Who can benefit from health professionals working to their full scope of practice? (Consumers, Funders, Health practitioners, Employers, Government/s, Other?) Any other groups that should be included here?

All (include families and carers of consumers, educators (teachers, coaches, etc)

How can these (groups benefit? Please provide references and links to any literature or other evidence.

When Credentialled Diabetes Educators (CDEs) work to their full potential, they serve as a linchpin in the multidisciplinary approach to diabetes care and can actively reduce the number of hospital admissions and diabetes-related complications. CDEs working to their full scope of practice are able to increase diabetes prevention rates and the prevention of diabetes-related complications, lowering the incidence of diabetes in Australia. This not only ensures better health and wellbeing outcomes for consumers but also streamlines the care process for health professionals and optimises resource use in the Australian health system, creating a better system for consumers, funders, and health practitioners.

Consumers, including the almost 1.9 million people living with diabetes in Australia and their carers and families, find empowerment in understanding, fostering greater adherence to treatment regimes. We know that for people living with diabetes, being at the centre of their care journey ensures not just improved health metrics but a tangible enhancement in their quality of life. These, in turn, enhance productivity, benefiting employers and the economy, and reduce costs for the health system. In 2018-19 AIHW estimated the direct cost of diabetes in Australia, which only includes medical expenses related to treatment, diagnosis, and care of diabetes accounted for $3 billion in the Australian health system. This is likely even higher in 2023 and underscores the urgent need for the prevention and efficient management of diabetes.

For health professionals, CDEs working to their full scope of practice means a more streamlined, coordinated, and comprehensive approach to patient management. A CDE provides a cohesive bridge between varied health disciplines and is an essential part of the multidisciplinary diabetes team. For the Australian health system, it ensures optimal resource allocation, potentially averting redundant tests and guaranteeing timely, effective interventions. From the consumer's perspective, this translates to a comprehensive, person-centred care regimen tailored to address every facet of their needs, offering a tangible promise of enhanced health outcomes.

The public health system stands to benefit immensely from several enhancements and integrations. One of the notable benefits is the decrease in waitlist time for diabetes clinics that are publicly accessible. This timely care in turn reduces the risk of co-morbidities and diabetes-related complications. There is also a marked improvement in inpatient diabetes management (see the ADS inpatient guidelines and the inclusion of QuIDS in Queensland).

In settings like **aged care, schools and disability**, CDEs can greatly enhance patient health and wellbeing outcomes. They aid in avoiding preventable hospital admissions and mitigating diabetes-related complications.

On a systemic level, this integration fills potential service gaps, leading to better resource distribution and cost savings. Working to full scope of practice supports GPs and GP practices: we

know that GPs are often stretched thin with extensive patient loads, and having CDEs, and other allied health working to their full scope of practice can reduce this load and support GPs as well as patients to receive optimal care. (see https://www.ama.com.au/articles/general-practitioner-workforce-why-neglect-must-end)

What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?

CDEs who are working to their full scope of practice, ensure the health system is operating smoothly, and relieve the pressure on GPs and other members of the multi-disciplinary diabetes care team. To better understand the role of the diabetes care team, please see ADEAs Diabetes Referral Pathways. **Unfortunately, without a CDE-specific scope of practice, CDEs must practice to the scope of practice of their underlying profession, subject to each of the state and territory laws and regulations.** A typical CDE's current scope of practice includes:

