

## Impact of the Medicare Chronic Disease Management Program on the conduct of Australian dietitians' private practices

Sarah Jansen<sup>1</sup>, Lauren Ball<sup>1</sup>, Catherine Lowe<sup>2</sup>

*1. Menzies Health Institute Queensland, Griffith University, Queensland*

*2. Dietitian Services Qld, Zillmere, Queensland*

Contact Author: Sarah Jansen [sarah.jansen@griffithuni.edu.au](mailto:sarah.jansen@griffithuni.edu.au)

### Abstract

**Objective:** This study explored private practice dietitians' perceptions of the impact of the Australian Chronic Disease Management (CDM) program on the conduct of their private practice, and the care provided to patients.

**Methods:** 25 Accredited Practising Dietitians working in primary care participated in an individual semi-structured telephone interview. Interview questions focused on dietitians' perceptions of the proportion of patients receiving care through the CDM program, fee structures, adhering to reporting requirements, and auditing. Transcript data were thematically analysed using a process of open-coding.

**Results:** Half of the dietitians (12/25) reported that most of their patients (>75%) received care through the CDM program. Many dietitians (19/25) reported providing identical care to patients using the CDM program and private patients, but most (17/25) described spending substantially longer on administrative tasks for CDM patients. Dietitians experienced pressure from doctors and patients to keep their fees low or to bulk-bill patients using the CDM program. A third of interviewed dietitians (8/25) expressed concern about the potential to be audited by Medicare. Recommendations suggested to improve the CDM program included increasing the consultation length and subsequent rebate available for dietetic consultations, and increasing the number of consultations to align with dietetic best practice guidelines.

**Conclusions:** The CDM program creates challenges for dietitians working in primary care, including how to sustain the quality of patient-centred care and yet maintain equitable business practices. To ensure the CDM program appropriately assists patients to receive optimal care for chronic disease management, further review of the CDM program within the scope of dietetics is required.

**What is known about the topic?** The Australian Chronic Disease Management (CDM) program is designed to facilitate patients to receive subsidised multidisciplinary care for chronic disease management. Dietetics is the third most utilised allied health profession within the CDM program.

**What does this paper add?** This paper demonstrates that dietitians experience challenges in providing services to patients using the CDM program, including pressure to keep fees down, high administrative load, difficulties accessing clear information on compliance requirements, and face barriers to providing best practice care to patients with chronic disease.

**What are the implications for practitioners?** Changes to the Australian CDM program are required to facilitate dietitians to provide health care in line with best practice guidelines for chronic disease management, and sustainable business practices.

## Introduction

The prevalence of chronic disease is increasing in Australia. In the 2007-08 National Health Survey, nearly all people aged over 65 years reported at least one chronic condition.<sup>1</sup> Chronic diseases such as type 2 diabetes, cardiovascular disease, cancer and arthritis have been named as National Health Priority Areas, due to the considerable economic and personal burden associated with these conditions.<sup>2</sup> The ideal management of chronic disease involves ongoing, multidisciplinary health care using a cooperative plan of care.<sup>3</sup> The Australian primary care setting has been identified as an ideal setting to provide chronic disease management to patients living with chronic disease.<sup>4</sup>

In 2004, Medicare introduced the Chronic Disease Management (CDM) program (previously referred to as Enhanced Primary Care), to facilitate patients to receive subsidised multidisciplinary care for chronic disease management.<sup>5</sup> Under a CDM care plan, a community-based patient with a chronic disease (existing for 6 months or more) is referred by their General Practitioner (GP) for a maximum of five consultations with allied health providers per calendar year, and receives a rebate of AU\$52.95 (85% of item cost) per completed consultation.<sup>6</sup>

Dietetics is the third most utilised allied health profession within the CDM program,<sup>7, 8</sup> with more than 300,000 Medicare funded dietetic consultations completed each year.<sup>9</sup> Dietitians are university-qualified health professionals trained to provide individual nutrition advice and medical nutrition therapy on a range of health conditions.<sup>10</sup> The private practice sector of dietetics has more than doubled since the introduction of the CDM program, and currently represents over 20% of Accredited Practising Dietitians.<sup>11</sup> One third of private practice dietitians report their annual income to be less than \$30,000, and many undertake other dietetic work to supplement their income.<sup>12</sup>

There are requirements placed on dietitians if providing services under the CDM program (Table 1). These requirements include ensuring the referral form is valid and accurate, providing a minimum consultation length of 20 minutes, and providing a written report to the referring GP after the first and last consultation. Each year Medicare audits approximately 4% of all providers for their compliance with requirements, focusing on services with high risk of noncompliance such as incorrect claiming or unusual growth in claims.<sup>13</sup> Incorrect procedures for claiming may result in Medicare seeking to recover from providers the benefits that have been paid to the patient.<sup>13</sup> Given the high utilisation of dietetics in the CDM program, it is anticipated that the potential for auditing is a source of concern for private practice dietitians.

