www.health.gov.au/mbs](http://www.health.gov.au/mbs).

†Note: a GPMP is not mandatory for CDM referral.

Thus, GPs receive fees for planning patient care (GPMP or TCA). It is recognised that planning may be delegated to practice nurses (also subsidised through commonwealth funding) or to others. In some cases this is a dietitian, such as when a diabetes team is in operation and a dietitian plans patient care. They could not reconcile the fees paid to GPs for planning with their own payment for what they regarded as a longer consultation (from 30 minutes up to one hour) in the patient education session. Further, dietitians were not compensated for required administrative tasks related to patient care such as report-writing or billing.

It is noted that GPs also receive trailing fees in that they are rewarded for annual performance by service incentive payments (SIP) for annual cycles of care for particular patient categories. For example, \$20 per patient for diabetes care, \$100 per patient for asthma care, and service outcome payments of \$20 per patient for diabetes patients receiving SIP.<sup>24</sup> Additionally, GPs are subsidised for employment of practice nurses and for training in order to assist patient management. They have bulk billing incentive payments for some patients (MBS 10990-1).<sup>15</sup> These are welcome additions for patients in need of such care.

Since November 2006, the Commonwealth Government has auspiced the Better Outcomes for Mental Health Initiative to assist other chronic disease patient diagnosis types under the Australian Better Health Initiative (ABHI).<sup>26</sup> This Medicare-subsidised program added a number of providers to the allied health list of providers- such as qualified mental health nurses, accredited social workers and psychologists. Additional MBS items of MBS 2710, 2712 were added which vary the previous CDM Medicare regulations and also payments to AHPs and GPs (Table 12).

**Table 12 GP and psychological MBS items under Medicare Better Outcomes for Mental Health Initiative (BMHI)†**

GP service	GP task	AHP service: psychology/ social work/OT/other
Item 2710 GP Mental Health Care Plan (Benefit \$153.30)	Assessment and prepare an individual plan for a patient with a mental health condition	Item 80000/80010 clinical psychologist AHP provides individual consultation of at least 20 minutes face to face. (Benefit 30-50 minutes \$76.65; 50+ minutes \$112.45)
		Item 80100/80010 psychologist AHP provides individual consultation of at least 20 minutes face to face. (Rebate 30-50 minutes \$54.30; 50+ minutes \$76.65) (Group therapy benefit \$28.60)
Item 2712 Review of GP Mental Health Care Plan (Benefit \$102.20)	Review of a patient's progress against the GMMP.	Item 80125/80135 Occupational Therapist; Item 80150/80160 Accredited Social Worker AHP provides individual consultation of at least 20 minutes face to face. (Benefit 30-50 minutes \$47.85; 50+ minutes \$67.50)

†BMHI also utilises services of Aboriginal health workers, mental health workers (such as nurses) as accredited.

Source: <http://www.health.gov.au/mbs/search>

Psychological therapy services under BMHI are available to eligible patients up to 12 times per year. When provided by a clinical psychologist for 30-50 minutes per session, the Medicare rebate is \$76.65 and the benefit for a longer consultation lasting at least 50 minutes is \$112.45. The time taken to deliver this psychological service is similar to the consultation time dietitians say they require to enable effective dietary interventions. Many dietitians are similarly qualified after five years study at university. Yet the fee for this class of psychologist is 1.6 times and 2.4 times the Medicare fee dietitians receive. Conversely, however, social workers and OT's provide a consultation of 30-50 minutes at rebate of \$47.85, which is greater allocated time than is mandated for dietitians (at least 20 minutes for \$47.85).

The reasons for these inconsistencies are difficult to understand, and must be even more difficult for chronic care patients to comprehend. Given our analysis of the circumstances of the program we strongly suggest that future iterations of the program should provide equity of benefit payments across services. Dietitians should be funded to provide longer consultations than 20 minutes for each.

**RECOMMENDATION:**

14. There should be parity between dietetics providers' payments and fees paid to other professional groups within Medicare EPC/CDM with similar competencies.

## A NEED FOR PROGRAM SUPPORT

### Training of private practice dietitians in the business of the Medical Benefits Scheme

In introducing the allied health Medicare program in 2004, the method of implementation in allied health seemed to be filtering of information down through the professions.<sup>3</sup> There was no known training for dietitians and as they were often working in sole positions, this has created a dilemma through not knowing how best to meet the program's guidelines.

In this study, characteristics of the workforce may impact on how dietetics patients were managed. Half of the respondent dietitians worked alone in a sole practice. Half worked less than 12 hours each week in private practice, and less working hours meant they were significantly less likely to have administrative assistance than those working a greater number of hours. Further, it is suggested that those dietitians with very sessional commitments are less likely to have opportunities to develop collaboration with others or to build expertise about the program or the referrals. The results of the current study indicate that many dietitians were unprepared to integrate their practices within a chronic disease model in a primary care setting with key participants who were GPs/PN who have the role of reviewing and reinforcing patients' behaviour change. There was no process by which detailed information could be shared between dietitian providers. Dietitians need to be central players who understand the idiosyncrasies of the MBS system. Sharing of information and support through further training may help overcome these barriers.

Since 2004, Medicare implementation strategies have changed. There has been an initial education program for dietitians and diabetes educators regarding implementation of the Medicare Group Services program for type 2 diabetes, although this is not known to be ongoing. It is noted that the Better Outcomes for Mental Health program providers have been granted an education and implementation program funded by the Commonwealth Government of 52 million dollars over four years to develop the best patient care.<sup>27</sup> This will allow both training and also evaluation of outcomes. The magnitude of the funding for implementation and delivery of mental health care is applauded. However, it also provides a useful comparative indicator of the under-funded and "under-implemented" nature of the dietetic allied health program. *Better nutrition* is a cornerstone of health improvement and risk reduction for the health of Australians' for the next 20 years.<sup>28, 29</sup> Thus, review of the conditions under which CDM dietetic allied health is provided is overdue. Dietitian practitioners should receive individual training to implement collaborative care with GPs and other health professionals. This may help overcome referral and administration difficulties and ensure that there is consistency in how dietitians administer the chronic health care CDM guidelines.

### Broader role for GP Divisions to support allied health

One-third of dietitian participants (101) worked in a clinic with a GP. Another half (176) worked in a sole practice, leaving them with no formal peer or professional support for managing practice development. This is different from hospital or community services, where they are often one of several similar employees or several allied health employees. A lack of program support for dietitian CDM providers was viewed as limiting both Medicare CDM implementation and development of practice improvements aimed at improving quality. There is no reason to suggest that this situation does not also exist with regard to many other professions that manage CDM referrals.

