



## **Delivering Safe and Sustainable Clinical Services – White Paper Exposure Draft**

**May 2015**

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. The DAA (Tasmanian Branch) appreciates the opportunity to provide feedback on the Delivering Safe and Sustainable Clinical Services – White Paper Exposure Draft by the Tasmanian Government Department of Health and Human Services.

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## **1. Introduction**

The Dietitians Association of Australia Tasmanian Branch (DAATas) commends the Government of Tasmania on its efforts to deliver effective and efficient services across a spectrum of care settings to achieve better patient outcomes by 2025. DAATas identifies most strongly with elements of the White Paper which address safety and quality in the healthcare of Tasmanians, including workforce, clinical governance, food service, evaluation and monitoring.

## **2. Proposed role delineation across Tasmania's four main hospitals (2.1)**

DAATAS endorses the strong multi-disciplinary focus in the Tasmanian Role Delineation Framework document. Dietitians are an integral part of multi-disciplinary teams across a range of acute care settings. Multi-disciplinary team care is recognised as achieving improved outcomes in many clinical specialties, such as stroke services<sup>1</sup>.

While the Tasmanian Role Delineation Framework document identifies the general need for multi-disciplinary teams (including dietetic services) in most clinical specialities, there are a number of specialties mentioned in the document where dietitians have a key contributory role and are not mentioned. Examples from the document are

- Endocrinology
- Gastroenterology
- Acute stroke
- Cardiothoracic services.
- based on the clinical needs of Tasmanians, and.

DAATas is able to assist in defining workforce requirements for dietitians based on the clinical needs of Tasmanians treated in clinical specialties and with reference to recommended staffing levels which have been published by authoritative clinical specialty groups. (Appendix 1: Dietitian-patient ratios in selected specialties – summary of key evidence documents).

Dietitians work well as team members in specialty units, but they are one of the smaller disciplines with individuals at risk of being spread thinly across more than one specialty, and of working in professional isolation. Governance models that allow access to leave coordination and succession planning, professional support for skills development, and peer review are important to provide timely service to patients, avoid service interruptions and optimise ongoing performance.

## **3. Statewide focus (2.1)**

Dietitians in Tasmania have worked cooperatively on a statewide basis in their various roles in policy, food regulation, public health advocacy, capacity-building and clinical service provision over many years. For example, dietitians have demonstrated leadership in

statewide adult and paediatric Cystic Fibrosis Teams by sharing their high level skills with local teams. This has been effective in improving outcomes for their client groups.

DAATas has identified several important opportunities which would facilitate statewide coordinated action and alignment of roles in the new Tasmania Health Service.

- A statewide health structure will allow streamlined processes for endorsement and review of policies such as the Tasmanian Food and Nutrition Policy and the Tasmanian Home Nutrition Policy.
- A new statewide Food Service structure presents a unique opportunity in Tasmania for clinical input into Food Service decisions, along with operational and financial drivers. Statewide Food Service structures exist in New South Wales and Queensland. They work well when there is effective representation by multi-disciplinary clinical staff in decision making on equipment purchases which has financial and clinical implications. For example, operational decisions like the length of a plating line will impact on whether patients are offered food they find acceptable and will consume, which in turn effects nutritional status, and the physiological response to medical and surgical interventions.
- A statewide structure for Food Services, with governance that includes a multi-disciplinary steering committee, would support adoption of Nutrition Standards for hospitals throughout Tasmania, similar to standards already developed in most other jurisdictions. It would allow better informed decisions such as selection of an IT system that meets both operational and clinical needs.
- Poor patient nutritional status impacts adversely on clinical outcomes and length of stay. There are opportunities for positive change through application of the clinical redesign process to Food Services. The patient journey is too easily compromised by unacceptable food and drink. Or by good food that is unappealing in presentation to the patient, arrives at the wrong time or place, is delivered to the wrong person, or is placed where it cannot be reached, opened or consumed. A clinical redesign process would ensure that the investment in meal preparation results in actual meal consumption and enjoyment.

