Capital Health Network Draft Needs Assessment

Response to consultation
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Recipient

Capital Health Network

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 8000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for food and nutrition for healthier people and healthier communities.

The Accredited Practising Dietitian (APD) program provides an assurance of safety and quality and is the foundation of self-regulation of the dietetic profession in Australia. APDs are the qualified and credentialed food and nutrition experts with a variety of roles in primary, secondary and tertiary health. APDs guide policy and programs to support improved dietary patterns, support people with established disease to improve their food choices and lead food services in hospitals and other care settings.

This submission was prepared following the Conflict of Interest Management Policy and process approved by the Board of Dietitians Australia. Dietitians Australia members have wide ranging expertise in areas including public health, food service, food systems, academia and primary care.

Key recommendations

- Strengthen efforts to ensure all Aboriginal and Torres Strait Islander people in the ACT have access to culturally competent health services.
- Acknowledge the role of and seek to address nutrition and food insecurity in the health and wellbeing of Aboriginal and Torres Strait Islander people in the ACT.
- Amend needs assessment report to acknowledge the role of dietitians in mental health, disability, aged care and prevention and management of chronic health conditions.
- Acknowledge and make recommendations to improve the lack of public funding for dietetic primary care for people with mental health conditions, older adults, people with disability and Aboriginal and Torres Strait Islander people.
- Acknowledge and address inconsistency and difficulty in access to electronic medical records for different professions in the primary care team.
- Acknowledge prevalence and severity of malnutrition in residential aged care facilities.
- Work with relevant stakeholders to embed routine malnutrition screening in residential aged care facility processes at the assessment stage, at the beginning of care and on a regular basis (ie quarterly re-screening).
- Support education of primary care providers to ensure referrals to dietitians are appropriate and timely to best support the health of people in the community.
- Provide education to upskill the workforce on the role of nutrition and dietetics in supporting the functional and health outcomes of people with disability.
- Provide education and training to support health system navigation and pathways to access nutrition and dietetic supports, in the context of both NDIS and mainstream services.
- Include an ‘emerging issues’ section, including the anticipated burden on primary health system due COVID-19, such as ‘long COVID’.

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Contents

Discussion

Aboriginal and Torres Strait Islander health

Health and wellbeing

The CHN needs assessment should consider the role of nutrition and food insecurity in the health and wellbeing of Aboriginal and Torres Strait Islander people in the ACT.

We acknowledge the needs assessment report highlights the gap in health outcomes for Aboriginal and Torres Strait Islander people[1] and wish to highlight that this also applies to nutritional status where inequities are observed. [2] Over 20% of Aboriginal and Torres Strait Islander people, compared to less than 4% in non-Indigenous populations were living in a household where someone went without food when the household ran out of food.[2]

Chronic disease

Accredited Practising Dietitians play an important role in supporting behaviour change in relation to nutrition to improve nutritional intake in the treatment of chronic conditions such as diabetes, heart disease and arthritis. A 2017 systematic review of dietetic interventions in primary care found that there is fair evidence to support that dietetic interventions improve dietary intake, weight loss outcomes and diabetes clinical measures.[3] Dietary interventions are not only effective but also relatively low cost and safe.

Service gaps and barriers

Dietitians Australia recognises this significant concern and support interventions to reduce the health inequalities experienced by this population, including provision of appropriate Medicare Benefits Schedule items. Access to healthy food and nutrition care are significant factors in improving the health and wellbeing of Aboriginal and Torres Strait Islander people. Improved access to nutrition and dietetic services, supported by Medicare, will support Aboriginal and Torres Strait Islander people improve their nutrition and overall health.

The Accredited Practising Dietitian program administered by Dietitians Australia is the platform for self-regulation of the dietetic profession and provides an assurance of quality and safety to the public. Accredited Practising Dietitians are food and nutrition experts who translate the science of nutrition into practical solutions for healthy living. Accredited Practising Dietitians have an important role in providing culturally appropriate, medical nutrition therapy to the Aboriginal and Torres Strait Islander population.

We strongly support the provision of culturally safe health services and urges the Government to invest in this. Providing guidance on what culturally safe health services looks like is critical. All health professionals need to undergo adequate training and be engaged in improving the culturally appropriate care provided to Aboriginal and Torres Strait Islander people. Aboriginal community controlled health services and Aboriginal Health Workers play integral roles in the provision of culturally safe health services.