INSERT TABLE 1 ABOUT HERE

Limitations of the Medicare CDM program have been investigated previously. The main limitation reported by allied health professionals is that patients are eligible for the five subsidised consultations,<sup>14</sup> whereas best practice chronic disease management recommends ongoing, regular consultations (Table 2).<sup>3</sup> Furthermore, allied health professionals feel the remuneration provided by Medicare is insufficient and not commensurate with best practice guidelines for chronic disease management.<sup>14</sup> Concern has also been raised over the rebate provided to dietitians,<sup>15</sup> as dietitians generally provide longer consultations compared with other allied health professions (e.g. 46 minutes for an initial consultation, 28 minutes for review consultations); and far exceed the minimum time of 20 minutes stipulated by Medicare.<sup>7,12</sup>

INSERT TABLE 2 ABOUT HERE

Anecdotal reports from dietitians suggest that the CDM program is affecting dietitians' ability to provide best-practice, sustainable care to patients.<sup>15</sup> It is important to further investigate the influence of the CDM program on dietitians' practices to determine how to support dietitians to provide sustainable, high quality care to patients. Therefore, the aim of this study was to explore private practice dietitians' perceptions of the impact of the CDM program on the conduct of their private practice, and the care provided to patients.

## Methods

This qualitative study was informed by a descriptive exploratory approach.<sup>16, 17</sup> A qualitative design was employed that utilised semi-structured interviews. Interview questions were open-ended to guide discussions, and were informed by a review of published literature. Table 3 outlines each question, including the inquiry logic for each question. The study received ethical approval from the Griffith University Human Research Ethics Committee (PBH/21/13/HREC).

INSERT TABLE 3 ABOUT HERE

Participants were Accredited Practising Dietitians working in primary care as a private practice dietitian at the time of the interview. The list serve of the Dietitians In Private Sector Interest Group (DIPSIG) was utilised to recruit participants. The DIPSIG list serve is an online email forum for members of the Dietitians Association of Australia to provide support to each other in relation to private practice, and has over 1500 members.<sup>12</sup> An introductory email was posted on the list serve in May 2013. The email included a description of the study, assurance of confidentiality, and details for contacting the research team. Interested participants were asked to contact the research team to receive further information, provide informed consent and arrange an individual telephone interview. After each interview, participants were asked whether they knew of anyone else that may be eligible and interested in volunteering for the study. Participant recruitment continued until saturation of response themes was considered to have been achieved by the interviewer. In practical terms, saturation was considered to have been reached when no new response themes were detected as interviews progressed.

Interviews were conducted by one member of the research team (LB) via telephone using the interview questions described in Table 3. Interviews were recorded with participants' permission, and ranged from 19 to 34 minutes in length. Transcription of the interviews was conducted by two members of the research team (LB and SJ). Analysis of transcripts involved an iterative process of data reduction, systematic comparison and conclusion.<sup>18</sup> Transcript data were thematically analysed using a process of open-coding involving responses being read through, re-read, coded using an iterative coding list developed during the analysis and organised within theme categories.<sup>19</sup> Triangular analysis was conducted by three investigators (LB, SJ, and CL) by independently coding and sorting interview data, and then comparing and discussing the themes to reach agreement about common and uncommon response themes. Example quotes were included to support key and/or contradicting themes identified.

## Results

One male and twenty four female dietitians participated in the study. The average time since graduation was 13 years (range 0.5 – 35 years), and the average duration working in private practice was 9 years (range 0.5 – 30 years). Approximately half of the dietitians (12/25) considered themselves to be full-time private practice dietitians and the remainder considered themselves part-time. The full-time dietitians reported to spend, on average, approximately 23 hours per week in consultations with patients and, on average, an additional 16 hours on administrative tasks. The part-time dietitians reported to spend, on average, approximately 10 hours per week in consultations with patients and, on average, an additional 10 hours on administrative tasks. More than half of the dietitians (14/25) reported to work only in a metropolitan area; a third of the dietitians (8/25) reported to work only in a regional or rural area and the remainder of dietitians (3/25) reported to work across metropolitan, regional and rural areas. Participants worked in practices in New South Wales, Northern Territory, Queensland and Victoria.