#### **4. Preventative health and improving health literacy (2.4.1)**

The White Paper Exposure Draft highlights the need to halt disease progression and protect the health of people with chronic conditions. Diet plays a central role in preventative health care and in clinical management of many of the chronic health conditions identified as being of concern in Tasmania, including hypertension, diabetes, cancers, heart disease and obesity. Dietitians have an important role in supporting individual approaches such as

health coaching, health literacy and self-management. The public health nutritionists in Tasmania's Division of Population Health have shown outstanding vision in this area. Innovative and effective nutrition programs such as Family Food Patch have won Australia-wide recognition.

However recent staff reductions in both public health and acute settings undermine the capacity to supporting individuals and communities in strategic preventative nutrition work. DAA considers this to be a false economy, as investment in preventive health activities has been demonstrated to save later spending on acute care.

In addition to individual and community approaches, DAATas also advocates for the creation of healthy environments and larger scale preventative approaches for primary and secondary prevention. However these approaches require long term strategic and legislative leadership at government level, and cross portfolio collaboration between health and departments such as education, transport, and housing. We look forward to hearing more about Tasmanian plans for preventative health.

#### **5. Partnerships between the public and private sectors (2.7)**

Dietitians in the public and private sectors in Tasmania work collaboratively and communicate well for patient hand-over. One barrier to professional communication relates to lack of access across sectors to health records. Better access to electronic health records would remove the barrier to effective and efficient care that currently exists when patients move from private to public hospitals without a complete hard copy medical history.

DAA would like to see improvements to the Home Nutrition Programs which supports Tasmanians who are unable to safely and adequately swallow ordinary food and fluids. The Home Nutrition Program is a hospital avoidance strategy where dietitians in public hospitals may prescribe nutrition products to support patients in their homes and prevent nutritional deterioration. More timely and equitable access could be achieved by accrediting private dietitians to prescribe under this program.

Improved sharing of health records would facilitate faster set-up of enteral (tube) feeds and nutrition support when these patients are admitted to hospital and facilitate efficient discharge of from hospital.

#### **6. Governance – Nutrition (3.4)**

DAATas supports the role of the current Clinical Advisory Groups, and those proposed in the White Paper. Clinical Advisory Groups will be most effective with representation from a range of disciplines in order to reflect the multi-disciplinary care of patients in each specialty.

We suggest that a Nutrition Clinical Advisory Group, including Food Service operations, would work well to refocus food as a therapeutic intervention rather than a 'hotel' service.

This approach would sustain a clinical focus to the investment made in patient meals. It would also provide healthy and appetising food as part of a health promoting work environment to staff on every shift.

## **7. Activity Based Funding**

Dietitians in Australian hospitals consider the continuing high prevalence of malnutrition as a major cause for concern in clinical terms and for the impact it has on quality of life for patients. Audits at the Royal Hobart Hospital demonstrate the prevalence of malnutrition at around 40%<sup>2</sup> in Tasmania is similar to that in other states.

Although Tasmania has not yet fully adopted Activity Based Funding, there may be opportunities in this area to reframe, malnutrition in financial terms. Dietitians in other jurisdictions<sup>3-6</sup> have demonstrated that under casemix or Activity Based Funding models, identification and coding of malnutrition as a comorbidity can change the Diagnose Related Group to which an episode of care is allocated, thus increasing the price paid for the episode. A Queensland study<sup>4</sup> showed potential revenue of \$1,677,000 per annum at the Wesley hospital from documentation of results of nutrition screening and assessment. Data from 16 Australian hospitals<sup>5</sup> was used to estimate that Royal Brisbane Women's Hospital could receive \$1,675,200 per annum revenue with the introduction of nutrition screening.

DAATas considers investment in screening, assessment and documentation of malnutrition may bring financial as well as clinical benefits in Tasmania. More investment in prevention and treatment of malnutrition has the potential to bring similar benefits such as demonstrated in nutrition and lifestyle interventions which prevented or delayed the onset of type 2 diabetes<sup>7-9</sup>.