Twenty years ago, GPs may have also been in this position as individually located professionals, though sole practices are now rare. The development of GP Divisions in regions throughout Australia<sup>30</sup> has assisted the dissemination of information and allowed 'collaboratives' to be formed and policies to be developed and implemented across widely dispersed locations.<sup>31</sup> GP Divisions now have treatment programs in place for diabetes education and they undertake research. They have on staff practice nurses, diabetes educators and other professionals as well as doctors. They have a role in education of primary care providers on staff and in the community. Allied health providers in private practice provide primary care services under Medicare, and could be included under the umbrella of Division of GP organisations as a healthcare group in order to implement and support team-based collaboration. General practice has already indicated commitment to working together with allied health professionals. This commitment to an integrated approach to care is suggested by the setting of national performance indicators for More Allied Health in divisions which are funded for this program.<sup>38</sup> The implication that can be drawn from these results is that CDM patients should be treated as a practice population. Efforts should be made to standardize care using evidence-based models of care and by engaging all relevant local allied health Medicare providers.

The expected benefit of this for dietitians is a progression from sole practices without structured links to Divisions to communities of practice able to apply team-based care (and more optimum communication between GP and dietitian and between dietitian and GP/PN). Such a move may provide an opportunity to evaluate patient outcomes and undertake economic evaluation as a standard part of the program. This method of supporting practitioners may lead to increased effectiveness on many levels.

**RECOMMENDATION:**

15. Divisions of General Practice should broaden their role to include support for allied health Medicare providers such as dietitians through education and training to implement best care for patients with chronic disease or complex conditions.

## POLITICS OF MEDICARE POLICY IMPLEMENTATION

The Medicare CDM scheme as part of the Enhanced Primary Care program has so far focused on general practice and is not available to medical specialists to access- for instance, for their patients with diabetes, or paediatric patients. As some dietitians worked in concert with medical specialists, they saw an opportunity to manage the chronic disease of patients alongside the GP referrals and they commented on this care gap.

*One very important team member that is unable to refer patients for EPCs is the specialist. This should be considered in the future as the specialist is certainly a team member that needs to be involved in the ongoing management and care of the patient.*

Furthermore, the politics of referral permeated the domain of all levels of doctor referrals.

*The process of accessing the funding via G.P. is too cumbersome and poor for business. However, if I am associated with a G.P. practice I will then be totally dependent on the one practice as other practices are reluctant to refer to another G.P. practice on the fear of losing patients. That is a major reason for associating myself with a specialist practice in order to accept referral from a wider range of G.P. But the endocrinologist can't refer. I can't believe the illogical nature of this funding.*

There was some evidence in the responses of dietitians of unethical preferential treatment of preferred providers in receiving CDM referrals, and hence a greater volume of work. This was perceived to have occurred with the delegation of referral decisions by doctors to other professionals, such as practice nurses or AHP's. For instance, a co-located dietitian may not receive any diabetes CDM referrals if the limited referrals are directed to diabetes educators to provide all diabetes education for a patient, including medical nutrition therapy. The problem is that the 1-5 sessions covered by the program include visits to all AHPs. Hence, if a patient needed to see a physiotherapist, occupational therapist and a dietitian then the practitioners felt that they were competing for sessions out of a basket which did not contain the number of visits required for optimal treatment by any of the AHPs. The current system creates a competition between providers. Dietitians disliked competing with other team members for patient referrals. For example:

*"At the moment we are competing with different allied health and it is very competitive- ...do not like competing with physios who I should be working in a team with."*

There is, indeed, potential within the Medicare CDM policy for referrals to be directed to any preferred providers. This appears to be exacerbated by the very limited number of CDM consultations for various allied health professions available to a patient annually.

A solution for many of the problems encountered by dietitians appears to be a relaxation of the tracking system under which GPs alone 'refer' and payments are made only on receipt of GPs' billing invoice. Similar to the Mental Health initiative, referrals should be receivable from any qualified medical doctor and the professionalism of dietitians invoked by allowing them to claim Medicare payments for all referred patients seen- up to say 12 visits per year. The impact of such a reduction of red-tape in claiming from Medicare may result in greater compliance with bulk-billing and consequent increased affordability to patients. The comments given by dietitian respondents in this survey uncover the real world of private practice and enable us to understand barriers and enablers to effective patient care.

## UTILISATION OF MEDICARE GROUP SERVICES

### KEY RESULT

- Only 28 (8%) of dietitians had provided group services to people with type 2 diabetes, although a further 28 intended to do so.

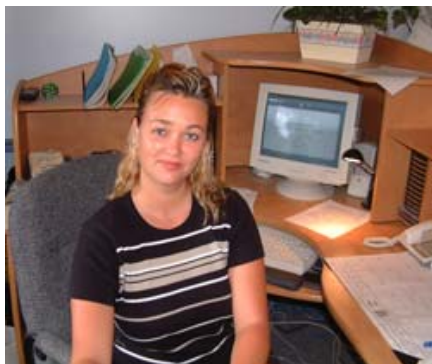
### KEY RESULT

- The number of sessions over which diabetes group programs were run was a range between 1-16.

Medicare group services for patient with diabetes type 2 commenced in 2007. The main barriers to starting group services were financial viability, lack of a suitable venue, lack of referrals from GPs, lack of multi-disciplinary team members and lack of a suitable already-developed program. Many explanations were given in positive and negative comments. However, others stated they were already busy enough or over-subscribed in their current practice with individual consultations. Of those who had commenced running group services, several dietitians stated that maintaining attendance had been a problem for them, and remuneration was low. Others praised the format. However, the number of respondents who had run a group program was not sufficient to evaluate the process and more time may be needed to develop proficiency in this particular arena.

There was uncertainty about whether the group program met the needs of patients with type 2 diabetes, as 21 dietitians (47% of 45 respondents) were unsure. However, this number included some who had not yet run a program. Seventeen dietitians (38%) were 'satisfied/very satisfied' with the program and 7 (15%) were 'dissatisfied/very dissatisfied'. What can be reasonably suggested in line with other findings discussed in this report is that dietitians may be further assisted by drawing on content from successful programs run in many states. Overall, results and comments indicated that some dietitians may need assistance from experienced program directors in order to set up and maintain attendance and quality of the group program. A system of mentoring via distance education may assist and reduce a level of frustration mentioned by some respondents.

What have we  
found out?



## IS PATIENT CARE STRENGTHENED THROUGH MEDICARE ALLIED HEALTH SERVICE PROVISION?

There are arguments for and against the notion that patient care has been strengthened through the Medicare Allied Health Program. Evidence has been revealed which both supports and also negates this as an outcome of dietetics care. For instance:

- Patients' access to dietetics has been increased, as the number of dietitians in private practice has almost doubled.<sup>iii</sup>
- Forty percent of dietitians in private practice endorse the program in its current form.
- Access is available to patients in the community- but not in all communities- as there is inequitable access across states (eg., negligible access in Northern Territory) as given in Medicare statistics.<sup>3</sup>
- Patients can access clinicians in private practice, but at present only half can utilize direct billing –and this is unlikely to change unless fees are increased – which limits access for low socio-economic groups.
- There is a lack of program support for dietitian Medicare CDM providers and an effective care model for dietetics for individual or group consultations is so far unresolved.
- There is a lack of evidence about whether patients benefit from the allied health program, as no research has been conducted on patient outcomes.