Overall, the CDM program was considered to be a considerable component of dietitians' practises. Approximately half of the dietitians (12/25) reported that most of their patients (>75%) received care through the CDM program, and only one dietitian reported that fewer than 25% of their patients did so. Dietitians with the highest CDM workload were those that had graduated within 2 years (10/12; 75-100% of workload) and those working part time (4/5; 75-90% of workload). Dietitians with more than 2 years experience and working full time appeared to have a lower CDM workload (5/6; 30-50% workload). Many dietitians (11/25) claimed that the proportion of their patients receiving care through the CDM program was consistent, however dietitians who had been practising since the inception of the CDM program (2003) reported a steady increase in proportion over time.

*When the system first came in... I would get one [CDM referral] a month, it wasn't really a big deal... Now it is a significant part of my workload. (Participant 23)*

Typically, dietitians did not modify their consultations for patients receiving care through the CDM program. Most of the dietitians (19/25) reported that they did not alter their services, hand-outs or time spent in consultations for those patients seen under the CDM program. However, some participants (6/25) did note inequities in their services between privately paying patients and patients receiving care through the CDM program. Of those who did alter their services, two described longer consultations for CDM patients, and two described shorter and more generalised consultations for CDM patients.

*A [CDM] patient takes longer...they may be elderly or low SES [socioeconomic status] or [there may be a] language barrier. (Participant 13)*

*If they are a private patient, they're obviously paying so I try and get more out for them as well. (Participant 17)*

A variety of fee structures were reported by participating dietitians, and most utilised a sliding scale for their services. Dietitians reported charging less to CDM patients compared with private patients, but the majority of dietitians charged a fee higher than the Medicare schedule, 4 dietitians bulk billed the initial consultation (\$52.95), and 13 bulk-billed review consultations (\$52.95). Dietitians with over 7 years' experience in private practice employed strategies that enhanced their income through the CDM program, such as having higher initial consultation fees (\$94- 160), limited bulk-billing, shorter consultations and lower overheads when bulk-billing. Recent graduates (<2 years since graduation) tended to charge lower fees for initial consultations (\$52.95 – \$110), provided longer consultations (5/12; 55-60 minutes), and would subsequently have a lower gross earning potential.

A number of dietitians reported pressure to keep their fees low or to bulk-bill, which ultimately influenced their fee structure.

*I have had phone calls from practice managers asking me if I bulk-bill, and have been told they won't refer to me unless I bulk-bill. (Participant 1)*

*I know I wouldn't get many clients if I was charging fees. (Participant 5)*

*I felt like I had to bulk-bill because other allied health professionals in the area did. (Participant 10)*

In addition to the pressure to keep fees down for CDM patients, many dietitians (17/25) reported that the time spent outside the consultation was longer for a CDM patient compared with a privately paying patient.

*It's quite substantial... because there is all the paperwork you have to do, it could be anywhere from 15 minutes to 45 minutes if you don't have all the correct paperwork that you need. (Participant 15)*

Dietitians had varied perspectives regarding the possibility of being audited on their compliance with Medicare regulations. Many dietitians (8/25) expressed concern about the potential to be audited. These dietitians were concerned about the time involved in the audit process, and insufficient recording and documentation practices.

*I would feel daunted. Not that I haven't kept good records, but I think of the time I would have to give that I wouldn't be reimbursed for. I would be concerned that something was astray; like I don't always check the patients are eligible... or there might be a doctor that wasn't doing [the referrals] properly. (Participant 9)*

Half the participants (12/25) felt confident about being audited as they felt their practices were compliant with Medicare requirements.

*I would like to think I would pass with flying colours! (Participant 3)*

*To my knowledge, we follow all the rules, so there shouldn't be any problems. (Participant 7)*

Of those who felt confident about being audited (12/25), only 6 dietitians reported practices which were actually compliant with requirements. For the remaining 6 dietitians, it was apparent they did not have compliant processes in place, and this was either due to a lack of awareness of required practices, lack of ownership for performing the required practices, or lack of access to clear information on the required practices.

