Time and Financial Outcomes of Private Practice Dietitians Providing Care under the Australian Medicare Program: A longitudinal, exploratory study.

ABSTRACT

Aim: To better understand the income of dietitians delivering Medicare Chronic Disease Management services by comparing the amount of time dietitians spend on activities with remuneration received.

Methods: Data were collected on time invested and remuneration received for 179 consultations provided by 20 dietitians through the Medicare Chronic Disease Management initiative. Descriptive statistics and t-tests were used to compare time spent and remuneration received. A mixed effects model was performed to assess the significant factors in predicting the mean hourly rate received for consultations.

Results: Consultations accrued an average of $67.32 ± $24.38 (range $0 – $150) in remuneration, and required an average of 44 ± 20 mins (range 14 – 136 mins) including over 10 mins of administration time. The average calculated gross rate of pay was $102.62/hour. Set fee consultations were longer than bulk-billed consultations (51 mins vs. 39 mins, P=0.002), but resulted in greater remuneration ($83.20 vs. $52.95, P<0.001). Initial consultations resulted in greater remuneration than review consultations ($76.52 vs. $60.75, P<0.001). Dietitians without administration assistance spent more total time on consultations compared with dietitians with administration support (54 mins vs. 42 mins, P=0.001), but there was no difference in fees charged (P>0.005).

Conclusions: The hourly income received by dietitians providing services under Medicare appears high, however practice expenditures have not been considered in this study. Dietitians should consider the logistical and financial outcomes of their practices in order to enhance financial sustainability.

Key words: allied health; chronic disease management; dietitian; Medicare

INTRODUCTION

In 2004 Medicare introduced the Chronic Disease Management (CDM) program to enable patients to receive subsidised multidisciplinary care for chronic disease management.[1] Under a CDM care plan, a community-based patient with a chronic disease (existing for 6 months or more) can be referred by their General Practitioner (GP) to allied health professionals for a maximum of five consultations per calendar year.[2] Dietitians are the only allied health professionals recognised as providing nurition care under the CDM program, and are the third most utilised allied health profession within the program.[3]

To comply with the requirements of delivering individual consultations under the CDM program, dietitians are required to undertake three broad tasks. First, a dietitian must receive communication from a GP or Practice Nurse regarding a new CDM plan, and agree to deliver services in accordance with the patient's goals. Second, a dietitian must provide a consultation to a patient in-person for at least 20 mins. Finally, a dietitian must summarise the care provided to the patient via a written report to the referring GP upon completion of the initial and final consultations.[4, 5] The remuneration offered by Medicare is currently AU$52.95,[4] which is provided after the completion of a consultation.

Dietitians report challenges in providing services under the CDM program protocol, including inadequate remuneration for time invested. Latest estimates suggest dietitians spend an average of 52 mins in initial consultations and 28 mins in review consultations, considerably more than the minimum 20 mins required by the CDM protocol.[6] Dietitians also report spending substantially longer time on administrative tasks related to CDM consultations compared with private consultations, and this time is not remunerated.[7] Finally, dietitians and other allied health professionals report that the remuneration provided by

Medicare (AU$52.95) is grossly insufficient for sustainable practice.[7-9] Dietitians are able to charge more than the schedule fee, which requires patients to pay the extra amount not covered by Medicare. However, dietitians experience pressure from doctors and patients to keep their fees down and bulk bill (i.e. charge Medicare directly for the schedule fee listed in the Medicare Benefits Schedule, incurring no expense for the patient).[7] Therefore, there are concerns that dietetics services under the CDM program may not be financially sustainable and clearly warrant further investigation.[10]

In order to clarify the impacts of these issues on dietetic services delivered under the CDM program, a better understanding is needed regarding (i) the total time commonly taken to complete dietetic services for a patient in the CDM program, including activities outside of a consultation, and (ii) the subsequent remuneration received by dietitians. By understanding these two aspects of practice, the factors that may influence a sustainable income can also be determined. Overall, this information will guide dietitians on practices that may facilitate sustainable services. Therefore, the aim of this study was to undertake a cost analysis of dietitians' time delivering Medicare services to patients by comparing the amount of time dietitians spend on activities related to CDM patients with the remuneration received.