A body of evidence is gathering about the necessary components of chronic disease self-management programs, and how to help patients engage in their own self-care.<sup>17 32-37 39</sup> This suggests that 'activated' patients working with planned multidisciplinary care can reduce symptoms and prevent further complications.<sup>14</sup> Overall, though, the outcomes of the Medicare chronic disease management program for dietetics patients are not adequately known to judge the effectiveness of the program re planning, referral, cost or impact on the CDM patients' health status. There is little evidence of success or failure of the CDM allied health program as no known evaluation has been undertaken. Utilisation statistics such as currently published by Medicare offer little prospect of describing the quality of care leading to knowledge about what efforts may be required to improve the program. Patients' health outcomes need to be known.

Nevertheless, many dietitians agreed that having the current program was a better option for many patients than what was available previously, and that there were positive aspects of the program. For instance:

*I think that the EPCs have had a very good effect in putting dietetic services more onto the map with GP's.*

*Great initiative, however should be extended to non chronic conditions. ... More people would probably visit a dietitian if this was the case, and more dietitians would be likely to bulk bill.*

### RECOMMENDATION:

16. Research should be commenced to identify health care outcomes for Medicare CDM-referred patients.

<sup>iii</sup> In 2001, there were 442 dietitians in private practice nationwide (DAA Members' Directory 2001. Canberra. 2001) versus 786 on the DAA private practice membership list in 2007-8, as reported by DAA for this study.

## CONCLUSION

The Medicare Enhanced Primary Care Program later called the Chronic Disease Management program was introduced by the Australian Government to:

“provide more preventive care for older Australians and improve co-ordination of care for people with chronic conditions and complex care needs.”<sup>1</sup>

The results of this study indicate that the program outcomes regarding better coordination of care are unknown. Provision of preventive care by dietitians usually faced considerable barriers, so that patients' goals set by GPs were unlikely to be achievable. Recommendations made in this report may help advance the Chronic Disease Management dietetics program.

Research by Zwar et al<sup>39</sup> indicates that chronic disease is best managed through increasing self-management skills of patients. However, to achieve this in general practice requires a team approach to deliver patient education and to increase patients' motivation. In addition, they reported that delivery system design and decision support such as education of professionals and use of audit and feedback were associated with improved physiological measures and other improved patient outcomes. The results of the present study also suggest that the systems as they are currently implemented need improvement.

Results of this study indicate that dietitians wish to be remunerated adequately for patient education using a dual fee structure congruent with the fees of other providers who require a longer consultation time (such as psychologists). Streamlined e-referral and e-reporting mechanisms between dietitian and GP would improve dietitians' access to patient records and facilitate and direct their reporting. This would allow tracking of patient referrals and their uptake to facilitate attendances and minimise redundant referrals. In addition, it is suggested that fast and direct communication would also reduce dietitians' overhead costs and thus may improve their satisfaction with the program. Dietitian and GP education may further assist the implementation of this program through identifying best practice. Rigorous evaluation is still needed to demonstrate the impact of the program on patients' outcomes.

Dietitians perceived there were many barriers to their practice as a Medicare provider for chronic disease management. These involved all steps of the process, from referral, to managing patients, to record-keeping, fees and billing. Further work should be done to simplify these and to reduce the barriers. Dietitians want to provide best care for complex patients. Now is the time to review the program's guidelines to enable longer-term preventive dietary management for patients referred under Medicare CDM

**END**

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## APPENDIX

### LIST OF THE RECOMMENDATIONS ARISING FROM THE MEDICARE CDM SURVEY\*

1. For collaborative planning to occur, dietitians should be financially compensated for time spent in patient care planning (as required for TCA, GPMP).
2. Agreed protocols should be developed to guide GPs/practice nurses/AHP to standardize practice of collaborative care planning, regarding which professions should receive referrals.
3. There needs to be clarity about the roles of GPs, practice nurses and dietitians over setting of clinical goals, as dietitians should be delegated the task of collaboratively developing agreed dietary goals with CDM patients.
4. There is a need to overcome administrative and financial barriers to bulk-billing to enable improved access to dietetics services for all consumers- in particular, for those in low socio-economic groups.
5. There should be an electronic mechanism for tracking patients' attendance at allied health services when referred under EPC/CDM. This requires shared software access to track which professions referrals were generated for and their number, services received and whether they were ever completed.
6. There should be a policy for medical professionals on provision of patient reminders for those patients managed under Medicare (TCA/CDM). This is needed to guide practitioners about review, reinforcement, reminders and tracking methods to best support CDM patients. Automated reminders are possible using a tracking system.
7. Research should be initiated to determine a number of dietetics consultations consistent with best practice for common chronic conditions.
8. There should be recognition of a dietitians' important counselling role in management of chronic disease patients through a longer time allocation of at least 50 minutes for the first consultation.
9. The Medicare schedule should include both a long and a short consultation due to variations in time required for certain conditions and for initial versus follow-up dietetics consultations. Dietitians require at least 50 minutes for their first consultations.
10. The number of dietetic consultations per patient should be increased to a limit of at least five annually, with an option for more.
11. The dietetics Medical Benefit Scheme scheduled fee payment should be increased.
12. Dietitians' MBS payment should include remuneration for proportional business costs and professionals' time in consulting with other professionals, such as case in conferencing.
13. A method of E-referral and E-reporting is required to facilitate sharing of information between dietitian and GPs/PNs- both about administering the program and about patient management- to reduce dietitians' overhead costs.
14. There should be parity between dietetics providers' payments and fees paid to other professional groups within Medicare EPC/CDM with similar competencies.
15. Divisions of General Practice should broaden their role to include support for allied health Medicare providers such as dietitians through education and training to implement best care for patients with chronic disease or complex conditions.
16. Research should be commenced to identify health care outcomes for Medicare CDM-referred patients.

\*KEY: GP: General Medical Practitioner; PN: Practice Nurse; CDM: Chronic Disease Management; EPC: Enhanced Primary Care; TCA: Team Care Arrangement; GP MP: GP Management Plan.





Australian Government

Department of Health and Ageing **Enhanced Primary Care (EPC) Program**  
**Referral form for Allied Health Services under Medicare**

**To be completed by referring GP:**

Please tick the relevant box below:

- Patient has a GP Management Plan and Team Care Arrangements in place (new CDM MBS items 721 AND 723) OR
- Patient has an EPC Multidisciplinary Care Plan in place (former MBS items 720, 722 or 730; or new CDM item 731)

**Note:** GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

Medicare rebates and Private Health Insurance benefits cannot both be claimed for these services.  
Patients should be advised that they must choose whether to access one or the other.

**GP details**

Provider Number

Name

Address  Postcode

**NOTE: Relevant MBS item(s) above must be BILLED by GP prior to patient receiving their first referred allied health service for Medicare rebate to be payable for that service.**

**Patient details**

Medicare Number           Patient's ref no.