To ensure culturally safe health services, it is important that there is community input into the development of programs and services. The benefit of community contributions to the development of health programs has been demonstrated in nutrition. A 2019 systematic review assessed the effect of nutritional interventions in Australian based Aboriginal and Torres Strait Islander people.[4] A number of studies included in the review observed improvements in dietary quality and positive health outcomes across a range of factors such as biochemistry measures following nutrition

education and promotion programs.[4] This review, along with a 2018 narrative review on food and nutrition programs highlight that for programs to be successful community involvement is critical.[4, 5]

Recommendations

- Acknowledge the role of and seek to address nutrition and food insecurity in the health and wellbeing of Aboriginal and Torres Strait Islander people in the ACT.
- Acknowledge the role of dietitians in supporting prevention and management of chronic health conditions in the primary care setting.
- Strengthen efforts to ensure all Aboriginal and Torres Strait Islander people in the ACT have access to culturally competent health services.

Digital health

We strongly agree that digital health is a core feature of primary care service delivery and should be included in the CHN needs assessment.

More information about dietitians and digital health can be read in our submission on the National Digital Health Strategy.

Electronic health records

We agree with comments about the challenges of using My Health Record. Dietitians are able to upload information only if they have conformant software which is expensive and typically not designed for allied health practice. The CHN needs assessment should acknowledge this inconsistency and difficulty in access for different members of the primary care multidisciplinary team.

Electronic health records are commonly used by dietitians in primary care. Evidence suggests that electronic health records improve patient care and efficiency of dietetic services.[6] The practice software used by dietitians in the primary care setting is dependent on several factors including cost, telehealth compatibility, and work locations. It is common for dietitians to work for multiple businesses and to use different practice software at each site. The CHN needs assessment should include these specific challenges in electronic record keeping.

We note a possible error on page 27 that states Digital Health Record was launched in September 2022, a date that has not yet passed.

Secure messaging

The needs assessment is missing information on allied health use of secure messaging. As with electronic health records, dietitians may not have access to the same secure messaging platforms as other members of the multidisciplinary team (eg GPs). This can present challenges when sharing information with the primary care team to provide best practice care for people in the community.

Impact of COVID-19 on digital health

This section of the needs assessment is missing information on use of telehealth in allied health primary care services during the peak pandemic period.

Dietitians and other allied health professionals responded quickly to the change to telehealth in 2020-21, updating our processes and training to ensure our workforce could meet the new demands of service delivery. Within 6 months of the pandemic being declared, almost 100% of private practice dietitians surveyed were providing telehealth services.[7]

Research shows nutrition services delivered via telehealth are just as effective as traditional in-person service delivery, whether it is for weight management, chronic disease management or the treatment of malnutrition.[8] Effective telehealth delivery methods include consultations by phone and videoconference (eg Coviu, WebEx), supported by email and text messages.[8]

Client access

We suggest the ‘issues with telehealth’ subheading would be better titled ‘limitations of telehealth’ or ‘limitations of digital health’.

We agree with assessment that some people in the community have less access to digital health than others. People from migrant and refugee backgrounds,[9] people with culturally and linguistically diverse backgrounds[10] and people experiencing low income[10] may face additional barriers to digital health. These include ‘poor quality internet, a lack of access to affordable technology and relatively

low levels of understanding and skills in using technology for some groups.'[9] We support the comments in the needs assessment as accurate and recommend that CHN invest into addressing these issues in the coming years.

Until March 2020, very few dietetic telehealth consultations were funded by Medicare, DVA and private health insurers. Now, 18 months later, telehealth has become the norm and consumers expect to continue to have access to rebates for telehealth services. Minister Greg Hunt announced in December 2020 that telehealth would become a permanent feature of Medicare, but has yet to consult with allied health about making the health infrastructure fit-for-purpose. This review period is also a prime opportunity to create telehealth item numbers specific to dietetic services, separate from the catch-all telehealth numbers for different allied health services that were implemented in March 2020. Separate telehealth items numbers will support service delivery data collection and result in improvements to healthcare in the ACT and across Australia. The CHN needs assessment should acknowledge and seek to engage the federal government on this key factor affecting client access to primary care services.

Opportunities

There are many opportunities for use of digital health to improve care. These include:

- Interoperability between consumer technology (eg health tracking apps) and electronic health records[11]
- Fit-for-purpose practice software
- Implementation of electronic health records across the healthcare system
- Artificial intelligence and deep machine learning to streamline assessment and diagnosis[12] so dietitians and clients can spend more time on intervention
- High health professional confidence in digital literacy
- Use of electronic health records to support high quality research activities
- Accessibility of digital health for people with different backgrounds

Recommendations

- Acknowledge and address inconsistency and difficulty in access to electronic medical records for different professions in the primary care team.
- Acknowledge and address challenges in electronic record keeping for primary care practitioners working across sites.
- Add information about use of telehealth in allied health primary care services during the peak pandemic period.
- Amend 'issues with telehealth' subheading to 'limitations of telehealth' or 'limitations of digital health'.
- CHN invest into addressing digital health access issues in the coming years.
- Acknowledge and seek to engage the federal government on funding for dietetic primary care services delivered via telehealth.
- Acknowledge and pursue the vast potential for digital health to improve primary care.

