Assistive Technology and Home Modifications Redesign Project April 2018

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6400 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the Assistive Technology and Home Modifications Redesign Project Report by the Engagement and Inclusion Branch of the NDIA.

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Opening remarks

DAA supports policies and processes which improve the NDIS participant and NDIS provider experience with respect to assistive technology (AT). The intention to empower people with disability, simplify processes, reduce time needed for approvals, and provide certainty to participants that their needs will be met in the short and long term by the NDIS is welcome.

DAA would like greater opportunities for Accredited Practising Dietitians and other allied health professionals to participate directly in design, implementation and review processes to support the development of robust policy and process which are fit for purpose across the range of AT in recognition of the similarities and differences within the AT environment. For example, we would like to assist with the refinement of templates related to access of nutrition support products and dietetic services.

DAA recognises the value of data collection and analysis by the NDIA to inform process and policy improvements. DAA encourages the NDIA to include allied health providers in review of data to inform future developments of AT processes in the NDIS.

Scope

The scope of AT is not well defined in the project report in terms of the types of broad areas of technology under consideration. Perhaps this is deliberate as it has the advantage of inclusivity but the experience of Accredited Practising Dietitians registered as providers to date is that not including professions or items on NDIS lists leads to exclusion of dietetic services in plans by planners.

DAA would like to see adequate recognition of AT related to nutrition related function and impairments for the purpose of process design and future interpretation by planners.

Low and medium to high complexity/risk

We agree in principle on stratification within NDIS participant plan budgets for AT according to low cost/low complexity and high complexity/high cost. Also, that an amount of $1500 or less can be included for low cost items in core budgets which participants will self-manage to streamline the process.

We support inclusion of capacity building funds if the participant needs support in selecting or using products. We suggest however that this be up to five hours of support, rather than the three hours proposed in the consultation documents.

Details on the pricing tool or cost estimation tools for medium to higher cost items have not been presented. DAA would like to know what is being developed

in this area. We would like to be consulted about pricing tools for nutrition related products as DAA members can contribute relevant information which has accumulated following the disruption which has occurred to pricing of nutrition related products since the implementation of the NDIS.

We haven't been able to consult DAA members sufficiently on the actual dollar figures for deciding low or high cost items in participant plan budgets which are presented in the project documents. We would expect that the figures be reviewed from time to time according to data collected and analysed by NDIA. We recommend that various stakeholders including peak professional bodies have the opportunity to comment on proposed figures and future changes to the figures. We would also like the opportunity to provide feedback on draft versions of printed material that informs participants for the pilot and thereafter.

Specialised assessors – concept

We do not reject the concept of appointing specialised assessors to inform planning which we understand is intended to address a perceived conflict of providers assessing participants and then providing services. We highlight that regardless of their role, professionals endeavour to provide objective advice and to comply with codes of conduct while respecting the choice of participants as a fundamental tenet of the NDIS.

We note that there can be advantages with a provider assessing participants and later providing services in terms of continuity of care and building a relationship with the participant. On the other hand, a specialised assessor is expected to see the participant at a moment in time with information made available for the assessment with the challenge of establishing the rapport needed to complete the assessment. For some participants this will be straightforward, but for some clients it may be difficult. For some participants the contact with a specialised assessor might be yet another retelling of the participant story, and be potentially uncomfortable, difficult or traumatic.

DAA recommends therefore that the pilot of the streamlined AT & HM process carefully evaluate the benefits and disadvantages of both the provider assessing the participant in planning as compared with the specialised assessor in designing future iterations of AT & HM processes. To this end, DAA would value the opportunity to contribute to design of the evaluation of the pilot project.

Single assessor organisation

Where a single assessor organisation is appointed by the NDIA, they should be required to provide a full complement of qualified, credentialed and experienced professionals relevant to the technology being assessed. This should include Accredited Practising Dietitians with relevant experience and recency of practice. It is not clear from the Project Report why the NDIA are not proposing the

appointment of individuals to a panel, which may be necessary of a single organisation does not already employ the full range of professionals.

