Scope of Practice Review Issues Paper 1

Response to consultation
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Recipient

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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 8500 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

As part of a National Alliance of Self-Regulating Health Professions (NASRHP)-regulated profession, the Accredited Practising Dietitian program meets strict regulatory standards commensurate with Ahpra regulatory standards and provides an assurance of safe and quality dietetic practice in Australia. Accredited Practising Dietitians (APDs) are uniquely trained to provide one-on-one nutrition and diet therapy to consumers across a broad range of health and disease conditions. Dietitians must hold the APD credential and meet continuing professional development and recency of practice standards annually to access Medicare, Department of Veterans Affairs, National Disability Insurance Scheme, worker's compensation schemes and most private health insurers. Accredited Practising Dietitians have a significant role in the delivery of primary care.

This submission was prepared by Dietitians Australia staff in consultation with members with extensive experience in primary care, academia and regulation following the Conflict of Interest Management Policy and processes approved by the Board of Dietitians Australia.

Discussion

1. Legislation and regulation

Consultation question: What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice?

Legislative recognition of self-regulating allied health professions is needed. This would significantly improve the ability of the allied health workforce not recognised under the National Registration and Accreditation Scheme (NRAS) to work to full scope of practice.

Dietitians Australia delegates the regulatory functions of the Australian dietetic profession to the Dietitian and Nutritionist Regulatory Council, and we are a member of NASHRP. The standards set by NASRHP represent a rigorous framework for self-regulation that ensures safe, effective and evidence-based practice. NASRHP standards are benchmarked against the standards administered by the Australian Health Practitioner Regulation Agency (Ahpra).

Without legislative recognition, the dietetic profession is significantly disadvantaged when compared to Ahpra-registered professions that are afforded title protection. In some settings, employers require practitioners from Aphra-registered professions to be registered but cannot apply this standard to self-regulated professions. Practitioners are faced with multiple layers of regulation and different funding bodies recognising different scopes of practice. To facilitate full scope of practice for dietetics, legislation and regulation need to be nationally harmonised.

Consultation question: To what extent do you think a risk-based approach is useful to regulate scope of practice (ie, one which names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than named professions or protected titles?)

Together with legislative recognition that provides title protection for dietetics, we support a risk-based approach to enable dietitians to perform activities we are currently precluded from providing. For example, prescribing.

Prescribing rights can be extended to dietetics, akin to the UK model described in Issues Paper 1. The model described ensures that practitioners undertake certified training, are registered with their professional body and only prescribe within their professional expertise and competence. We would support these as minimum requirements.

Advantages of a risk-based approach include: improved consumer experience, greater agility in service provision, improved use of finite resources, quality assurance and transparency. A risk-based approach would provide for greater flexibility to use the full scope of practice of all practitioners, and adaptability in a continuously changing healthcare environment.

To implement a risk-based approach, there needs to be a robust and nationally consistent credentialling process designed in collaboration with peak bodies to ensure inclusivity, appropriateness, consistency and fairness in its development, implementation and outcomes.

This would include interprofessional education to ensure safe, equitable and consistent application of the revised approach.

Consultation question: What do you see as the key barriers to consistent and equitable referral authorities between health professions?

Single health professional 'gatekeeping' imposes significant restrictions on dietetic scope of practice and significant barriers to consumer access to allied health services, creating an unnecessary cost burden and restrictive and convoluted care pathway. Legislative and funding reform that provide for more equitable and efficient referral pathways would be a key reform. Where GPs have limited involvement in care, direct referral would free up their time, streamline the consumer experience and reduce costs to the consumer and to the healthcare system. Supporting this model with accessible and interoperable digital health systems can ensure that GPs can still access information about their patients' referrals. Interoperable systems would also enhance communication and collaboration among healthcare providers.

A nationally agreed framework would need to be developed to define competencies required, standardise referral systems and ensure professional scopes of practice are well-understood across the sector to enable appropriate and timely referrals. Interprofessional collaboration is essential for managing interprofessional scope of practice boundaries and overlap and establishing equitable referral pathways. Regulatory changes that enable new referral systems are needed to allow all healthcare providers involved in patient care to initiate referrals, as appropriate, based on patient needs.

2. Employer practices and settings

Consultation question: What changes at the employer level would you like to see to enable health professions to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements.)