METHODS

This exploratory study utilised a longitudinal, observational design to compare the time invested on individual CDM consultations to the remuneration received. Ethical clearance was received from [blinded for peer review] Human Research Ethics Committee (PBH/01/14/HREC).

Participants were Accredited Practising Dietitians (APDs) working as sole traders and delivering services under the Medicare CDM program. Convenience and snowball sampling were utilised to recruit participants. An initial email was sent to private practice dietitians (*n* = 37) within the researchers' networks, and they were asked to forward the email on to their own contacts. The initial contact email provided an overview of the study, stating its objectives and requirements of participants. A total of 20 dietitians across NSW, Queensland and Victoria consented to participate.

The primary data collection tool, a log sheet, was divided into columns to specify time invested on each component of the consultation; (i) before, (ii) during, and (iii) after the consultation. The activities conducted and fee received for each consultation were also recorded. Piloting of the log sheet was conducted on four private practice dietitians to determine ease of use and clarity of the log sheet. Their feedback resulted in minor changes, completed prior to data collection.

Dietitians were instructed to collect data on 10 consecutive CDM patients. Upon completion and return of the log sheet, a phone interview was arranged to collect demographic and practice information based on the most recent workforce profile of private practice dietitians.[6] This included information on gender, age, geographical location, setting of service, workload,

administration assistance, contribution of CDM patients to client load, and remuneration arrangements.

Data analysis was performed using IBM SPSS Statistics for Macintosh (Version 22). Data provided that did not meet the eligibility criteria were excluded from analysis. Incomplete data sets, due to patients not attending their consultation or unfinished log sheets, were utilised in the analysis when possible to provide a more accurate picture of dietetic consultation characteristics. Descriptive statistics were calculated for participant characteristics and each component of the consultation, including preparation time and activities, consultation time, post-consultation time and activities, total consultation time and remuneration. Hourly rate was calculated from remuneration divided by the total time. The relationships between (i) initial and review consultations, (ii) bulk billed and set fee consultations, and (iii) whether dietitians had administration assistance or not, and their effect on time and remuneration were explored using independent t tests. A mixed effects model was performed to identify the significant factors in predicting the mean hourly rate received for consultations in consideration of subject effects between and within the participating dietitians. Statistical significance was set at $P< 0.05$.

RESULTS

A total of 179 consultations provided by 20 dietitians were included in the study (76 initial, 100 review, 3 undetermined; 94 bulk billed, 85 set fee). Of the 20 dietitians who recorded consultation data, 18 were females. The majority (12) were over the age of 40 years and located in a metropolitan setting. Thirteen consulted in GP clinics, while others consulted from a medical specialist practice, a private practice or conducted mobile visits. Four of the dietitians worked less than 10 hours per week, eight worked 10-30 hours per week, and eight dietitians worked more than 30 hours per week. Eight dietitians consulted less than 20 patients per week, five dietitians consulted 21-30 patients per week, and seven dietitians consulted more than 30 patients per week. Sixteen dietitians received administration assistance, with the remaining four completing their own administration tasks. Although most dietitians (16) were utilising electronic medical records, 14 dietitians also used paper medical records. The contribution of CDM consultations to patient load varied, from less than 10% of patient load (2), 11-40% of patient load (4), 41-60% of patient load (8), 61-90% of patient load (4), and over 90% of patient load (2). Bulk billing was the sole method of payment for six dietitians, while a further six used a combination of bulk billing and set fee (i.e. charged an amount above the Medicare schedule fee) depending on the patient circumstances, and the remaining eight dietitians did not offer bulk billing for any patients.

Table 1 summarises the time taken for each component of the consultation, and the influence of consultation characteristics on time. Consultation preparation time included all activities related to the patient before the actual consultation. The most frequent activities were confirming the appointment (61% of consultations), reviewing patient referral notes (56% of consultations) and arranging and booking appointments (13% consultations). The mean preparation time for dietitians was 3 ± 4 mins (range 0 – 39 mins). Preparation time was

similar for initial consultations compared with review consultations ($P>0.05$), and for consultations with a set fee compared with bulk billed consultations ($P>0.05$). Dietitians completing their own administration activities (4/20) spent longer preparing for consultations than dietitians who employed administration assistance (5 mins vs. 3 mins, $P=0.003$).