First Name  Surname

Address  Postcode

**Allied Health Professional (AHP) patient referred to:** (Please specify name or type of AHP)

Name

Address  Postcode

**Referral details – Please use a separate copy of the referral form for each type of service**

Eligible patients may access Medicare rebates for up to 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker	10950		Dietitian	10954		Physiotherapist	10960
	Audiologist	10952		Exercise Physiology	10953		Podiatrist	10962
	Chiropractor	10964		Mental Health Worker	10956		Psychologist	10968
	Chiropodist	10962		Occupational Therapist	10958		Speech Pathologist	10970
	Diabetes Educator	10951		Osteopath	10966			

Referring General Practitioner's signature

Date signed

AHP must provide a written report to patient's GP after each service – except where the AHP provides multiple services to a patient under the one referral. In this case, the AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health professionals should retain this referral form for record keeping and Medicare Australia audit purposes.

Allied health services funded by other Commonwealth or State/Territory programs are not eligible for Medicare rebates under this initiative.

This form may be downloaded from the Department of Health and Ageing website at [www.health.gov.au/strengtheningmedicare](http://www.health.gov.au/strengtheningmedicare) or ordered by faxing (02) 6289 7120. (This form does not have to accompany claim forms)

## APPENDIX

### Questionnaire contents

<b>QUESTION</b>	<b>No. OF ITEMS</b>	<b>EXAMPLES OF MEASUREMENT ITEMS</b>
1. Demographic characteristics	7	State of employment, practice type, speciality, year of qualifying, sex, whether Medicare provider/what year registered (multiple choice; yes/no; open-text response)
2. Referrals from general medical practitioners	10	Number referred, proportion of all patients, whether referrals have changed since Medicare CDM, referrals detail, goals detail, advertising or not, satisfaction with CDM (multiple choice; five-point frequency scale; five-point satisfaction scale; yes/no; open-text response).
	1	Referral of 9 diagnosis types (five-point frequency scale)
3. The patient	6	Use of reminders, tracking, awareness of reason referred, patients' awareness of goals, non-attendance, availability of consultations (yes/no/unsure; five-point frequency scale)
4. Fees and billing	8	Administrative assistance, bulk-billing, ever bulk-bill, fees charged, continued attendance, remuneration opinion ( yes/no; yes/no/unsure; open-ended text)
5. Medicare group services	6	Provision, barriers, team members, number of sessions, satisfaction (yes/no; multiple choice; five-point satisfaction scale)
Total	38	

†Frequency scale: always/often/sometimes/rarely/never. Satisfaction scale: Very satisfied/satisfied/unsure/dissatisfied/very dissatisfied. Each question was accompanied by an open-ended text box inviting comments.

## Appendix

### FOUR CASE STUDIES:

Nine dietitian participants were interviewed by telephone and these four narrative extracts are provided in order to give a greater explanation of some practice issues that dietitians faced in the workplace which were reported in the earlier survey results. These include whether to opt for short or long consultations given the level of payment, how the referral process works, models of report-writing to GPs, and information about the nature of dietetics practice.

#### CASE STUDY 1

A high volume Medicare provider, who is satisfied with the Medicare program. She is a recently qualified dietitian (2006) who works fulltime in a group dietetic practice in a state capital, and sees between 50 and 100 CDM patients per month (60-80% of her practice).

Receptionists handle the bulk- billing for new and review visits of 20 minutes each. She stated that the allowed number of visits was sometimes adequate but "most often it is not". She communicates with referrers through entries in case notes (using shared electronic software), letters and speaking with doctors by phone if necessary.

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*Interviewer: You were satisfied with the Medicare program?*

Um, I guess because I don't really have anything to compare it to. Um, I see- I guess because we charge less for our private consults, so I am quite happy with how much we get for them. The number of consults per calendar year is probably the one that I would like to see increased. The time also, particularly for the initial consult, I would like to be longer.

*Interviewer: How much time do you allow for your initial consult?*

Ahh, for the Medicare ones its 20 minutes, for my private paying ones its 40 minutes and I charge 110 dollars.

*Interviewer: Ok. Perhaps another issue is that GPs are remunerated for all their costs including administration and writing reports. Would you expect to write your report after the 20 minutes and have that paid for within the fee?*

Um, I'm not 100 percent sure. At the moment I spend 20 minutes, and then that is the time I'm getting paid for, but I am not getting paid for the time I take to write the reports.

*Interviewer: Could you estimate the time it takes to write up the report?*

Ahh, if they're referring from within the centre it's probably a couple of minutes per patient, but if they are from external practices, then it is five to ten minutes.

*Interviewer: With that difference between reporting, is that anything to do with the way that you report?*

Yes. We're all computerised, and um, we've got templates. So I just put in the individual details into the template and then send it. But with the external ones, it's a matter of writing it all out and then printing it and then posting it.

*Interviewer: Does the software also give you access to the patient's medical details, so that to you can have two-way communication?*

Yes, that's correct. It's fantastic! I think we have been quite spoiled! It uses MedTech 32.

*Interviewer: Just a couple of other things you responded about: you said "At least 40% of patients will come back for a further review". You say the initial consultation is fairly short, so do you see this as a way of increasing the overall consultation time by giving them short bursts of information more frequently?*

Yeh. I guess so! Because I am not fitting as much into my initial [consultation], then there is always more that we can go through. And so these people are happy to come back for a review, and then er pay for a review, and some people are happy to continue for an ongoing period of time. How many visits they need depends on what they want to get out of it, and on their level of education and understanding. For some people two, three, four, five visits is adequate, but usually up to ten. That's what I would feel more comfortable with, in a year, definitely.

*Interviewer: When Medicare introduced the program, they stated that this was to improve care for patients with chronic disease. Can you tell me about any training you may have had to manage patients with chronic disease?*

Um, er ...

*Interviewer: In your course?*

Oh, I think just a general- probably learning about the chronic diseases and their management, I think there wasn't much information provided about private practice in the lectures or workshops that I can remember.

*Interviewer: I'm not sure if you are a Flinders Uni graduate, but have you studied the Flinders model of chronic disease management?*

Oh, yes. Oh, we did go through all of that, yes.

*Interviewer: Do you have any other suggestions about how the current Medicare program could better meet patient needs?*

Er... No, I don't think so.

*Interviewer: Do you have any other suggestions about how the Medicare program could better meet your needs as a provider running a practice?*

Oh, no not really, I think it works quite well for me. Other than the number of consults allowed, I think that is probably the major thing that I would like to see increased.

*Interviewer: Right. You said that "yes", you were marketing your services- so are you seeking to increase your Medicare referrals?*

Yes, we are always er writing letters to GPs in the area. If we get private clients coming through, we will send a letter along with the marketing pack, particularly telling them about the Medicare scheme, to get more patients that way. I speak with most of the doctors in the centres and try and gain referrals that way.