- Provide healthy lifestyle advice including basic nutrition and physical activity
- Consider psychosocial factors, their impact on self-management and how to address these factors to enhance diabetes education and care
- Educate people with diabetes and their carers on the relationship between diabetes and other health conditions and how to prevent, recognise and treat short-term and long-term complications
- Individualise structured blood glucose monitoring regimens to assist people with diabetes, their carers and their health professionals to assess the effectiveness of, and evaluate, lifestyle/ medication interventions
- Educate people living with diabetes and their carers in the safe and effective use of diabetes technology, including interpretation and how to respond to changing blood glucose data, and/or effectively using an insulin pump.
- Educate people with diabetes and their carers in the role, options, safe use, side effects and storage of diabetes medications
- Educate people on how to prevent, identify and treat hypoglycaemia
- Educate people on how to prevent, identify and treat hyperglycaemia and diabetic ketoacidosis, which includes developing a sick day care plan and managing sick days
- Initiate referral to a medical practitioner or Nurse Practitioner to optimise the medication regimen if required
- Educate and evaluate the knowledge and skills of people with diabetes, their carers and health professionals to inject glucose lowering medicines
- Regularly re-evaluate the person with diabetes' and/or their carer's self-management knowledge, skills and strategies over the continuum of diabetes care
- Input into policy and procedures relating to all aspects of diabetes education, management and care
- Community education and health promotion programs that aim to prevent diabetes and diabetes complications
- Providing advice or education about medication dosage and administration
- Advising about the dose including titration of medicine (related to diabetes care) within a range set out by the prescriber

- Recommending medication changes; however if the CDE identifies that the dosage should differ from the instructions of the prescriber, the CDE must contact the prescriber to request an updated prescription.

However, variations in the CDE scope of practice may occur with:

- Ordering of pathologies (blood tests, including HbAIc)
- Insulin titration and adjustment
- Administration of diabetes medicines
- Prescribing of certain diabetes medications/technology
- Access to MyHealthRecord

Ensuring that CDEs are adequately trained to take on expanded roles requires additional educational infrastructure, resources, and regulatory changes. **ADEA can provide the educational infrastructure; however, the government must provide the regulatory changes that will acknowledge CDEs as a singular workforce with one consistent scope of practice.**

As is the case with all health practitioners, there is and will always be a need for rigorous quality assurance and regulatory oversight to ensure that health outcomes continue to improve, patient safety is maintained, and economic burden is reduced. ADEA provides oversight and quality control for the CDE profession. However, enhanced data collection by the Government (see Parliamentary Inquiry Submission) would contribute to better measurements and data on both health practitioners working to their full scope of practice and on health outcomes.

Allowing any health practitioners to operate at their full or expanded scope of practice presents both opportunities and challenges. A critical opportunity lies in the potential for CDEs to bring tangible benefits to the public health system. **When CDEs are empowered to work to their full scope of practice there will be substantial financial savings to the health system due to improved patient outcomes and reduced hospital admissions.**

Please give examples of your own experiences of risks and other impacts of health practitioners working to their full scope or expanded scope of practice. Please give any evidence (literature references and links) you are aware of that supports your views.

One member shared, “Many people living with diabetes cannot get access to diabetes technology in particular insulin pumps due to the long waiting time in public hospitals. During this six-month wait, I have met patients whose diabetes has deteriorated. A simple foot ulcer became a severe foot infection, worsened and required amputation. Had these people commenced insulin pump therapy and improved their glycaemic control sooner, the amputation may well have been avoided.”

It is important to note that our members have encountered several instances where the limited scope of practice has had a significant negative impact on patient care and healthcare professionals, however they have experienced far less risk associated with working to one’s full scope of practice.

However, a risk arises concerning the governance of healthcare. Determining which health practitioner—be it the GP, endocrinologist, CDE or even the patient themselves—takes overarching responsibility for a patient's diabetes care can lead to potential overlaps or gaps in care. Ideally, the

GP should be the singular healthcare practitioner who manages a patient's treatment to ensure continuity and clarity of care. Moreover, effective communication among all health practitioners, including at public hospitals, is paramount. **In the absence of clear communication channels and sharing of relevant clinical information with relevant members of the multidisciplinary care team including allied health professionals (e.g. through MyHealthRecord), there's a risk of fragmented care, miscommunication, or conflicting advice, which could compromise patient outcomes**. (https://www.oecd.org/health/oecd-reviews-of-health-care-quality-australia-2015-9789264233836-en.htm)Thus, while expanding the scope of practice can optimise resources and enhance patient care, it necessitates a robust governance structure, clear referral pathways, clear communication protocols and sharing of relevant clinical information to mitigate potential risks.