The mean consultation time was 34 ± 14 mins (range 12 – 90 mins). Although the mean time for initial consultations appeared longer than review consultations, this was not statistically significant (42 mins vs. 28 mins, $P>0.05$). Consultations with a set fee were significantly longer than bulk billed consultations (39 mins vs. 30 mins, $P<0.001$). Dietitians without administration assistance held longer consultations than dietitians with administration assistance (39 mins vs. 33 mins, $P=0.008$).

Post-consultation time constituted the time following the consultation spent on activities for the patient. The most frequent activities included processing payments (80% of consultations), booking future appointments (63% of consultations) and writing letters to GPs (42% of consultations). The mean time spent on these activities by dietitians was 7 ± 7 mins (range 0 – 47 mins). Initial consultations required similar post-consultation time compared with review consultations ($P>0.05$). Set fee consultations incurred longer post-consultation time than bulk billed consultations (9 mins vs. 6 mins, $P=0.005$). Dietitians completing their own administration activities spent significantly more time on post-consultation activities than dietitians with administration assistance (12 mins vs. 6 mins, $P<0.001$).

The total time spent on each patient was 44 ± 20 mins (range 14 – 136 mins). Initial consultations had a similar mean total time than reviews ($P>0.05$). The total time for set fee consultations was longer than bulk billed consultations (51 mins vs. 39 mins, $P=0.002$).

Dietitians without administration assistance required longer total time than dietitians with administration assistance (54 mins vs. 42 mins, P=0.001).

INSERT TABLE 1 ABOUT HERE

Table 2 outlines the remuneration for each consultation component and equivalent hourly rate of pay. The overall mean remuneration was $67.32 ± $24.38 per consultation (range $0 – $150). When a patient did not attend their consultation (2 consultations), no remuneration was received ($0). Initial consultations incurred significantly more remuneration than review consultations ($76.52 vs. $60.75, P<0.001), and set fee consultations incurred significantly more remuneration than bulk billed consultations ($83.20 vs. $52.95, P<0.001). Dietitians without administration assistance charged similar fees to dietitians with administration assistance (P>0.05).

The mean calculated hourly rate of pay was $102.62 ± $43.35. The highest hourly rate of pay was $300.00 per hour. For initial consultations, the calculated mean hourly rate of pay was significantly lower than review consultations ($86.55 vs. $115.51, P=0.006). Set fee consultations incurred a significantly higher hourly rate than bulk billed consultations ($113.71 vs. $92.71, P=0.012). Dietitians without administration assistance earned less per hour than those with administration assistance ($82.15 vs. $108.36, P=0.004).

INSERT TABLE 2 ABOUT HERE

The mixed model approach takes into account both fixed (individual patient level) and random (group or dietitian level) effects to predict the change in hourly rate. The results of

fixed effects (Table 3-A) showed that two factors independently increased the calculated hourly rate of pay for dietitians; (i) charging a set-fee for the consultation (P<0.001), and (ii) spending less overall time on the components of the consultation (P<0.001). Table 3-B summarises the variance estimates of random effects in the model. The variance estimate for hourly rate between dietitians is 273.80, accounting for 36.6% (273.80/747.57=36.6%) of total variance in hourly rate. The significant results (both P<0.05 in Wald Z tests) suggest that hourly rates vary between patients (63.4% of total variance, patient fixed effects) under the same dietitians and also vary among the dietitians (36.6% of total variance, due to dietitian and consultation characteristics).

INSERT TABLE 3 ABOUT HERE

DISCUSSION

This observational study has provided insight on the time taken to provide dietetic services under the CDM program, and the impact this has on remuneration. Bulk billed consultations and their related pre- and post-consultation activities were significantly shorter than set-fee consultations, leading to a total of 12 mins less time spent on the patient. These results show a larger time discrepancy between bulk billing and set fee consultation than reported in previous literature.[6] As the Medicare rebate is paid per consultation, rather than on a time pro rata,[9] there is no remuneration provided for dietitians who choose to spend greater than 20 mins with a patient. Previous studies have hypothesised this difference as 'abbreviated care', which may reduce the effectiveness of care provided.[9] However, no research has assessed differences in perceptions or patient outcomes of dietetic services based on consultation length, warranting investigation. Despite allied health professionals requesting an increased fee benefit from Medicare,[7] the private practice dietetics workforce continues to grow considerably,[6] indicating that the positive factors for providing services under Medicare outweigh the barriers.