## **8. Workforce**

DAATas supports the Government of Tasmania's commitment to working with the Chief Allied Health Advisor regarding workforce profiles in the Tasmanian Role Delineation Framework and look forward to their further development, recognising the roles of dietitians within different specialties, in addition to their roles in public health, health promotion, community services and teaching and research.

Despite a slow and steady growth in nutrition and dietetics services since, Tasmania still has the lowest number of dietitians per head of population in Australia with just 13.5 dietitians per 100 000 people, compared to the 20.1 per 100 000 nationally<sup>10</sup>. Recent staff reductions have impacted adversely on these figures. DAATas calls for adequate staffing of dietitians in the new Tasmanian Health Service.

The shortfall in dietetic services affects all parts of the health system in Tasmania. However, it is of particular concern in the primary care sector where professional leadership and clinical governance is lacking. A critical mass is needed to sustain clinical services and offer

placements to student dietitians on placement from interstate universities. Placements are an important strategy for recruitment to Tasmania which does not have a dietetic training course.

### **9. Proposed Tasmanian Health Service Structure (Consultation Paper)**

The provision of food and drink needs to be recognised in health structures as a clinical service which delivers food as a therapeutic intervention. The clinical accountability for these services is currently problematic, with frequent public criticism of hospital food.

When around 40% of hospital inpatients are malnourished and 30% inpatients require specific therapeutic diets, it is critical that food is considered to be a therapy, not a hotel service.

Satisfaction with hospital meals is one of the strongest indicators of a patient's perception of their hospital care<sup>11</sup>. Well governed Food Services are responsive to customer needs and link hospital meals to clinical outcomes. The organisational structure should reflect the clinical purpose of Food Services.

### **References**

1. Australian Institute of Health and Welfare. Cardiovascular Disease Series Number 24: How we manage stroke in Australia. Canberra: Australian Institute of Health and Welfare, 2006.
2. Tasmania Health Organisation South (unpublished). Nutritional status of adult inpatients. Nutrition & Dietetic Service; 2013
3. Agarwal E, Ferguson M, Banks M, Bauer J, Capra S, Isenring E. Malnutrition coding shortfalls in Australian and New Zealand hospitals. *Nutrition & Dietetics* 2015; 72:69 – 73
4. Ferguson M, Capra S. Coding for malnutrition enhances reimbursement under casemix-based funding. *Australian Journal of Nutrition & Dietetics* 1997; 54:102
5. White M, Dennis n, Ramsey R et al. Prevalence of malnutrition, obesity and nutritional risk of Australian paediatric inpatients: A national one-day snapshot. *J Paediatrics and Child Health*. 2015; 51: 314
6. Lazarus C, Hamlyn J. Prevalence and documentation of malnutrition in hospitals: A case study in a large private hospital setting. *Nutrition & Dietetics* 2005; 62: 41-47
7. Huang Y, Cai X, Qiu M, Chen P, Tang H, Hu Y, Huang Y. Prediabetes and the risk of cancer: a meta-analysis. *Diabetologia* 2014; 57: 2261-2269
8. Parker AR, Byham-Gray L, Denmark R, Winkle PJ. The effect of medical nutrition Therapy by a registered dietitian nutritionist in patients with pre-diabetes participating in a randomized controlled clinical research trial. *J Acad Nutr Diet* 2014; 114: 1739-1748

9. Diabetes Prevention Program Research Group: Herman WH, Brandle M, Hicks K, Sorensen S, Zhang P, Hamman R, Ackermann R, Engelgau M, Ratner R. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *New England Journal of Medicine* 2002; 346: 393-403.
10. Dietitians Association of Australia. DAA Workforce Area Statistics: DAA. 2013
11. Askew D, Capra S, Sardie M. *New Perspectives in Measuring Client Satisfaction with Food Service*. Centre for Public Health Research Best Practice in Nutrition and Dietetic Research. Brisbane, Australia: Queensland University of Technology. 1996