In addressing the potential risks associated with healthcare professionals working within an expanded scope of practice, it's essential to acknowledge that patient safety is paramount. Without appropriate supervision, mentoring, and understanding of how to educate on various topics, there is a heightened risk of consumers not receiving safe care and accurate information. To mitigate these risks, there must be comprehensive training and supervision protocols in place to ensure safe and competent practice.

It is important to note here that there are risks associated with limited scope of practice which are also of concern, and our members report having experienced situations where they are unable to provide comprehensive care to patients because of these restrictions. For instance, one member illustrated this frustration: *"Working as a CDE, I am still required to consult with the person's GP even when the patient requires frequent minor adjustments to maintain their well-being, the current process requiring further patient appointments with the GP which may take weeks or months or not ever occur.This is inefficient and wasteful. Diabetes medication doses cannot be kept static for 6 - 18 months due to our current processes, and a more dynamic arrangement requires consideration".* Patients often don't want to return to their GP for an additional appointment or are reluctant to take additional time off work or their weekend to attend the additional appointment. GPs are often working very long hours to see their patients and may not have the capacity to see them in a timely manner, or need to prioritise other patients. It's an inefficient model which taxes the existing health system and results in suboptimal care for people with diabetes.

Another member shared, *"I am frequently seeing clients who have not had the recommended pathology such as HbA1c and renal function completed for over 12 months. They are referred to me by the GP for assistance with managing care and advice on the next steps with medication. Without this vital information, I currently need to write to the GP to request the pathology be completed and then make an appointment with the client so I can complete my assessment. This is a clunky system, the client sees the GP who does a referral to a CDE, they then see me and I refer back to the GP due to lack of information. [The client goes] back and sees the GP to get the pathology request completed and then comes back to see me to ...assess the results and make some suggestions, then back to the GP [to consider}... my suggestions and order new medication. That's 5 medical appointments with no tangible result for the client. If I could request pathology, I could pre-empt at least 2 of these appointments by organising the required pathology to be completed prior to my consultation with the client*."

Another member shared their experience working to their full scope/expanded scope of practice in a regional town, "*I don't see any risks or issues as long as the scope of practice is reflected in*

competencies and training. My experience working to an expanded scope is being able to practice in all aspects of diabetes education in a small regional/rural town – as a sole CDE practitioner, busy and stretched GPs, lack of podiatry services, no Endocrinologists. GPs are happy with me offering advice on medications and dose adjustment of insulin, setting up insulin pumps based on known algorithms, checking feet using tools available (FootForward resources), teaching injection technique, commencing CGM, teaching carb counting. They expect this of the diabetes educator and assume this is all our role: all aspects of diabetes management and care. People with diabetes deserve to be able to attend their CDE for all the things that they need/expect when consulting a CDE. A healthcare professional specialising in diabetes management and support MUST be able to provide it."

Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care? Please give examples, and any evidence (literature references and links) you have to support your example. Please provide references and links to any literature or other evidence.

The Role of a CDE in Primary Care: Referral to a CDE, or a CDEs inclusion in the multidisciplinary diabetes care team, has been shown to enhance primary care for those with pre-diabetes or type 2 diabetes. A CDE's training makes for a more holistic approach to patient care as the CDE can address a range of concerns, including dietary, exercise and diabetes-related complications, and broader diabetes management, reducing the need for patients to see multiple professionals for intertwined issues. Our members' experience suggests that both people with diabetes and General Practitioner (GP) clinics appreciate this expertise, as it streamlines care and can improve patient engagement.

Benefits of a CDE in Regional Areas: In regions where access to specialised diabetes centres may be limited, especially in smaller hospital settings, a CDE can play a pivotal role in bridging the gap. This is not only beneficial for immediate patient care but also ensures that the wider community in these areas has access to quality care and education about diabetes. This is particularly essential when considering the skills required for diabetes technology, the use of which is growing exponentially.