No significant differences in the time dietitians spent on initial and review consultations were found in this study. Dietitians have previously reported that due to the counselling nature of dietetics, half hour initial consultations are insufficient to provide adequate care.[10-12] However, dietitians consider the time frame covered by Medicare (20 mins) adequate for review consultations.[8, 10, 11, 13] Therefore it appears more financially sustainable for dietitians to retain patients through review consultations, rather than conducting numerous initial consultations.

The calculated hourly rate for both bulk billed ($92.71) and set fee ($113.71) consultations appears high compared to other common areas of dietetics, such as clinical hospital work. As an example, new graduate dietitians beginning employment in a Queensland public hospital can expect to earn upwards of $32.18 per hour (correct as of July 2015), based on full time work of 76 hours per fortnight ($63, 807 per annum).[14] However, expenditures associated with private practice work are not accounted for in this study, which may include rent, administration assistance, insurance, and other practice costs such as stationery and cleaning. The most recent profile on the private practice dietetics workforce found that 43% of respondents spent more than 40% of their gross income on expenditures.[6] While there are no benchmarks for expenditure set in the DAA Small Business Manual,[15] benchmarks for other allied health expenditure are available. As an example, the expenses for physiotherapy businesses with an annual turnover of $75 000 – $240 000 in 2011 – 2012 was 39 – 59% of income.[16] For chiropractic and osteopathic services with an annual turnover of $65 000 – $200 000, expenses ranged from 45% – 61% of income.[17] Therefore it can be assumed the actual amount taken home by private practice dietitians is approximately half of the hourly rate. In order to maintain a sufficient income, continuous consultations would be required each day. Future research on the expenditure of private practice dietitians may support the current study and inform dietitians on the likely income for working in private practice.

Results showed that dietitians who employed administration staff spent less total time on patients. Although no difference in consultation fees was found between these dietitians, the hourly rate was significantly higher due to the time saved. The increase in calculated hourly rate was $26.21, approximately equivalent to the wages of an administration assistant.[18] Hence, it appears the expense of administration assistance may be justified by the increased capacity to see patients.

Despite the continued growth in the CDM program, the economic efficiency of continuing the CDM program has been questioned. A 2010 qualitative study suggested the CDM scheme wastes public resources, as patients with private health insurance are referred under the scheme, and some patients may return to public services after their consultation cap is reached, duplicating assessments and treatments.[19] Additionally, only one prospective observational study has investigated patient outcomes of dietetics services under the Medicare CDM program, and showed only modest improvements in weight and waist circumference in patients.[20] The capacity of GPs to provide nutrition care is still much greater than dietitians.[21, 22] Therefore, instead of increasing schedule fees for allied health services, it could be argued that it would be more economically efficient to put these funds towards supporting GPs and Practice Nurses to provide nutrition care. Regardless, the input of dietitians should not be undervalued, particularly regarding complex cases in which GPs recognise they do not possess the necessary skills and expertise in nutrition care.[21]

The present study has some notable limitations. The small convenience sample used may have impacted the results of this study, and therefore limited the transferability of results to the entire dietetics private practice workforce. Although each participant recorded data for multiple patients, it is recognised that certain dietitians will have different logistical processes, which may affect the time and remuneration received. As participants were required to record activities as they occurred, it is possible that they modified their behaviours, either intentionally or unintentionally. Finally, this study was not able to capture all aspects of patient related work. As each dietitian was asked to start recording from their next 10 CDM consultations, processes such as receiving the referral, initial contact with the GP to accept the care plan, and booking the appointment may have been missed.

This study compared consultation fees accrued by private practice dietitians to the amount of time spent on each patient, including administration duties, resulting in an average hourly rate of $102.62 before accounting for expenditures. The findings of this study may provide opportunities for dietitians to consider the structure of their private practice, including fees and administration support. Future studies may research ways to reduce the burden of administration time found in this study, such as the use of automated reminders and feedback letters to GPs, and may include time invested in essential non-patient related activities. Further research clarifying the common expenditures incurred by private practice dietitians will facilitate a better understanding of the anticipated incomes of private practice dietitians. These results may also provide evidence to support increasing the Medicare schedule fee for allied health services in order to more closely align the incomes of bulk billing dietitians to those who charge a set fee. However, prior to increasing the Medicare schedule fee, further investigation into the cost effectiveness of dietetic services, including expected patient outcomes, is needed.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

AUTHORSHIP

[Blinded for peer review]

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TABLES

Table 1 Summary of time taken for each consultation component, and influence of consultation characteristics on time (n=179).