## **Appendices**

Appendix 1: Dietitian-patient ratios in selected specialties – summary of key evidence documents

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Specialty	Dietitian staffing ratios	Source
<b>Services for patients 18 and over</b>		
Emergency medicine	0.4 FTE per 55,000-70,000 presentations per year 0.2 FTE per 40,000-55,000 presentations per year 0.1 FTE per 25,000-40,000 presentations per year	Allied Health Workforce Advice and Coordination Unit. <i>Discussion paper: Allied health profession staffing in Queensland Health emergency departments</i> . Queensland: 2011 March
Intensive Care	0.3 FTE per 10 beds	Ferrie S, Allman-Farinelli M. <i>Defining and evaluating the role of dietitians in intensive care: State of play</i> . European Journal of Clinical Nutrition and Metabolism. 2011;6:121-125.
Cancer services	10 Dietitians per 100,000 catchment population (not per oncology population)	Victorian Department of Health and Human Services. <i>Cancer framework and strategic cancer plan 2010-2013</i> . Melbourne: DLA Phillips Fox; 2010
Endocrinology	<ul style="list-style-type: none"> <li>• 6.0 hr per patient per year for new diagnosis on insulin</li> <li>• 4.5 hrs per patient per year for new diagnosis (no insulin)</li> <li>• 0.75 hrs per patient per year for new diagnosis of gestational diabetes</li> <li>• 1.0 hour per patient per year for ongoing care</li> </ul>	Australian Institute of Health and Welfare. <i>Diabetes management and the allied health workforce: an overview of workforce mapping techniques and related data issues</i> . Canberra, Australian Institute of Health and Welfare (Health Division Working Paper No. 5); 2004
Acute Stroke	0.5 FTE per 10 beds	Stroke Foundation. <i>Rehabilitation stroke services framework</i> . Australia: Stroke Foundation; 2013
Renal	1.0 FTE per 170 chronic kidney disease patients 1.0 FTE per 50 haemodialysis or peritoneal dialysis patients 1.0 FTE per 150 transplant patients	<i>Workforce recommendations for renal dietitians in Australia and New Zealand</i> ANZ Renal Dietitians Workforce Planning Group 2012
Cystic Fibrosis	0.5 FTE for 50-75 patients 1.0 FTE for 75-100 patients 2.0 FTE for >150 patients	Bell S, Robinson P. <i>Cystic fibrosis standards of care Australia</i> . Sydney: Cystic fibrosis Australia; 2008.
Rehabilitation	0.4 FTE per 10 beds, for patients with Amputation, Orthopaedic, Major trauma, Spinal cord dysfunction, Pain  0.5 FTE per 10 beds, for patients with stroke, TBI, reconditioning	Australasian Faculty of Rehabilitation Medicine, Royal Australasian College of Physicians, <i>Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals</i> , 2011
<b>Paediatric services up to 17 years of age</b>		
Cystic Fibrosis - Paediatric	0.5 FTE for 50-75 patients 1.0 FTE for 75-100 patients 2.0 FTE for >150 patients	Bell S, Robinson P. <i>Cystic fibrosis standards of care Australia</i> . Sydney: Cystic fibrosis Australia; 2008.
Diabetes – Paediatric	7.5hrs per patient per year for new diagnosis 1.5hrs per patient per year for ongoing care	Australian Institute of Health and Welfare. <i>Diabetes management and the allied health workforce: an overview of workforce mapping techniques and related data issues</i> . Canberra, Australian Institute of Health and Welfare (Health Division Working Paper No. 5); 2004.
Oncology – Paediatric	1.0 FTE per 85 newly diagnosed paediatric oncology patients	NICE guidelines UK
Neonatology	0.05 - 0.10 FTE per intensive care cot	British Association of Perinatal Medicine <i>Service standards for hospital providing neonatal care</i> (3 <sup>rd</sup> edition) British Association of Perinatal Medicine, London <a href="http://www.bapm.org">www.bapm.org</a> 2015