Specialised assessor – conditions

To whatever extent the specialised assessor model is implemented, a number of conditions should be met to satisfy quality and safeguarding concerns. If not implemented carefully the requirement for specialised assessor will create an additional step without adding value and may lead to adverse outcomes for participants, frustrations for providers and additional administrative burden for NDIA staff. In the case of nutrition support for example, it may mean a participant may be at risk of not receiving essential products and professional advice in a timely manner. This is presents a risk where enteral nutrition is the participant's sole means of managing an eating and drinking impairment.

We recommend the following conditions should apply in the use of specialised assessors

- Where an external assessing panel is appointed, it will be important that the panel comprises the right professionals at the right time with the right skill mix to assess the diversity of needs which are presented by participants. Material from the Design Hub suggests that assessors will assess in areas outside of their scope of practice. This presents a practical and ethical dilemma to professionals and has serious implications for quality and safeguarding. It is also likely to be inefficient because inappropriate assessments will inevitably lead to the need for review and delays.
- Reports from Accredited Practising Dietitians and others about the use of AT by participants prior to entry into the NDIS should be accessible to specialised assessors. Feedback from DAA members is that this material has not always been considered at entry to the NDIS.
- Only appropriately qualified, credentialed and experienced professionals should be appointed. For nutrition support related technology for example this must be an APD with recency of practice in nutrition support.
- Sufficient numbers of assessors should be appointed to reflect the breadth of participant needs. For example, many professionals will offer paediatric experience, while others can bring specialist skills and knowledge with adults. DAA recommends that peak allied health bodies are consulted regarding their professions as the areas or ages of expertise will vary across professions.
- Sufficient numbers of assessors must be appointed to ensure timely assessment processes across all geographic regions. It may be that agreed time targets vary according to the AT. The three weeks nominated for return of the specialised assessment in the Project Report may be too long for some participants requiring nutrition support. Nutrition support would

be expected to have very short turn around times, where other AT assessments may have longer turn around. DAA would be pleased to contribute to the work on time frames.

Registration and primary groups

It is not clear where nutrition support will sit in the six registration groups discussed in the Design Hub. DAA strongly recommends an additional category of Nutrition Support be added to the following. he registration groups

- Therapeutic supports
- Custom prostheses
- Early Intervention for Early childhood
- Community Nursing
- Home Mod Design and Construction
- Vehicle Mods.

The only acceptable way of matching a participant to an assessor is to appoint according to discipline specific expertise. The NDIA already recognises this in registration processes as part of quality and safeguarding arrangements.

DAA strongly rejects the concept of four primary groups proposed in the Design Hub as these do not relate sufficiently to assessment for nutrition support.

- Vision impairment
- Physical disability
- Hearing Impairment
- Cognitive or intellectual impairment.

Role of planners

Performance of planners currently falls short of expectations of providers and participants, and this has been acknowledged by the NDIA. Planners will need thorough training in the new system, ongoing access to expert advice and training updates from time to time. Allied health professions would like to be consulted in the development of training content. Allied health professional bodies can assist with recruiting professionals with the necessary skills and knowledge to build content.

Participants and parents of participants have stated publicly that they value the contribution made by professionals in planning and that they expect greater consideration by planners in the application of professional advice in the development of participant plans.

Under 3.2 Stage 5: Create a plan it is stated that the planner is the decision maker and the assessment is not binding. This is concerning since it is expected that the specialised assessor has high level skills and knowledge of the AT concerned, where the planner does not have this expertise. Feedback in public forums

provided by participants and/or their families demonstrates dismay at decisions taken by planners over the professional advice of medical practitioners and allied health professionals.

This is an important area which requires further work to maintain confidence of participants and families and respect the principle of participant choice and control. It should be clear to participants what their avenues of appeal are if they wish to act upon the specialised assessment but the planner decides to disregard a specialised assessment

Feedback on Workbook

DAA members note that the Project Report 3.1 Stage 4 pg 5 refers to the inclusion prompting questions around daily life but Planning Workbook 2 has no prompts about eating and drinking impairments, dietetic services, nutrition support or other prompts about functional issues related to nutrition. DAA would like to contribute suggestions in this area, for example on page 7 of Planning Workbook 2 under 'What does your week usually look like' there could be a heading of meal preparation/cooking/shopping/ordering nutrition support products.