*I'm not sure if we have the responsibility [for writing the final letter to the GP] if they don't attend. I would say [checking the validity of the referral] is more from an administrator's perspective. (Participant 3)*

*It's really hard to find information on the correct procedures and how the Medicare claims work, and what our responsibilities are and what you need to do from a legality point of view in terms of auditing. (Participant 15)*

Many dietitians voiced concern over responsibilities on them when providing services through the CDM program. For example, 11 dietitians were concerned about being accountable for the accuracy of the CDM referral paperwork and for ensuring patients had not exhausted their allocated consultations.

*I would like the onus of the referral being accurate to be on the GP... It is the GP's responsibility to make sure they have filled out the form correctly, not my responsibility to double-check and then chase around to fix it up. (Participant 1)*

*If we have been referred a patient for several consults, but they have used up their quota, why should we have to suffer financially? If we bulk-bill and the patient has already seen too many allied health professionals, we don't get paid for that... I just write that up as a loss. (Participant 4)*



Furthermore, it was apparent that the dietitians faced challenges in accessing clear, consistent information regarding the requirements of dietitians providing services through the CDM program.

*If people actually call and ask what the criteria is... there's nothing really out there, apparently there's something in the legislation, but there is no list of conditions or criteria that you can distribute to people. (Participant 13)*

Dietitians made many recommendations to improve the CDM program. Overall, the practice of dietetics was considered to be disparate to other allied health professions, as it is counselling-focused rather than procedural, and requires frequent patient reviews. Consensus was that the length of appointment required for best practice was far greater than the minimum 20 minutes stipulated by CDM guidelines, and did not correspond with the rebate provided. Additionally, numerous (11/25) participants agreed that the number of consultations available under the CDM program is insufficient to support dietetic best practice.

*The rebate is not justifiable.... [The appointment] is anything from half an hour to an hour and the rebate is only \$52.95. (Participant 3)*

*The published guidelines for overweight and obesity say you should review a person for weight reduction every two weeks for the first three months. Well there is no way we can do that at the moment... (Participant 10)*

## Discussion

This study explored private practice dietitians' perceptions of the impact of the CDM program on the conduct of their private practice, and the care provided to patients. The CDM program was considered to be a substantial component of dietitians' practices. The dietitians generally did not modify their consultations for patients receiving care through the CDM program, which differs to previous reports of dietitians providing significantly shorter consultation times to CDM patients.<sup>12</sup> However, dietitians with more experience in private practice reported strategies to enhance their income and increase the sustainability of best practice care. Dietitians reported pressure to keep consultation fees to a minimum for patients using the CDM program, despite spending additional time outside of consultations to complete tasks required for compliance with the program.

The structure of the CDM program is not conducive to the provision of best practice dietetic care for patients with chronic disease.<sup>15</sup> The most common conditions for referral to dietitians under the CDM program are type 2 diabetes, obesity, and cardiac conditions.<sup>15</sup> The Australian best practice guidelines for these conditions stipulate that frequent, extended consultations are most likely to support long term behaviour change,<sup>20, 21</sup> and these recommendations are supported by international guidelines such as the American Dietetic Association practice guidelines,<sup>22</sup> and the New Zealand Dietetic Association practice guidelines for type 2 diabetes<sup>23</sup> (Table 2). Consequently, increases in the number and length of dietetic consultations available to patients may facilitate additional counselling and enhanced education, thereby supporting nutrition-related behaviour change for patients with chronic disease.

The rebate provided by Medicare for patients receiving care under the CDM program was considered by participants in the present study to be disproportionate to the time spent providing care to a CDM patient. Half of the dietitians sampled in this study reported that the majority of their patients received care through the CDM program. In addition, while services did not differ greatly for patients in the CDM program, time outside consultations was considerably longer. Dietitians also experienced pressure to bulk bill, or keep fees down for these patients. These two factors understandably resulted in reports that the rebate provided by Medicare was insufficient. Previous literature suggests that the rebate amount encourages shorter consultations, which ultimately impacts on rapport building, assessment and education.<sup>14</sup> Furthermore, although some dietitians charge a fee that is higher than the rebate provided by Medicare,<sup>14, 15</sup> this is likely to reduce equity of healthcare access to low socio-economic groups, and the dietitians in the present study displayed concern of reduced referrals and attendance rates at consultations. Most of the dietitians in this study reported to provide identical care for patients receiving care through the CDM program and

privately paying patients. However, some participants altered their services for patients with CDM referrals with regards to length and content. The aim of the CDM program is to facilitate patients to receive subsidised multidisciplinary care for chronic disease management.<sup>5</sup> However, it is apparent that the care provided under the CDM program is potentially not equitable to that received by a privately paying patient, and the implications of this on patients' health outcomes requires further consideration.