Mental health

Dietitians are key members of the primary care team in mental health. This is clearly outlined in the Dietitians Australia evidence brief on mental health and Dietitians Australia Mental Health Role Statement. The CHN needs assessment must recognise dietitians in this area of practice.

Opportunities to improve care

The role of dietitians in preventing and treating both depression and anxiety has been shown to be effective. Recent reviews clearly demonstrate that healthy dietary patterns containing fish, legumes, fruits, vegetables, nuts, and whole grains as recommended in the Australian Dietary Guidelines and typically found in Mediterranean diets, can lower the risk of depression.[13, 14] Large population based studies and reviews of these have shown strong associations between diet quality and mental health.[14-18] This includes prospective studies such as the large SUN cohort in Spain (over 10,000 participants) that found a healthy Mediterranean diet pattern was associated with a reduction in the risk of developing depression.[17] Conversely, a high intake of discretionary items such as sweets, highly processed cereals, chips, fast-food and sugar sweetened drinks increases the risk of poor mental health.[13, 14]

Further review of the literature demonstrates that, (i) whole of diet, rather than individual nutrient, interventions are effective in improving symptoms of depression and anxiety; and (ii) dietitians should deliver the nutrition intervention.[19] Three Australian-based, dietitian-led intervention studies have shown efficacy in improving symptoms of depression and anxiety.[20-22] Dietetic interventions can be considered effective adjunctive care for these conditions.

Psychotropic medications, particularly antipsychotic medications, stimulate appetite and excessive food intake. Mental illness can also have a marked impact on energy levels and motivation (often referred to as the 'negative symptoms' of the illness). Mental illness may impact on a person's life and nutrition status in many other ways, including social stigma, social and geographical isolation, access to transport, financial status and self-esteem. These factors can impact on a person's capacity for lifestyle change. They can also impact on a person's ability to follow a healthy lifestyle, and to plan, access, prepare and consume nutritious food and undertake physical activity. These challenges mean that lifestyle intervention often requires intensive behaviour change and lifestyle change techniques that dietitians are well placed to provide. Dietitians have been shown to provide more effective nutrition interventions for the physical health of people with severe mental illness than other clinicians and should be considered core members of mental health teams.[23] In addition to nutrition-related side effects, dietitians are ideally placed to manage the specific psychotropic medication-nutrient interactions. The role of dietitians working in severe mental illness, and practice recommendations, are well-documented.[24, 25]

The report recognises the inextricable link between mental and physical health. Indeed, 80% of people living with mental illness have comorbid physical illnesses. These illnesses have recognised effective dietary interventions for prevention, treatment and management when delivered by dietitians. This link between diet and chronic illness highlights the importance of focusing on nutrition as part of prevention and early intervention strategies for mental health.

Medicare does not currently provide mental health-related item numbers for dietitians except for eating disorders, even though there is strong evidence to support dietary intervention in other mental illnesses and for commonly associated physical illnesses. Alternative funding and models of care should be explored to improve access to dietitians through multidisciplinary practices. Adjunctive dietary interventions lead by APDs offer cost-effective approaches to managing mental health symptomology and physical health.

Recommendations

- Amend needs assessment report to acknowledge the role of dietitians in mental health.
- Acknowledge and engage the federal government to address the lack of public funding for dietetic care for people with mental health conditions.
- Make recommendations to improve public funding of dietetic and other allied health primary care services.

Aged care

Older Canberrans living in residential aged care facilities

In residential care, Australian studies have identified a prevalence of malnutrition from 22% up to 50%. There is a failure in safety and quality systems for the prevention and management of malnutrition in older Australians. It is vital for routine malnutrition screening to become embedded in residential aged care facility processes at the assessment stage, at the beginning of care, and on a regular basis (ie quarterly re-screening).

It is important that all aged care staff receive annual training (eg via an e-learning module) on how to identify and manage those who are truly at nutritional risk using a standardised process with a validated malnutrition screening tool (eg Mini Nutritional Assessment – Short Form).

Residents identified as being at risk of malnutrition or malnourished by the screening process must be referred to an Accredited Practising Dietitian for nutrition intervention.