Consultation Component	*Consultation Type*	*Mean ± SD (mins)*	*Significance (P value)*
Preparation Time • Confirm appointment (text, phone call, email, phone message) • Review patient notes/ referral • Arrange and book appointment • Collating/printing resources, research • Discussions with patient/family before appointment • Enter referral/appointment into system • Communicate with GP (e.g. bloods) • Obtain/prepare file • Reschedule appointment • Received payment • Other (e.g. explanation of rebate process, send out information packet, review other health professionals notes)	Initial	4 ± 3	>0.05
	Review	3 ± 5	
	Set fee	4 ± 5	>0.05
	Bulk billed	3 ± 3	
	Without administration	5 ± 7	0.003
	With administration	3 ± 3	
Consultation Time • Assessment and delivering dietetic intervention	Initial	42 ± 12	>0.05
	Review	28 ± 13	
	Set fee	39 ± 16	< 0.001
	Bulk billed	30 ± 11	
	Without administration	39 ± 19	0.008
	With administration	33 ± 12	
Post-consultation Time • Receive and process payment/receipt • Arrange/book future consult • Write and send letter to doctor • Finished patient notes (including updating software) • Dictate doctors letter (administration types and sends) • Refile patient notes • Communication regarding patient care (GP, reception, allied health) • Communication with patient	Initial	9 ± 7	>0.05
	Review	6 ± 6	
	Set fee	9 ± 8	0.005
	Bulk billed	6 ± 5	
	Without administration	12 ± 10	< 0.001
	With administration	6 ± 5	
Total Time	Initial	55 ± 17	>0.05
	Review	36 ± 18	
	Set fee	50 ± 24	0.002
	Bulk billed	39 ± 14	
	Without administration	54 ± 28	0.001
	With administration	42 ± 16	

Table 2 Summary of remuneration for each consultation component, and influence of consultation characteristics on remuneration (n=179).

Consultation Component	*Consultation Type*	*Mean ± SD ($)*	*Significance (P value)*
Total Remuneration	Initial	76.52 ± 28.39	< 0.001
	Review	60.75 ± 18.52	
	Set fee	83.20 ± 27.80	< 0.001
	Bulk billed	52.95 ± 0.00	
	Without administration	66.52 ± 24.09	>0.05
	With administration	67.55 ± 24.54	
Hourly Rate	Initial	86.55 ± 29.90	0.006
	Review	115.51 ± 48.13	
	Set fee	113.71 ± 51.01	0.012
	Bulk billed	92.71 ± 32.32	
	Without administration	82.15 ± 27.66	0.004
	With administration	108.36 ± 45.26	

Table 3 Estimates of Fixed and Mixed Effects for Hourly Rate

A. Estimates of Fixed Effects

Parameter	*Estimate*	*Std. Error*	*df*	*t*	*Sig.*	*95%CI*	
						Lower	*Upper*
Intercept	87.89	5.49	22.92	16.02	<0.001	76.54	99.24
Set fee	38.68	5.72	105.27	6.76	<0.001	27.34	50.02
Bulk billed	0	0					
No paid administration support	-9.71	10.53	17.20	-0.92	0.369	-31.90	12.49
Paid administration support	0	0					
Total administration staff time	-0.33	0.37	163.91	-0.91	0.362	-1.06	0.39
Total dietitian time	-1.44	0.10	170.50	-13.69	<0.001	-1.64	-1.23

B. Variance Estimates of Mixed Effects

Parameter	*Estimate*	*Std. Error*	*Wald Z*	*Sig.*	*95%CI*	
					Lower	*Upper*
Residual	473.77	54.22	8.74	<0.001	378.58	592.89
Intercept (Subject:Participant) Variance	273.80	118.49	2.31	0.021	117.24	639.46