One of our members who works in a regional area shared this experience, "*GPs in my region will either refer to me or contact me directly in regards to the best medications for their clients to improve [blood glucose] control. Very few are confident enough to prescribe without seeking my advice initially. This shows they value the expertise I have, if they follow my advice as they generally do. Why can't we expand our scope to prescribe the medications we are requesting?"*

See: https://pubmed.ncbi.nlm.nih.gov/35143741/

CDEs in Public Hospitals: CDEs working to their full scope of practice as part of the multi-disciplinary care team in public hospitals, can ensure that everyone in hospital with diabetes is having their diabetes managed well, and can help to advise on referrals upon discharge and provide follow-up diabetes education. A skilled CDE is required to support people who require insulin to manage their diabetes (whether through multiple daily injections or using diabetes

technologies) who are admitted to hospital for surgery or for other reasons. One member shared this about CDEs in a public hospital, "*Many of my clients have mentioned, and I have personally witnessed, people developing diabetic ketoacidosis (DKA) as an inpatient for a purpose not related to their diabetes. Hospital staff are ill-equipped to manage type 1 diabetes managed by ...insulin injections and insulin pumps*." DKA can develop quickly and if unrecognised or untreated it can lead to death.

CDES in Aged Care:

An ADEA member shared this about her experience in aged care*, "There are multiple examples of where a CDE can assist in aged care. Several years ago I was called in to see a gentleman in his 80's who was newly admitted into [a residential aged care facility] and had deteriorated quickly. He had type 1 diabetes and the GP who took over his care assumed that as he was elderly he had type 2 diabetes, so simplified his insulin regimen to just long acting insulin daily and added Metformin. As soon as I saw the man (whom I had never met) I realised he was in DKA. He was immediately transferred to hospital where he later passed away. I have had 2 other similar experiences with clients who I do know being admitted to [a residential aged care facility] and staff once again wanting to simplify care. It ended up being quite a battle to ensure they stay on a basal bolus insulin regimen and [were allowed to use their] get to keep their CGM* (see note below*). One family ended up bringing their father with dementia back home after he had 2 episodes of unconscious hypoglycaemia requiring transfer to hospital within the first couple of weeks as a resident, due to staff delivering the rapid insulin at the wrong times. His wife cared for him at home until he passed away some 10-12 months later. The issue in [residential aged care facilities is that the staff cannot deliver medication unless ordered by a GP so I cannot advise changes directly I need to contact the GP and request a new medication chart be completed*." Note: CGM is a form of diabetes technology.

What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence. Please provide references and links to any literature or other evidence.

Given the complexity and daily self-management demands of diabetes and the need for a comprehensive and integrated approach to education and support, CDEs should be recognised as a single, standalone profession with a single scope of practice by Health Departments and in legislation and regulation. **CDEs are the diabetes health care experts, and the only profession with advanced training and clinical expertise in diabetes education**. ADEA recognises that the role of the CDE will continue to evolve in the context of social, epidemiological, workforce and health system change. ADEA is committed to its responsibility to promote, enhance and strengthen the integral role CDEs play in the specialty practice of diabetes self-management education.

ADEA is committed to national uniformity and recognition of CDEs. Significant barriers to scope of practice for Credentialled Diabetes Educators include **inconsistencies in state and territory human resource practices,** such as employment criteria for diabetes education service providers, and in legislation and regulations governing practice. As the Commonwealth government funds Medicare and is a key funder of state and territory hospitals, they should **require consistency in legislation and**

regulations relating to Credentialled Diabetes Educators as well as consistency in staffing of diabetes centres. The ADEA will represent and advocate for CDEs in workforce reform programs addressing issues such as prescribing rights and CDEs to have direct referral pathways. However, it is essential that Commonwealth and state and territory governments remove regulatory barriers and recognise the profession.