The results of this study can be used to inform modifications to the CDM program to support best practice dietetic care. Firstly, the framework of the CDM program (including the number of consultations, length of consultations, and rebate provided) require review to align with evidence-based best practice guidelines for dietetic chronic disease management. In order for this to occur, an investigation is warranted into whether there is potential for dietetics to be identified as a unique health profession in the context of the CDM program, with subsequent enhancements in the number of consultations available, and rebates provided for dietetic services. For example, psychology services are arranged under a unique program (Better Access Initiative) which provides support for longer consultation times and subsequently a higher rebate.<sup>24</sup> Secondly, the addition of CDM-specific competencies to the national dietetic competency standards<sup>25</sup> may support dietitians to be practice-ready in this expanding area of dietetics.

An important consideration for the present study is that there is still limited evidence on how the CDM system affects patients' health outcomes. Recently, one study monitored weight and waist circumference outcomes of patients with type 2 diabetes utilising a dietitian under the CDM program.<sup>26</sup> This study found that patients who attended more dietetic consultations lost more weight, and identified the need for better understanding in the determinants of consultation attendance. These findings suggest that strategies to enhance the impact of the current CDM program are required, including research that investigates patients' perceptions of dietetic services under the CDM program, and opportunities for improved services and health outcomes.

Key limitations of the present study should be noted. Firstly, the strategy used to recruit participants may have resulted in some selection bias.<sup>27</sup> It is likely that those agreeing to participate may have had a particular interest in the CDM program and therefore may have stronger views about the topic. Secondly, the majority of participating dietitians practised in metropolitan areas of New South Wales, Queensland and Victoria. It should be recognised that style of practice is likely to vary between remote and metropolitan areas and state-to-state, and the opinions of these dietitians may not be representative of others in Australia. Finally, the sample size of 25 dietitians in the present study is relatively small. However, the qualitative approach to the study was not intended to include

a representative sample of dietitians; rather to explore dietitians' views on an emerging topic that is relatively underexplored. Importantly, data saturation was reached when no new response themes were detected as interviews progressed; thus it was deemed unnecessary to continue recruiting participants.

### **Conclusion**

The CDM program creates challenges for dietitians working in primary care, including how to sustain the quality of patient-centred care and yet maintain equitable business practices. Dietitians believe it is imperative to improve the length and number of consultations available to patients in line with current best practice guidelines, to increase the rebate provided for each consultation, and to reduce the administrative responsibilities of dietitians. To ensure the CDM program appropriately assists patients to receive optimal care for chronic disease management, further review of the CDM program within the scope of dietetics is required.