Extract from dietitian interview 106L

## CASE STUDY 2

A low volume provider for Medicare CDM. Dietitian in a sole private practice in a suburban area of a capital city who qualified for dietetics in 2001. She is employed fulltime in a public hospital, as well as seeing up to 10 Medicare patients per month (up to 10% of her patients) in her 15 hours per week in private practice. Her practice does not bulk-bill, and charges a fee gap to patients. She is dissatisfied with the current Medicare program.

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In discussion about GPs' referrals under Medicare CDM:

*Interviewer: At the moment they send you the referral, they don't really collaborate in producing the referral or making the goals?*

No

*Interviewer: Ok. So, when you feed back to doctors in your report, do you put in the patient goals and expect them to support the patient to try and achieve those?*

Errr, no. I don't. Um, I think a lot of the time its just sort of whatever electronic program they have...I don't always see the care plan, either, I mean I'll often just be presented with the one-page EPC referral. But, quite often, its just the generic EPC sort of- the generic care plan and its- er weight loss, glycaemic control, whatever, [they ask for] its::: you know, its very, its not patient specific at all, so what I end up discussing with the patient can be quite different. Well, you know, its heading in the same direction, but no, I don't use their base goals and I don't report back on that aspect.

*Interviewer: Can you suggest how your collaboration with the GP might being improved, or suggest any need about that?*

Ahhh, I'm probably not the best person to answer that just because I am not relying on it so much [for income] so I'm not generally going out there and developing any- you know, I'm getting referrals that have come from THEM being aware of my work from other aspects [hospital employment] so... I can see it would be very important for those [other] people.

*Interviewer: In another study that I'm aware of, of GPs and dietitians, the GPs have said they would like to receive back from dietitians information about the goals that are set for the patient because often they are the person that sees the patient more frequently than the dietitian for instance? That's the reason I ask that.*

Ok, if a patient stated to me-- like, I always ask the patient what they want to achieve and I guess that will always go er- er into my letter in some format. Er, that's not under a heading of goals, you know, but it will be ... what the patient's aiming for and what we have discussed. That's there in a format, but it may not relate to what they've initially said [in the referral].

*Interviewer: Ok. With your fee structure, can you comment on any feedback from patients about how much they have to pay in the gap payment?*

Um::: Most are fine. I mean, they understand generally that there is going to be a gap. There are some who, once they realise there is going to be a gap, then they won't make an appointment. Um- so for those, obviously, I mean it's definitely an issue. And it will impact on whether they have any input from anyone- I mean, I know there are people [ie., dietitians] around that do bulk-bill, but otherwise they don't really have much other- option.

*Interviewer: Can you see any solution to improve the service to meet the needs of these patients with chronic conditions?*

You could also structure it so that its over a longer time, so that may also be more effective than allowing for free one-hour consults in a whole year.

*Interviewer: So that might be beneficial to the patient in cost terms, you are saying?*

Yeh. In ongoing support terms, for those people for whom that's applicable, so you would see them for a shorter time but also more frequently, so the total cost is going to be the same, but they would structure it differently.

*Interviewer: OK. I guess they may be able to access community health services wouldn't they?*

Yeh, but

*Interviewer: Oh, may be they don't have a health care card?*

Well, they may not have a HCC but- oh, I don't know what community health dietetics is like. I mean, there is generally not really a lot um, out there. Yeh, its very:: scant on the ground [*is it?*] Yeh! Like, even in the hospital system. I also work fulltime for a hospital- a public hospital- and just from a resource point of view- we don't do any weight loss, we really don't do any um inpatient diabetes management. So if someone from the community rings up re weight loss, it's generally Weight Watchers or a private dietitian [they need]. They are not necessarily people that can afford dietetics, so its very difficult. In community, there is paediatrics, and there is the aged care program, but in the middle there is really not much out there. Not in any ongoing individual sense, you know? I mean, more groups are set up and groups are fine, but it doesn't give you quite the same level of service.

Extract from interview with dietitian number 120 (N).

### CASE STUDY 3

A high volume provider for Medicare CDM. A dietitian working in sole private practice in a large provincial town for 25 hrs per week. She qualified for dietetics in 2005. CDM referrals are received from a number of GP practices, estimated at 11-25 CDM patient referrals per month (40-60% of her patients), for diabetes types 1 and 2, obesity, cardiac and respiratory and other diagnoses.

She stated in the questionnaire she is dissatisfied with current Medicare program, although she can provide a service to patients in a way which allows her adequate remuneration "only because I charge a gap for the first consult" Not co-located with other professionals; handles own billing and does not intend to bulk-bill.

*Interviewer: ...In the survey, dietitians suggested the Medicare fee rebate was too low. Should there be a fee structure for a short and longer consultation, for instance?*

That would certainly help to sort out the issues. But, basically –just to give you a run-down about how I treat my patients I get referred on a care plan- I treat them like any other client that comes and sees me. And I feel in a way, you know, that these clients need more time, they need more attention, because mostly they've got a heap- a heap of chronic conditions, and they need a lot more management, a lot more counselling, so::: Basically, everyone I see in the initial consult, it's an hour. It's that same for everybody. I don't charge them less because I am putting in just as much effort. In fact, more! You know? Because I have to then, um, write reports to doctors, um, a few er letters, and in fact, you know, more input with the letters to the doctors, so that's my initial consult. It is \$80, and I tell the people this when they book in. So they are aware of it!

*Interviewer: Yes.*

Er, Um::: See, in all the time that I've seen people in the last 3 years, maybe half a dozen have said 'Oh, look, I'm not going to go ahead with that' because - And its mostly because the doctors have told them "Oh, its free"!

*Interviewer: Yes. Yes.*

And each doctor who sends me someone who says "Oh, I thought it was free", I will then send them a fax and I outline the services I provide; I say 'this is my fee and there will be an out of pocket cost for a consult'. And some doctors have stopped referring to me, but most doctors have continued to.

*Interviewer: Right. So you do get referrals from a number of GPs in various practices?*

Yes. But, remember I live in a regional centre so to speak, [name of city] which has got quite a big population. About 50,000. ...I'm getting enough to keep me going, perhaps three- maybe four days a fortnight, being predominantly care plans.

*Interviewer: How do you see GPs are managing these referrals?*

Um, there are a lot of GPs who have taken up care plans. So there are those GPs who have basically said 'every one of my patients who have diabetes is going to go through a care plan'. There is that lot. And then there are the others [GPs] who just send me a care plan here and there. So they will send me a care plan which will involve a diabetes educator, a podiatrist, quite often a physio, but pretty much a podiatrist and myself are involved in a care plan.