The clinical care requirements of people with diabetes are diverse and best met by a multidisciplinary diabetes care team consisting of a CDE, general practitioners (GPs), endocrinologist, and other allied health professionals. Evidence-based clinical practice guidelines guide the clinical care provided. **Employers, particularly hospitals, can ensure that they hire CDEs and use them as an integral component of a multi-disciplinary diabetes care team, and ensure they have sufficient CDEs so that every patient in hospital with diabetes is able to see a CDE while in hospital**. The nature of diabetes, however, demands that much of the day-to-day management of diabetes is carried out by the person living with diabetes. The involvement of the person with diabetes is critical for the achievement of their health goals. The self-management demands of diabetes are perhaps greater than for all other chronic conditions, requiring up to 180 diabetes-related lifestyle and treatment decisions to be made on a daily basis. These decisions can include managing blood glucose levels, food intake and exercise and extend to the management of serious diabetes complications. People with diabetes require information and education to support them in their self-care, and CDEs are ideally equipped to support them to live their healthiest lives. As stated earlier, **the lack of a specific and single scope of practice for CDEs is** a significant barrier. CDEs are often dependent on their underlying health profession's scope of practice and the varying regulations in each state and territory.

The **current funding model is a barrier** to CDEs and other allied health working to their full scope of practice. Insufficient visits, short visits, and a lack of adequate funding for preventive health all contribute to the funding model as a significant barrier.

What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

To address CDEs working to their full scope of practice the following enablers are essential:

1. **Legislative and Regulatory Changes**:
    - CDEs must be recognised as a singular profession with one scope of practice, not based on their underlying profession
    - State and national legislation and regulations should be updated and nationally consistent to reflect the evolving role of CDEs, enabling them to provide a full range of services.
2. **Recognition and Understanding**:
    - GPs, allied health, people living with diabetes, and the general public should be educated about the role and value of CDEs. This can be done through clear referral pathways from GPs to CDEs upon a diagnosis of diabetes or prediabetes. Also,

awareness campaigns by government, PHNs, and local health districts, geared to people living with diabetes, their families and carers and those at risk of developing diabetes through a genetic link or pre-diabetes.

- Public hospitals should also have a referral pathway to ensure that every person in hospital living with diabetes can be referred to a CDE. Clear referral pathways from from public hospitals to CDEs are needed.

3. **Reimbursement**:

    - Medicare should better cover CDEs and diabetes education (See Parliamentary Inquiry and Pre-Budget Submission), and private insurers should cover CDE-delivered structured diabetes education. This recognises the value of CDEs and diabetes education and better promotes CDE integration into the healthcare system.

4. **Upskilling the Diabetes Workforce**:

    - Ongoing training and upskilling of the current and emerging workforce is vital, especially if there is a singular scope of practice. ADEA is committed to providing the education and training to ensure that every CDE is equipped to work at their full scope of practice for a singular CDE profession. However, there is a broader role for government to support this through recognition of the profession, funding, training programs, and continued education. (See Parliamentary Inquiry Submission)

5. **Multidisciplinary Collaboration**:

    - Foster stronger collaboration between CDEs, GPs and other healthcare professionals through referral pathways, to ensure referral to a CDE upon diagnosis of diabetes or prediabetes, and enhanced funding to support multidisciplinary diabetes care teams. Robust interprofessional collaboration will ensure comprehensive multidisciplinary care for the person living with diabetes.

    - CDEs working in public hospitals and Diabetes Centres often collaborate quite closely with a multidisciplinary care team to ensure that all people living with diabetes who are hospitalised receive comprehensive diabetes care. This model should extend to all hospitals and beyond discharge, and should promote ongoing collaboration with the primary care multidisciplinary diabetes care team.

6. **Evidence-Based Practice**:

    - ADEA is committed to regularly updating practice standards based on the latest research and, in conjunction with ADEA's credentialling process, ensures CDEs are up to date on the most current evidence.