## References

1. Australian Government. Chronic Disease. 2012, Canberra: Australian Government; [cited 2013 4 August]; Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/chronic>.
2. Australian Bureau of Statistics. Chronic Disease. 2010, Canberra: Australian Government; [cited 2013 4 August]; Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/0/895A3D95B6ACAE9CCA2573D200107617?opendocument>.
3. Wagner E, Austin B, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Affairs*. 2001;20(6):64-78.
4. Australian Government. Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy. In: Department of Health and Aging, editor. Canberra: Australian Government; 2009.
5. Australian Government. Chronic Disease Management (CDM) Medicare Items. 2013, Canberra: Australian Government; [cited 2013 7 August]; Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseaseamangement>.
6. Australian Government. Allied Health Services Under Medicare - Fact Sheet. 2012, Canberra: Australian Government; [cited 2013 4 August]; Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health\\_pro-gp-pdf-allied-cnt.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm).
7. Cant RP, Foster MM. Update on Medicare-funded allied health chronic disease management consultations in dietetics and the five most referred professions in 2010. *Nutrition and Dietetics*. 2012;70:42-8.
8. Cant RP. Patterns of delivery of dietetic care in private practice for patients referred under the Medicare Chronic Disease Management: Results of a national survey. *Australian Health Review*. 2010;34:197-203.
9. Australian Government. Medicare Benefits Schedule Statistics, Item Reports 10954. 2013, Canberra: Australian Government; [cited 2013 7 August]; Available from: [www.medicareaustralia.gov.au/statistics/mbs\\_item.shtml](http://www.medicareaustralia.gov.au/statistics/mbs_item.shtml).
10. Dietitians Association of Australia (DAA). Accredited Practising Dietitians (website). 2013, Accessed April 2013, Canberra Available from: [www.daa.asn.au/for-the-public/find-an-apd/what-is-an-accredited-practising-dietitian](http://www.daa.asn.au/for-the-public/find-an-apd/what-is-an-accredited-practising-dietitian).
11. Dietitians Association of Australia. Dietitians Association of Australia Membership Work Areas. Canberra 2013.
12. Ball L, Larsson R, Gerathy R, Hood P, Lowe C. Working profile of Australian private practice Accredited Practising Dietitians. *Nutrition and Dietetics*. 2013;70(3):196-205.
13. Australian Government. What is an audit? Your questions answered. Canberra: 2010. Available from <http://www.medicareaustralia.gov.au/provider/files/what-is-an-audit-factsheet.pdf>.
14. Foster M, Cornwell P, Fleming J *et al*. Better than nothing? Restrictions and realities of enhanced primary care for allied health practitioners. *Australian Journal of Primary Health* 2009;15:326-34.
15. Cant RP. Today's profession: Views and practices of private practice dietitians re Medicare Chronic Disease Management program. *Nutrition and Dietetics*. 2010;67:77-83.
16. Smith J, Flowers P, Larkins M. Interpretative Phenomenological Analysis. Theory, Method and research. London: Sage Publications; 2009.
17. Fade S. Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society*. 2004;63:647-53.
18. Miles M, Huberman A. Qualitative data analysis. 2nd Ed. London: Sage Publications; 2004.

19. Fade S, Swift J. Qualitative research in nutrition and dietetics: data analysis issues. *J Hum Nutr Diet*. 2011;24(2):106-14.
20. Dietitians Association of Australia (DAA). Evidence Based Practice Guidelines for the Nutritional Management of Type 2 Diabetes Mellitus for Adults. Sydney 2011 Accessed January 2011.
21. Dietitians Association of Australia (DAA). Best Practice Guidelines for the Treatment of Overweight & Obesity in Adults. Canberra 2011 Accessed January 2011.
22. Monk A, Barry B, McClain K, Weaver T, Cooper N, Franz MJ. Practice guidelines for medical nutrition therapy provided by dietitians for persons with non-insulin-dependent diabetes mellitus. *Journal of the American Dietetic Association* 1995;95:999-1006.
23. New Zealand Dietetic Association, Diabetes Special Interest Group. Standards of Practice for the Nutritional Management of Type 2 Diabetes Mellitus. Auckland, 1999, Accessed January 2011.
24. Australian Government. Better Access to Mental Health Care Services. Canberra: 2014. Available from:  
[http://www.health.gov.au/internet/main/publishing.nsf/Content/0F792912834609B4CA257BF0001B74FA/\\$File/patients2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/0F792912834609B4CA257BF0001B74FA/$File/patients2.pdf)
25. Dietitians Association of Australia (DAA). National Competency Standards for Entry Level Dietitians in Australia. Canberra 2009 Accessed February 2012.
26. Spencer L, O'Shea MC, Ball L, Desbrow B, Leveritt M. Attendance, weight and waist circumference outcomes of patients with type 2 diabetes receiving Medicare-subsidised dietetic services. *Aust J Prim Health*. 2014 (Online early view).
27. Neuman L. *Social Research Methods: Qualitative and Quantitative Approaches* (6th ed.): Pearson International Edition. ; 2006.
28. Australian Government. Chronic Disease Management combined preparation of a GP Management Plan and coordination of Team Care Arrangements. In: Department of Health and Aging, editor. Canberra: Australian Government; n.d.