*Interviewer: Some dietitians have suggested that the fees should be more similar to the Medicare psychology rebates- that is, allowing for a 30 minute service and a 50 minute one. How would that match with your services currently??*

Oh, my initial consult needs to be about 45 to 50 minutes, usually at least an hour. You see, the whole thing is- creating rapport with these patients, taking a really good history of where they have been at. And then, when you are working with them, to try and identify the places that they are at, you know, what they are happy to work with [to try and change]. And that takes er, a good part of an hour! And er then the followup er generally takes a half an hour. What I use, I charge er whatever they get back for the second consult.

*Interviewer. Yes. How much if this time you mention would be devoted to patient education versus writing a report?*

Its all patient education- I write my reports after. I have a writing day when I write my reports, do my admin.

*Interviewer: Mmm. Ideally, would you see that as being included in your overhead costs?*

Well, that would be nice! But I can't see it [laughter] ...

*Interviewer: Well, the doctors get paid for their admin don't they? And their planning?*

That would be great! [laughter] For each patient - for my initial- for my initial I send a letter. And that probably takes me er.. it may be 10 minutes- 10 minutes by the time you write up your notes, and then do the letter. At the end of the care plan I do a report, and that report probably takes me about 20 minutes! That's the outline, all the goals, you know? The assessment, the goals, and what the outcomes were, and then a comment. Its all personalized. And that's where I have templates. You know, for every single client that I see I do reports to doctors, and it takes time. So you are looking at about half an hour of admin um, for each time you see a new care plan person.

*Interviewer: Yes. I'm interested that you told me you place your goals and detail in your letter, as other dietitians have told me that their letter doesn't extend to that detail?*

My initial letter to the doctor basically says "I have seen your patient, um, this is what has been identified", and the last paragraph says "I have discussed with them these various things to address". I do actually put very broad detail in the [first] letter. And then when I do the final report, I state specifically what the goals were and then exactly what was achieved. And then generally the comments. I also do what is called an evaluation of the care plan so I actually write down some tangible and some non-tangible items, to see how the care plan has gone for that person. I write down all the things that were achieved.... such as, for instance, "now achieving low GI foods, ...choosing low fat dairy foods" and so on, and all that is done. And Ill actually say: "ok, that their weight was reduced by 6 kilos in three months, their BMI or their blood sugar has come down to this", and so on.

*Interviewer: Yes.*

And then I have three questions in which I try and determine from the client about how this has gone for them. And its really basically looking at the emotional side of it. So its asking "well, how did you go with the care plan? Did you find it of any benefit to you? How do you feel about the changes you have made? How do you feel in yourself? What is your wellness state?" And I just use a linear scale for that, zero to er, well, nine is fantastic, over the moon!

And then there is a final one, which is "How do you feel you are going to go with these changes and improve on them?" And that is a really good one because a lot of people might say "well, I have got these issues and that is why I may have difficulty maintaining them".

*Interviewer: Yes.*

I have GPs who re-refer patients to me! And, you know, that's really good! Because I see them again and its really great so see how many of the things they have managed to keep on top of. And you can re-focus the patient. And some of them, they need that sometimes! It's a chronic condition, its ongoing and they need ongoing support!

*Interviewer: Yes [omitted discussion about goals and GP communication]*

*With regard to electronic reporting, can you see a role for that in your practice?*

I do something like that with a bariatric surgeon that I work with. Its in a system called 'Genie' and basically it er I have access to all the clients information, health information, basically any blood tests that they might have. And then I also then document my assessment so the doctor can see every time I see a patient, he can see exactly what I have gone through with them.

*Interviewer: So, you are experiencing that right now. Do you find that system is beneficial?*

Yes, absolutely! I'm not sure how that would work, like with GPs, you'd have to be on the same program with them. ....[discussion omitted]

Clients always come back if they need to see me. I often see clients pro-bono- especially the ones that are really struggling, though its not for all of them. ...It [the program] should have the option there to perhaps speak to the GP and say if this client needs a longer period of being seen- there should be an application thing, perhaps not carte-blanch. To me, three visits is minimal, one- assessment, two to see how they have gone, three- to troubleshoot, you know?

*Interviewer: Yes. I can see that that might be more rewarding to the professional s too, if the dietitians are actually able to help them achieve their goals?*

Oh! Absolutely! There is nothing worse than feeling you are just churning people through, just for the process. If the government is really serious about people making lifestyle changes, its not going to happen with just two or three visits to a dietitian! [laughter] Its [success] not going to happen! Its just not going to do it!

Extract from interview: dietitian number 346D.

## CASE STUDY 4

A medium volume Medicare provider. A dietitian who qualified in 2003, working in several private clinics in a capital city, both co-located with a GP and in a multidisciplinary practice without a GP. She sees 11-25 CDM referred patients per month (11-20% of her referrals). One clinic is for sports management. She is dissatisfied with Medicare as she states “the rebate for dietitians needs to be higher” and “we can’t do our job properly in 30 minutes! There is no way the fee rebate covers the cost of a 1-hour initial consultation, which is the time I believe you need to spend with these difficult patients to make a difference for them.” She does not bulk-bill, Patients pay the fee and obtain their own rebate.

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*Interviewer: Now I am just looking at your response in the questionnaire. You said “generally a lot of these clients are unmotivated clients that don’t want to be there”. Can you tell me more about that?*

Yeh. They seem to be- they are generally middle-aged, um clients. Who feel like they are here because they have to be here, and er, and um, er, yeh! Unmotivated is really the best way I can describe it.

*Interviewer: So, I suppose, if they don’t know about their goals in their referrals, its hard for us to expect them to be motivated. Is any way that the referral process can be improved when the goals are set-by the practice nurse or the doctor?*

Yeh, well I guess if the doctor had a better understanding of what it was that they were sending them off to, perhaps that would – it would make it a little bit better. And then they would know a little bit more about what to expect, that might make it a little better from the patient’s perspective. It seems to be- I don’t know if that is a major concern. I think its that a lot of those people tend to be unmotivated individuals, anyway. It’s a really big difference- like, other people from- like, what you would think is the same demographic- like, overweight female who has been given high blood results, say high cholesterol, coming in to see you- its different than the ones that are referred to you on care plans. They just tend to always cancel their appointments, they then they always rebook them, but the number of that that I do for them is just so different [laughs] to other people who I see.

*Interviewer: So, a lot of barriers, you’re saying? [Yeh] Ok. Can you tell me whether you have had any training with regard to managing patients with chronic disease?*

What do you mean, training?

*Interviewer: Oh, well, I know that you qualified in recent years. Did your studies include chronic disease management strategies, or have you undertaken any CPD on those sorts of topics?*

Yeh, I go to the Australian Institute of Sports conference every year, or other sports conferences, so there is some a lot of stuff in that that is related to chronic diseases.

*Interviewer: Like getting patients to take responsibility for their own health care, and those sorts of self-management strategies?*

Yes, I attended a workshop called [name], and it was sort of looking at behaviour change, so that was really worthwhile. So, in terms of- with these patients, it’s a lot of about behaviour change as opposed to what it is they are actually eating.