7. **Feedback and Quality Assurance**:

    - Government and peak-body systems for regular feedback and quality assurance ensure that CDEs are delivering high-quality care and can identify areas for improvement or further training.

    - Data is essential to enabling CDEs to work to their full scope of practice. All CDEs should have access to MyHealthRecord to enable best-practice, multidisciplinary care, and Medicare should capture services provided by allied health professionals

via telehealth, by profession. At present Medicare groups all allied health-provided telehealth services and individual profession data is not captured.

- Follow patients who are referred to multi-disciplinary care teams working to their full scope of practice to determine if patients who have multidisciplinary care teams have better health outcomes.
- Using Quality Improvement frameworks there is a need to assess the necessary changes in diabetes service delivery in both hospitals and primary care, pinpointing essential alterations specific to different health disciplines.
- Employing the RE-AIM framework will help in refining current education and training programs for CDEs, Endocrinologists, and GPs in diabetes. The objective is to amplify the adoption of, and ensure that diabetes specialists adopt, a consistent, unbiased, evidence-based, and non-stigmatising approach to care and support for diabetes patients. Finally, it is imperative to delve into the impact of organisational cultures on practices, the needs of leadership, how health professionals perceive their scope, and the backing required for them to reach their peak potential. Moreover, understanding the effects of rurality, exemplary care models, organisational practice models, and the implications of professional indemnity insurance is crucial.

Please share with the review any additional comments or suggestions in relation to scope of practice.

CDEs operate in diverse settings, with their practice rooted in three core domains: **(1) Clinical Practice (2) Research and Evidence-based Practice, and (3) Management, Administration, and Leadership**. At the heart of their role is Structured Diabetes Self-Management Education. CDEs provide comprehensive guidance, helping patients and their carers set appropriate goals and develop effective self-care behaviours. This systematic approach considers an individual's holistic well-being, including their mental, physical, spiritual, and cognitive aspects. CDEs also act as care coordinators, bridging the gap between patients and other healthcare specialists, ensuring that all health needs are addressed comprehensively. CDEs are always informed by current best practices, research, and interdisciplinary guidelines in diabetes care.

ADEA recognises that the role of the CDE will continue to evolve in the context of social, epidemiological, workforce and health system change. ADEA is committed to its responsibility to promote, enhance and strengthen the integral role CDEs play in the specialty practice of diabetes self-management education.

ADEA is committed to national uniformity and recognition of CDEs, and ensuring they work to their full scope of practice. To achieve this, it is necessary for the Commonwealth and state and territory governments to address inconsistencies in state and territory human resource practices such as employment criteria for diabetes education service providers, and in legislation and regulations governing practice. ADEA will represent and advocate for CDEs in workforce reform programs addressing issues such as prescribing rights and direct referral pathways.

Unfortunately, because CDEs are not recognised as a singular profession, their scope of practice currently does not include a few key areas that should unify the profession and enable it to operate

to its full scope of practice, improve health care for people with diabetes, and ultimately result in savings to the health system in Australia, including:

- Ordering and interpreting pathology
- Possession, administration, or adjustment of medicines
- Adjusting the dose, in response to changing blood glucose levels, of the patient's prescribed diabetes medication
- Referral to other members of the multidisciplinary diabetes care team

The Australian healthcare system is at a crossroads, consumer expectations are growing for care closer to home and greater access to information and involvement in decision-making as new technologies emerge leading to new models of care, and the financial sustainability of the health system means new measures must be cost effective. This can be achieved with all health practitioners being enabled to work to their full scope of practice in a patient-centred multidisciplinary care team. This is especially true with the multifaceted skills and knowledge of CDEs, combined with their frontline experience. **Recognising CDEs as a singular, standalone health profession is not just a matter of professional identity but a crucial step towards improving the quality and efficiency of diabetes care across the nation.** We urge the government to consider this recognition, for the betterment of people living with diabetes and the health system.