**Table 1: Requirements of dietitians to provide services under the CDM program (item number 10954) (adapted from <sup>5</sup>)**

<b>Program component</b>	<b>Requirement</b>
Referral	<ul style="list-style-type: none"> <li>• Check referral validity by:               <ul style="list-style-type: none"> <li>▪ Checking referral form contains all components required by Medicare<sup>28</sup></li> <li>▪ Ensuring referring doctor is eligible to refer under CDM program (GP must contribute, even if patient is in an aged care facility)</li> <li>▪ Checking patient is eligible by:                   <ul style="list-style-type: none"> <li>○ Contacting referring GP to discuss patient’s diagnosis and management</li> <li>○ Contacting Medicare to ensure patient has not exhausted allocation of consultations (maximum 5 per year across all allied health professions)</li> <li>○ Ensuring the patient is not currently admitted to a hospital</li> </ul> </li> </ul> </li> <li>• Obtain missing information</li> <li>• Check accuracy of given information</li> </ul>
Consultation	<ul style="list-style-type: none"> <li>• Duration must be at least 20 minutes</li> <li>• Consultation must be in person</li> <li>• Consultation must be provided to the individual only</li> </ul>
Administration	<ul style="list-style-type: none"> <li>• Written report must be provided back to the GP               <ul style="list-style-type: none"> <li>▪ After the first consultation, and</li> <li>▪ After the last consultation (patient is not eligible for the rebate unless completed, even if they have missed their last scheduled appointment)</li> <li>▪ After each consultation, if deemed necessary</li> <li>▪ Report must 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</li> </ul> </li> <li>• Medicare will provide the rebate after receiving:               <ul style="list-style-type: none"> <li>▪ Patient’s name</li> <li>▪ Date of consultation/service</li> <li>▪ Medicare Benefits Schedule item number</li> <li>▪ Dietitian’s name, provider number and practice address</li> <li>▪ Referring doctor’s name, provider number and practice address</li> <li>▪ Date of referral</li> <li>▪ Amount charged, paid and the outstanding amount</li> </ul> </li> <li>• Private health insurance cannot be used to supplement the rebate provided</li> <li>• The fee for MBS item number 10954 is \$62.25. The patient is responsible for any charges above the \$52.95 rebate (85%) provided by Medicare (accurate as of July 2014)</li> <li>• If bulk-billing, dietitian can only accept the Medicare rebate (no gap can be charged). If charging a higher fee, the patient must pay the full fee and then claim back the Medicare rebate.</li> </ul>

**Table 2: Best practice guidelines for consultation lengths for Australian dietitians.**<sup>20, 21</sup>

<b>Condition</b>	<b>Appointment</b>	<b>Recommended Length for Dietitians</b>
Type 2 diabetes	Initial	≥60 mins
	First and Second review	30-45 mins
	Three month review	45-60 mins
Overweight and obesity	Weekly, then monthly for 2-3 months	≥20 mins

*mins=minutes*



**Table 3: Semi-structured interview questions and inquiry logic.**

Interview Questions	Inquiry Logic
Dietitians' attributes obtained: Practice type, working with other dietitians, full-time or part-time, rural (if applicable), and other work undertaken.	Identify background of practice and acknowledge any identified influence of practice attributes on dietetic service provision within the CDM program.
Can you describe the approximate proportion of your patients receiving care through the Medicare CDM program, and how this has changed over time?	Identify influence of the CDM program on business sustainability, and changes over time.
Can you describe whether your services or hand-outs differ for patients receiving care through the CDM program compared with private or other patients? <i>E.g. fees, length, administration time, perceived client motivation/outcomes.</i>	Investigate whether there is an influence of the CDM program on equality of care.
Can you describe the fee structure in place for patients receiving care through the Medicare CDM program?	Investigate the level and rationale of fees charged for dietetic services provided within the CDM program.
Can you describe the approximate amount of time spent inside and outside of consultations for patients receiving care through the CDM program?	Investigate time spent in funded care (within consultation) versus non-funded (unpaid) care, and perceived influence on sustainability of practices.
How would you feel if you were selected by Medicare to undergo an audit of your practices relating to CDM patients?	Explore whether dietitians are aware of what the requirements to provide dietetic services under the CDM program, and how these requirements affect business practices and attitudes towards working in private practice.
Can you describe any practices you have in place so the first and last letters are written back to the GP for each patient receiving care through the CDM program, and that the referral form is valid?	Identify the extent to which dietitians check and adhere to requirements of dietitians to provide services under the CDM program.
If you had the opportunity to change the way Medicare provided rebates for the CDM program, how would you like it to work, and why?	Investigate dietitians' highest priorities in improving the administration of rebates for the CDM program.
Is there any other part of the Medicare program that we haven't discussed yet or any other information you would like to provide?	Allow participants to provide additional information considered relevant.