Older Canberrans living in the community

Older Australians express a preference to remain in their home and community. The ability to maintain self-care activities specific to eating and drinking for nutritional requirements is a key determinant of staying at home. This includes the ability to purchase enough food, prepare and cook food, consume enough food and to store food safely. The ability to undertake these self-care activities may diminish with dementia, with acute or chronic disease, or changes to socioeconomic situations such as financial stress, carer strain, social isolation, cultural barriers or widowhood.

The experience of Accredited Practising Dietitians is that these issues are not sufficiently identified, nor are responses sufficient when they are identified. Evidence for this are the studies of malnutrition among older adults living in the community and reports of screening for malnutrition at admission to hospital.

My Aged Care has capacity to identify care recipients who are at nutrition risk because there are questions in the National Screening and Assessment Form10 used in the My Aged Care process which asks about shopping, appetite, swallowing, intake, special diet etc. It also references the Mini Nutritional Assessment nutrition screening tool. Efficacious use of the form and the Mini Nutritional Assessment tool depends on the time and priority set by the assessor from the Regional Assessment Service or Aged Care Assessment Team to ask all relevant questions for an individual and the skills and knowledge to synthesize an appropriate response. Staff employed in Regional Assessment Teams and Aged Care Assessment Teams are rarely from a professional background of dietetics, and the training related to food and nutrition content is limited. As a result, timely and appropriate recognition and response to food and nutrition problems is compromised.

Dietitians Australia members relate occurrences when malnutrition, unintentional weight loss or underweight have been identified in an Aged Care Assessment but no referral is made to an Accredited Practising Dietitian. The dietitian only becomes aware of the client after a prolonged period when they are in a debilitated state and referred through other avenues (eg community nursing, hospital referrals).

Home care service providers may not employ dietitians, dietitians may not be available through local community health services and the older person may not have private health insurance to pay to see an Accredited Practising Dietitian. Access through Medicare Allied Health Chronic Disease Management items is limited to five services per year across all eligible professions where each session is a minimum of 20 minutes (the norm would be 40 – 60 minutes). This is rarely sufficient to meet the complex needs of older people. The CHN needs assessment report must acknowledge this barrier to older Canberrans accessing primary care services to support aging well.

Lack of timely referral to an Accredited Practising Dietitian in the community is also reported as a problem when an older person requiring enteral nutrition through a feeding tube returns home from a hospital. Without dietetic review, the initiation of enteral feeding products is delayed, which presents an immediate risk of dehydration and malnutrition when that is the sole source of nutrition for the person. The CHN should support education of primary care providers to ensure referrals to dietitians are appropriate and timely to best support the health of people in the community.

Recommendations

- Acknowledge prevalence and severity of malnutrition in residential aged care facilities.
- Work with relevant stakeholders to embed routine malnutrition screening in residential aged care facility processes at the assessment stage, at the beginning of care and on a regular basis (ie quarterly re-screening).
- Acknowledge the lack of public funding for dietetic care for older people.
- Make recommendations to improve public funding of dietetic and other allied health primary care services for older people.
- Support education of primary care providers to ensure referrals to dietitians are appropriate and timely to best support the health of people in the community.

People with disability

Specialist services

APD services are essential components of comprehensive health care for people with disability and should be provided throughout life in a manner that is interdisciplinary, person-centred and culturally appropriate.[26-28] However, access to APD services for people with disability is inadequate, across the spectrum of health care and in both mainstream and NDIS service settings.[29] This must be acknowledged in the CHN needs assessment.

Lack of appropriate funding is a key barrier to access of mainstream APD services. There are few funded positions for APDs in community and hospital settings (both inpatient and outpatient) and APDs do not have access to Medicare items for autism, pervasive developmental disorder and disability. Existing MBS chronic disease management items do not support effective dietetic services for people with disability.

While the National Disability Insurance Scheme (NDIS) provides an opportunity for people with disability to access nutrition and dietetic supports, there is still unmet need for APD services and neglect in recognising the nutritional needs of people with disability. There is a lack of evidence-based policies and training to guide NDIA planners and delegates, regarding appropriate engagement with APD services. NDIS participants and Dietitians Australia members frequently report that NDIS Planners reject 'reasonable and necessary' requests for nutrition and dietetic supports.

Across both mainstream and NDIS service settings, there is a lack of understanding about how nutrition and dietetics can support the functional outcomes, health and wellbeing of a person with disability. While Federal policy is needed to address key structural issues, PHNs have a role to play in upskilling health care professionals about the role of nutrition and dietetics in supporting a person with disability to meet their needs, and providing education about how to navigate health systems, to ensure that people with disability have timely access to APD services and comprehensive multi-disciplinary care.