*Interviewer: Yes. Do you feel you have enough training to manage these types of patients?*

Um::: I am thinking of becoming a psychologist! (Laughter) No, seriously, like, I think that it is an area I would like to go into. I feel like a LOT of what I do is counselling, that I am NOT trained to do! I enjoy, it, but I just don’t know if I am as effective as what I could be.

*Interviewer: What do you mean you are not trained to do counselling?*

Well:, you don’t get very much in- certainly at uni, a very very small amount is about counselling and behaviour change. Uni, it seems to be more directed towards clinical dietetics as opposed to private practice. Like it should be in the preventative stages.

*Interviewer: Well, that brings up another question. The Medicare program is supposed to offer preventive programs to these patients with chronic diseases. Is it preventive?*

Well, definitely not! It needs to be more upstream, I think.

*Interviewer: Do you have any other suggestions about how the program could better meet your needs as a provider running a business practice?*

Well perhaps the guidelines for the actual care plans could be different, like, you know, rather than waiting until they have got chronic diseases, when they are overweight perhaps that is when the doctors can actually refer even if they are otherwise healthy, having that as an actual criteria for referral?

Extract from dietitian interview 182S

## APPENDIX: Medicare Benefits Schedule - Item 10954 (Dietetics)

### Category 8 - MISCELLANEOUS SERVICES

**DIETETICS SERVICES:** Dietetics health service provided to a person by an eligible dietitian if:

- (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and
- (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and
- (c) the person is referred to the eligible dietitian by the medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 20 minutes duration; and
- (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c):
  - (i) if the service is the only service under the referral - in relation to that service; or
  - (ii) if the service is the first or the last service under the referral - in relation to that service; or
  - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year  
**Fee: \$56.25 Benefit: 85% = \$47.85**

**Source:** <http://www.medicareaustralia.gov.au/mbs>

### Associated Notes

#### Category 8 - MISCELLANEOUS SERVICES

#### **M3.1 Allied Health and Dental Care Services**

#### **M.3 ALLIED HEALTH (ITEMS 10950 TO 10970)**

##### M.3.1 ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The allied health services must be recommended in the patient's EPC plan as part of the management of their chronic condition.

##### Chronic conditions and complex care needs

A chronic medical condition is one that has been or is likely to be present for at least six (6) months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, mental disorders, arthritis and musculoskeletal conditions. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two (2) other health or care providers.

##### EPC plan

Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has put in place a GP Management Plan (MBS Chronic Disease Management (CDM) item 721) and Team Care Arrangements (MBS Chronic Disease Management (CDM) item 723); or
- their GP has reviewed their existing EPC plan and claimed MBS item 725 and 727; or
- their GP has contributed to or reviewed a multidisciplinary care plan prepared for them as a resident of an aged care facility and claimed item 731.

For more information on the CDM EPC planning items, refer to the explanatory notes for these items - Note A.30.

Important note: Before a Medicare rebate can be paid for the allied health service, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and that claim has been processed.

### **EPC planning team**

The allied health professional providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic and complex care needs. However, the service may also be provided by an allied health professional that is not part of the EPC planning team, provided that the service has been identified as necessary by the patient's GP.

### **Group services**

In addition to individual services, patients who have type 2 diabetes may also access new MBS items 81100 to 81125 which provide allied health group services - refer M.9.

## **M.3.2 REFERRAL REQUIREMENTS**

### **Referral form**

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using an *EPC program referral form for allied health services under Medicare*. GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs may use one referral form to refer patients for single or multiple services of the same service type (eg five chiropractic services). If referring a patient for single or multiple services of different service types (eg two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP has previously provided it directly.

Allied health professionals are required to retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

A copy of the referral form is not required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

The referral form may be downloaded from the Department of Health and Ageing website at [www.health.gov.au/epc](http://www.health.gov.au/epc) or ordered by faxing (02) 6289 7120 or phoning (02) 6289 4297. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information is substantially retained.

### **Referral validity**

Medicare benefits are available for up to five (5) allied health services per patient per calendar year. If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of five services for which the patient is eligible in that calendar year.

When patients have used all of their referred services, or require a referral for a different type of allied health service recommended in their EPC plan, they will need to obtain a new referral from their GP. GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared each calendar year in order to access a new referral(s) for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under an EPC plan as long as the need for eligible services continues to be recommended in their plan.

## **M.3.3 ELIGIBLE ALLIED HEALTH SERVICES**

### **Eligible allied health providers**

The following groups of allied health professionals are eligible to provide services under Medicare for patients with a chronic condition and complex care needs. Allied health professionals must meet the provider eligibility requirements set out at paragraph M.3.4, and be registered with Medicare Australia.

- Aboriginal Health Workers
- Audiologists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental Health Workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

### **Number of services per year**

Medicare benefits are available for up to five (5) allied health services per eligible patient, per calendar year. The Medicare rebate for each allied health service is \$47.85.

The five allied health services can be made up of one type of service (eg five physiotherapy services) or a combination of different types of services (eg one dietetic and four podiatry services).

### **Checking patient eligibility for allied health services**

Patients seeking Medicare rebates for allied health services will need to have an *EPC program referral form for allied health services under Medicare* signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place and the number of allied health services already claimed by the patient during the calendar year. The

allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

#### **Service length and type**

Services provided under the allied health items must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

#### **Reporting back to the GP**

Where an allied health professional provides a single service to the patient under a referral, they must provide a written report back to the referring GP after each service.

Where an allied health professional provides multiple services to the same patient under the one referral, they must provide a written report back to the referring GP after the first and last service only, or more often if clinically necessary. Written reports should include:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

#### **Out-of-pocket expenses and Medicare Safety Net**

Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient. Allied health services in excess of five (5) in a calendar year will not attract a Medicare benefit and the Safety Net arrangements will not apply to costs incurred by the patient for such services.

#### **Publicly funded services**

Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 10950 to 10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. These services must also be direct billed (that is, the Medicare rebate is accepted as full payment for services).

#### **Private health insurance**

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

### **M.3.4 ALLIED HEALTH PROFESSIONAL ELIGIBILITY REQUIREMENTS**

The allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, allied health professionals must meet the specific eligibility requirements detailed below:

Aboriginal Health Workers practising in the Northern Territory must be registered with the Aboriginal Health Workers Board of the NT; in other States and the Australian Capital Territory they must have been awarded a Certificate Level III in Aboriginal and Torres Strait Island Health (or an equivalent or higher qualification) by a Registered Training Organisation that meets the training standards set by the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Diabetes Educators must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Chiropractors must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise Physiologists must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sport Science (AAESS).

#### **Mental Health Workers**

'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

Psychologists, occupational therapists and Aboriginal health workers are eligible in separate categories for these items.

A mental health nurse may qualify if they are -

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or
- a 'Credentialed Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, if providing mental health services in other States or the Northern Territory.

A social worker must be a 'Member' of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999', as in force on 1 November 2006

Occupational Therapists in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Physiotherapists must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.