Consistent application of the nationally agreed scope of practice for dietetics is essential. Currently, full dietetic scope of practice as defined by the Scope of Practice for dietitians and in the Code of Conduct for Dietitians and Nutritionist (2021) is inconsistently applied across the country. It is instead determined by jurisdiction and/or funding bodies.

Employers need to adopt practice standards that offer pathways for practitioners to work to full and extended scope, value Ahpra- and non-Ahpra-registered allied health professions equally, foster interprofessional collaboration and implement multidisciplinary care as the gold standard.

Applying consistent employment standards for Ahpra-registered and self-regulated practitioners by employers will enable practitioners to work to full scope. For example, where Ahpra-registered professionals are required to demonstrate for employment purposes that they are registered, self-

regulated health professionals should be required to demonstrate an equivalent standard (eg, accreditation or certification with the professional body-or delegate).

Consultation question: Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?

Increased employer support is needed for medication management (eg, in diabetes, cystic fibrosis, renal disease, percutaneous endoscopic gastrostomy management), enteral nutrition and direct referrals.

For example, Queensland Health is leading a credentialling program that enables dietitians to lead insulin-dose adjustments within clinics. Using a prescribed dose from the medical officer, appropriately credentialled dietitians with local approvals in place can lead the adjustment of insulin.

Also in diabetes care, remote dietitians with diabetes education post graduate qualifications can work with the nurse practitioner and doctor as first contact practitioners for clients with diabetes, including titrating insulin under medically approved guidelines.

Employers can also increase support for the innovative models of care in diabetes,[1-6] gastroenterology, [7-9] enteral feeding and feeding tube placement,[10, 11] dysphagia screening and intervention[12] and neurodivergent-affirming and trauma-informed approaches[13-15] described in detail in our previous submission.

Other in-scope and extended scope activities that employers could support dietitians to deliver include case management, engagement beyond individual consultations (eg, group education including and beyond Type 2 Diabetes education), menu assessments for institutions (eg, early childhood, schools, aged care, prisons) and nutrition literacy and cooking skills.

Consultation question: How can multidisciplinary care teams be better supported at the employer level, in terms of specific workplace policies, procedures or practices?

Employers can elevate multidisciplinary team-based care through:

- support for case conferencing and interprofessional collaboration and practice
- providing access to comprehensive interprofessional education and training and other professional development relevant to fostering cohesive, collaborative multidisciplinary teams
- providing access to interoperable digital health systems.

These supports are especially important where multidisciplinary teams are not employed by the same employer.

Employers can further support multidisciplinary care teams through:

- offering leadership and progression opportunities to all appropriately qualified and skilled allied health professionals, without restricting opportunities to specific professions only
- encouraging and incentivising diversity in leadership roles.

3. Education and training

Consultation question: What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope?

Cost can be a significant barrier, especially for sole practitioners and small business owners. Employers also may not provide financial assistance for further education, requiring practitioners to

self-fund any education and training. This can be a barrier for both ongoing professional development and acquiring additional credentials.

Where additional skills or extended scope of practice are not recognised by the employer, undertaking additional training to develop new skills may not lead to changes in practice or to any professional gains.

Local credentialling requirements can cause practitioners to undertake additional unnecessary training because of lack of understanding of professional qualifications, competencies and scope of practice.

Consultation question: How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?

Interprofessional education and collaboration need to be strengthened. A culture shift across the whole health care sector is needed for collaboration to be effective. It can be facilitated through well-designed interprofessional education programs and nationally agreed education standards.

Through benchmarking and research for the review of both Dietitians Australia's National Competency Standards (2021) and Accreditation Standards (2022), interprofessional education was a key inclusion in alignment with other health professionals, most notably those registered under Ahpra. The revised standards highlight the importance of working with and learning from and about other health professionals and the value of experiences working and learning in interprofessional teams. It allows for students to work in interprofessional teams to co-develop client health plans/goals for improved health outcomes.

Multiple studies point to the significant advantages of interprofessional education on students' attitudes, knowledge and understanding of other disciplines and the value of interprofessional collaboration.[16-18] Evaluations of patient outcomes have also shown improvements when healthcare teams operate collaboratively. Providing for interprofessional education and active engagement in collaborative multidisciplinary teams from the outset of training and throughout the span of a practitioner's career will help to foster a culture shift across the sector.