Recommendations

- Place greater emphasis on the lack of access to nutrition and dietetic supports for people with disability in the needs assessment report.
- Provide education to upskill the workforce on the role of nutrition and dietetics in supporting the functional and health outcomes of people with disability.
- Provide education and training to support health system navigation and pathways to access nutrition and dietetic supports, in the context of both NDIS and mainstream.

Workforce

Overview

This section includes statistics for only some professionals in the primary care team. Dietitians Australia is undergoing membership and accreditation renewals for 2022 and will have up-to-date data about our primary care workforce in the first quarter.

Workforce shortage

There is not a shortage of dietitians in the ACT but there is a shortage of service delivery due to lack of publicly funded services.

Dietitians are key members of the primary care team in mental health, disability, aged care and chronic disease. The CHN needs assessment report must recognise dietitians in this area of practice.

We agree with the comment in the needs assessment that GPs need a greater understanding of the role of allied health in primary care.

We support the comments in the needs assessment that allied health should be given greater opportunity to work to our full scope of practice in primary care. Dietitians can gain additional credentialing in areas such as diabetes education, nasogastric tube (NGT) insertion and Percutaneous Endoscopic Gastrostomy (PEG) site care.[31] Dietitians are also able to order blood tests (private pathology fees apply) to inform ongoing dietetic management of health conditions.

Viable remuneration

We strongly agree that Medicare benefits payments are not viable to fully fund primary care services delivered by dietitians. Dietitians and other allied health professionals typically have to charge a gap fee as the ~$58 paid by Medicare is not sufficient to cover the cost of delivering services. This is a key inclusion in the needs assessment report and should inform recommendations to improve public funding of dietetic and other allied health primary care services.

We seek clarification on the statement ‘Large movement in staff is reported to be a barrier for young people in particular, as they then need to tell their story over and over again’ on page 74. Does this statement mean that young people in the community find staff turnover to be a barrier to accessing healthcare because they don’t want to establish a care relationship multiple times? Is a similar effect observed in other population groups?

Telehealth

The draft needs assessment states that telehealth is new for allied health. This is not accurate for dietetics.

Telehealth is a service delivery platform that dietitians have used for years, but only in the past 18 months has it become a key feature of practice for the majority of the workforce. In March 2020, Australia went into lockdown due to the COVID-19 pandemic. For the first time in the history of our health system, Medicare, the Department of Veterans’ Affairs and private health funds put in place a blanket approval for funding of telehealth services. This enabled significantly greater access to telehealth for a range of people.

Dietitians and other allied health professionals had to respond quickly, updating our processes and training to ensure our workforce could meet the new demands of service delivery. Within 6 months of the pandemic being declared, almost 100% of private practice dietitians surveyed were providing telehealth services.[7]

Research shows nutrition services delivered via telehealth are just as effective as traditional in-person service delivery, whether it is for weight management, chronic disease management or the treatment of malnutrition.[8] Effective telehealth delivery methods include consultations by phone and videoconference (eg Coviu, WebEx), supported by email and text messages.[8]

Recommendations

- Amend needs assessment report to acknowledge the role of dietitians in mental health, disability and aged care.
- Clarify comment on staff turnover and barriers to care for younger people.
- Amend statement on telehealth to reflect that telehealth is not a new platform for service delivery for dietitians.
- Use assessment that remuneration is unviable to inform recommendations to improve public funding of dietetic and other allied health primary care services.

Other comments

Every use of 'nutritionist' should be replaced with Accredited Practising Dietitian (APD). Nutritionists without the APD credential are not qualified to deliver one-on-one services to people with health conditions. APDs are nutrition professionals with at least 4 years of university training accredited by Dietitians Australia. APDs are qualified to advise individuals, groups, organisations and governments. APDs use scientific evidence in their practice and have yearly professional development requirements. They follow the Dietitians Australia Code of Conduct. The APD credential is the only credential recognised by the Australian Government, Medicare, the Department of Veterans' Affairs, the National Disability Insurance Agency and most private health funds as the quality standard for nutrition services in Australia. It is a trademark protected by law.[32]

We suggest including an 'emerging issues' section, including the anticipated burden on primary health system due COVID-19, such as 'long COVID'.

We suggest seeking services of editor to check for appropriateness of language. For example, to make corrections like 'prevalence of people living with overweight or diabetes…' rather than 'prevalence of being overweight or a diabetic' as written on page 1 of the draft document. Also, to check for use of common language such as 'occasion of service' instead of 'contact' when referring to service delivery statistics.

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