Podiatrists in all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a "Full Member" of the Australian Podiatry Association (ApodA) in any other State or the Australian Capital Territory.

Psychologists must be registered, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising.

Speech Pathologists in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

A copy of these eligibility requirements may be obtained from Medicare Australia by calling 132 150 or at [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) or [www.health.gov.au/epc](http://www.health.gov.au/epc).

#### **Registering with Medicare Australia**

Provider registration forms may be obtained from Medicare Australia on 132 150 or at [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au).

Chiropractors, osteopaths, physiotherapists and podiatrists who were already registered with Medicare Australia on 1 July 2004 to order diagnostic imaging under Medicare, do not need to re-register to provide services under this initiative. Allied health professionals registering with Medicare Australia for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging tests etc., where appropriate, under Medicare.

#### **Changes to provider details**

Allied health providers must notify Medicare Australia in writing of all changes to mailing details to ensure that they continue to receive this book and any updates about Medicare rebateable allied health services.

Related Items: [10950](#), [10951](#), [10952](#), [10953](#), [10954](#), [10956](#), [10958](#), [10960](#), [10962](#), [10964](#), [10966](#), [10968](#), [10970](#)

Source: <http://www.health.gov.au/mbs> accessed 12 June 2008

## GP Management Plan /Team Care Arrangement – Generic

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Patients Name: <<Patient Demographics:Full Name>>

Date of Birth: <<Patient Demographics:DOB>>

Does Patient identify as Aboriginal or Torres Strait Islander: <<Does patient identify as ATSI?>>

Date of GPMP/TCA: <<Miscellaneous:Date>>

**Details of Patient's Usual GP:** <<Doctor:Name>> <<Doctor:Qualifications>>

<i>Assessment of patient</i>	<i>Patient Identified Problems / Health Care Needs</i>	<i>GP/Nurse identified Problems / Health Care needs</i>
<b>Date of Diagnosis:</b> <<Date of Diagnosis?>>  <b>Previous Care Plan (date, objectives) :</b> <<Previous Care Plan (date, objectives)?>>		

**Medical / Surgical History:**

<<Clinical Details:History List>>

**Medications:**

**Allergies:**

<<Clinical Details:Allergies>>

**Social History:**

<<Clinical Details:Social History>>

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**Patient Consent**

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I have explained the steps and costs involved, and the patient has agreed to proceed with the service and gives their consent

\_\_\_\_\_ (GP Sign & Date)                      Copy of GPMP given to patient: <<Copy of GPMP given to patient?>>

Relevant copies of GPMP/TCA given to other providers: <<Copies of GPMP/TCA given to other providers?>>

Patient Consent & Date: \_\_\_\_\_

Planned Review Date: <<Planned Review Date?>>

<b>Management Goals to improve outcomes in Patients with Chronic Conditions</b>	<b>Current Measurements</b>	<b>Required Actions by the patient – GP / practice nurse (complete for a GP Management Plan)</b>	<b>Other Providers and Services (complete for a Team Care Arrangement)</b>
<b>ASSESSMENT / MONITOR</b>			
<b>BP</b> and pulse within recommended range	<b>BP lying:</b> <b>Standing:</b> <b>Pulse:</b>	<b>Measure BP/ Pulse every &lt; &gt; mths</b> Ace inh <input type="checkbox"/> B blocker <input type="checkbox"/> Diuretic Other _____ <input type="checkbox"/>	Cardiology review Consider Ambulatory BP monitoring
<b>Weight and waist</b> circumference within recommended range Aim for <b>BMI 20 – 25</b> Waist: men < 94 cm women < 80cm	<b>BMI:</b>  Waist circ:	Aim for patient : < > kg cm waist circ.	Dietary / exercise advice consider dietitian /physio /chronic disease self - management programs and other resources
<b>Lipids</b> within recommended range Aim for Chol < 4.0 mmol/L LDL Chol < 2.5 HDL chol>=1.0 Trig < 2.0	Tot Chol: LDL: HDL: Trig:	lipid profile every 12 <input type="checkbox"/> or < > mths lipid lowering therapy:	Consider referral to dietitian for patient education Cardiologist
Other relevant issues:	Other tests eg. Blood tests, radiology, ECG	Regular review by GP team every < > months	

LIFESTYLE / GENERAL

<i>Management Goals to improve outcomes in Patients with Chronic Conditions</i>	<i>Current Measurements</i>	<i>Required Actions by the patient – GP / practice nurse (complete for a GP Management Plan)</i>	<i>Other Providers and Services (complete for a Team Care Arrangement)</i>
<b>Smoking Cessation</b>	Smoker: Yes <input type="checkbox"/> No <input type="checkbox"/> Willingness to quit: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Pack Years _____ Date since last cigarette _____	Promote smoking cessation <input type="checkbox"/>	<b>Smoking cessation clinic RGH Quitline</b>
<b>Healthy diet</b> <b>Aim</b> for low fat diet	Generally good <input type="checkbox"/> Needs improvement <input type="checkbox"/>	Dietary advice <input type="checkbox"/>	Dietitian
<b>Physical activity</b>	Minutes per week exercise < > /wk	Moderate physical activity 30 min /day. For most days of week <input type="checkbox"/>	Chronic Disease Self Management Programs/Physio Activity program/ Exercise group
Assess <b>Alcohol</b> Intake	Standard drinks per week:	Promote reducing alcohol intake and regular alcohol free days <input type="checkbox"/>	
Assess <b>Immunisation</b> Status	Vaccinations up to date: Yes <input type="checkbox"/> No <input type="checkbox"/>	Influenza vaccine - yearly Pneumococcal vaccine - once, then booster as per schedule Tetanus - booster aged 50 ( if nil > 10 yr)	

Optimal management of <b>psychosocial</b> problems and <b>mental health</b> issues	Symptoms of Depression ( ) Anxiety ( ) Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	Awareness of higher risk of anxiety and depression in chronic conditions -regular screening during consultations -consider questionnaires eg K10 ( med dir)	Social Workers, Psychologists, Psychiatrists, Aboriginal health workers
Discuss <b>Sexual / Erectile / Continence</b> issues	Yes <input type="checkbox"/> No <input type="checkbox"/>	Awareness of higher prevalence of sexual and continence dysfunction in patients with chronic disease	Urologist, counselling
Good understanding of <b>medication</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Educate on medication <input type="checkbox"/> Consider HMR	Pharmacist
Optimal oral Health	Optimal Oral Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Encourage regular Dental visits	Dentist

**References:**

1. Diabetes Management in General Practice 2004/5, Diabetes Australia and Royal Australian College of General Practitioners.
2. Lipid Management Guidelines – National Heart Foundation website - <http://www.heartfoundation.com.au/index.cfm?page=40>

**Source:** Southern Division of GP, Brighton, South Australia 2008.

**Note:** Divisions have often developed a version of the plan suitable to their population and administrative requirements, and these are often available on a Divisions' Home page on the Internet.