4. Funding policy

Consultation question: How could funding and payment be provided differently to enhance health professionals' ability to work to full scope of practice, and how could the funding model work?

Current access to allied health through Medicare is limited as described in our previous submission. For consumers living with long-term complex care needs, new funding models are required to provide consumers with ongoing access to multidisciplinary teams.

It is likely that a mix of funding models are needed. To date, there has been limited interest in alternative funding models outside of a general practice-centric model, and therefore there is insufficient Australian evidence to demonstrate successful alternative models. A range of different approaches need to be trialled.

Dietitians Australia recommends that the funding model be determined by the health care needs of the population to be serviced, and this needs to include investment in preventive services and provide for value-based, comprehensive multidisciplinary healthcare.

Investment in preventive care is imperative. Prevention optimises long-term health outcomes, reduces long-term healthcare costs and reduces pressure on the healthcare system. A value-based funding model would incentivise practitioners to provide services that deliver outcomes most important to consumers.

Consultation question: Which alternative funding and payment types do you believe have the most potential to strengthen multidisciplinary care in the primary health care system?

As discussed in the previous question, regardless of funding type, investment needs to allow for access to value-based, comprehensive multidisciplinary care with a focus on the consumer and provisions for models that support prevention.

Consultation question: What risks do you foresee in introducing alternative funding and payment types to support health professionals to work to full scope of practice, how do these risks compare to the risks of remaining at status quo, and how might these risks be managed?

Retaining current funding models would see continuing fragmented and costly care with poor access for consumers to the care they need, when and where they need it. Shifting to alternative funding models has the potential to close current service gaps, improve preventive health care, be more cost effective and reduce pressure on a stretched healthcare system.

Appropriate and adequate alternative funding models would support greater access to low- and no-cost services for consumers and would support clinicians to continue to offer essential services. This is especially important in light of declining bulk billing rates and heavier reliance on charging high gap fees to cover practice expenses.

5. Technology

Consultation question: How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?

Dietitians lack access to interoperable digital health systems that can be used to facilitate collaborative care. Current clinical information systems used in practices often do not offer interoperability with other systems such as My Health Record (MHR). The Australian Digital Health Agency is currently working to increase usability of and access to MHR for allied health practitioners. This work needs to be inclusive of all allied health professions, supported and maintained as a priority.

Cost and availability of interoperable systems present barriers to access. A further barrier is the process to obtain a Health Practitioner Identifier (HPI-I) number to enable uploads to the system. HPI-Is are automatically provided to Ahpra-registered professionals but not to practitioners whose professions sit outside of NRAS, including dietitians. Applying consistency across Ahpra-registered and self-regulated professions would facilitate access to MHR.

Improving allied health access to interoperable digital health systems would allow for significantly better data capture, more complete health records and improved workflow. This would facilitate improved delivery of multidisciplinary care, working to full scope, and could also support quality improvement activities. Interoperable systems could alleviate pressure on GPs and support direct referral pathways.

Consultation question: If existing digital health infrastructure was to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?

Access. Allied health professionals not registered with Ahpra do not currently have equitable access to interoperable digital health systems. This includes access to HPI-Is.

Sole practitioners and small businesses should be enabled to have equitable access to conformant software. Software needs to be designed so that it is affordable, easy to access and user-friendly, and accompanied by appropriate training.

Measures to ensure data security are imperative to gain the trust and confidence of users and consumers.

Digital health systems should also be designed to support direct referrals with clear frameworks developed to ensure referrals are appropriate and initiated by appropriately qualified and skilled professionals.

Consultation question: What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?

Data security breaches are a primary risk of any digital system. Rigorous safeguards are needed throughout the development of digital systems and throughout their use. This needs to be accompanied by education and training that explains use, storing and sharing of personal data and that can respond to user/consumer concerns.

Cost is a primary barrier to access and could present a limiting factor for sole practitioners and small businesses. To enable businesses to adopt digital health system use, the government should offer grants or other financial assistance for sole practitioners and small businesses to implement technological upgrades.

Legislative amendment is also needed to ensure Ahpra-registered and self-regulated professionals have equitable access to digital health systems, including MHR.

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