Executive Summary

National Credentialing and Accreditation for Assistive Technology Practitioners and Suppliers

An Options Paper

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Executive summary

DisabilityCare Australia will shift control of resources for their disability-related goods and services to people with disability. This will include the way assistive technology (AT) is funded. The shift away from block funding of AT programs will require replacement of current bureaucratic structures used to ration scarce resources equitably and manage the risks associated with AT prescription and supply processes with a new framework more in keeping with a person-centred market-based system.

AT is a primary enabler for many people with disability. Within DisabilityCare it is estimated that 12% of expenditure will go towards AT, including home and vehicle modifications. Nationally 10% of the population (40% of people with a disability) rely on aids and equipment. Consumers often utilise advice and support to identify, select and make the fullest use of AT. Consequently, ensuring the competence of AT practitioners and the quality of AT suppliers is critical.

This paper identifies the primary issues and options for establishing a national credentialing and accreditation system. Credentialing of individual AT practitioners and accreditation of AT suppliers, particularly for higher risk and more complex AT, will provide consumers and their families with a decision-making aid when making choices in seeking assistance to identify and meet their AT needs. It will also assist DisabilityCare and other individualised funding programs to identify AT practitioners with the relevant levels of competence to assist with assessments and planning.

For good AT outcomes consumers and families need:

- timely and accurate information
- advice that is directly applicable to their situation
- accurate assessment of their needs and capabilities, and
- effective implementation of the right solution.

Delivering good AT outcomes often hinges on the combined expertise of all parties: consumer and family; AT practitioners and suppliers.

The creation of DisabilityCare Australia signals a major shift in the culture and language of service delivery. In relation to AT, the role of AT practitioners will move away from ‘prescription’ with its inherent gatekeeping aspects, to one of ‘advice’, ‘assessment’ and ‘implementation’. This shift in roles and language is reflected in the credentialing and accreditation options proposed in this paper. AT practitioners may undertake these different roles in a myriad of configurations. Practitioners and suppliers will need to strengthen their consumer focus, and address any potential conflicts of interest, particularly where these roles are combined such as in specialist seating clinics and for orthotists and prosthetists.

To develop this options paper, a consultation paper was widely circulated. Responses were received from approximately 65 organisations and individuals throughout Australia and internationally, comprising over 120 pages of written feedback, as well as a number of individual and group discussions. Research included a review of peer reviewed and grey literature, and existing AT

accreditation and credentialing systems; critiques of those systems; and research into existing regulatory systems to identify key elements related to success/failure and best practice.
This paper is a modest first step, and much more work will need to be done in negotiating and implementing key decisions regarding selecting which options are most appropriate and achievable; and developing the detailed resources, structures and processes to implement an effective and sustainable credentialing and accreditation system.

Research results

The literature review identified a number of outcomes that regulatory schemes such as credentialing and accreditation can achieve, including:

- reduced abandonment (<5%) (Strong et al., 2011)
- greater high-competency practitioner availability by directing demand for guidance on lower risk/less-complex AT to lower skilled practitioners (Winchcombe & Ballinger, 2005)
- consolidation of a 'body of knowledge' and reduced sector fragmentation (Gebbie et al., 2007)
- agreement on the necessary AT competencies (Elsaesser & Bauer, 2011).

However, these and other positive benefits can be achieved only if credentialing and accreditation systems function effectively. Key elements identified for this include:

- 'right-touch' regulation, with the level of regulation commensurate with level of risk
- transparency and accountability to the community broadly and consumers particularly
- efficacy of monitoring and enforcement, with clear recognition that up-front requirements and supports to engender good practice are the best way to generate good outcomes
- ongoing evaluation of the system itself, and its effectiveness in enhancing consumer outcomes, with the caveat that AT outcome measures are improving but need more work.

Information was collected on 17 credentialing and accreditation systems nationally and internationally. Well-established and typical examples were reviewed against key criteria including:

- governance and structural relationships, such as affiliation with funder (Enable NSW) or independent (RESNA)
- costs: detailed information was not generally available, but funding structures were
- legal status (statutory or other basis of authority)
- entry requirements (restricted to registered health professionals or other limits)
- credentialing/accreditation attainment and continuing requirements
- addressing poor performance/problems/complaints
- links to education/training
- evaluation and transparency of the system.

There are few evaluations of existing systems, and information on all these criteria was not available for all systems. However strengths and weaknesses were identified utilising a combination of comparisons against the broader literature about what is required for effective regulatory systems, and informal discussions with people involved in the systems. Our discussions also helped highlight some of the inevitable trade-offs in building and operating such systems. The results of this research, as well as the literature and the consultation process were used to develop the framework for an Australian AT credentialing and accreditation system.

Framework for a national AT credentialing and accreditation system

This summary presents the major elements of the proposed system, including some results from the consultation. There are four main parts in the framework:

- broad systemic issues
- practitioner credentialing
- supplier accreditation
- timelines and tasks for the next stages.

Broad systemic issues considered included the System's purpose, objectives, principles and implementation fundamentals. Overall these were well supported in the consultation, and several important suggestions are now included.

Purpose: The credentialing and accreditation system will identify, develop and continually enhance high-quality practitioner and supply practices in the Australian AT sector that achieve the best outcomes for consumers and their families, and improve process and economic efficiency for funders, AT practitioners and suppliers.

Objectives: These emphasise that the System must:

- enhance AT consumers' outcomes, and improve process and economic efficiency
- be appropriate to the risk, cost and complexity of the AT being provided
- be accountable, transparent and just, and
- be effective, viable and sustainable.

Principles: The three principles are:

- that the System will evolve over time to ensure that: it is affordable and sustainable; does not create bottlenecks in the availability of AT practitioners and suppliers; can develop incrementally based on ongoing evidence of effectiveness; incorporates awareness and flexibility regarding meeting the needs of rural and remote communities
- credentialing and accreditation requirements should be appropriate to risk, and should include a matrix structure incorporating (a) levels of competency and (b) areas of practice (e.g. communication solutions)

- transparency and evidence regarding key indicators of good practice in AT provision will be essential including: collaborative practice between consumers, AT practitioners and suppliers; and adherence to UN Convention on the Rights of Persons with Disabilities.

Implementation fundamentals: This covers five major areas: basis of authority and scope; governance; financial sustainability; operational requirements; and evaluation. While all of these are pivotal, only issues of authority, scope and governance are discussed here.

The basis of authority for the System could be statutory, contractual, and/or as a decision-making aid to assist consumers/families (and DisabilityCare planners). The use of the System as a decision-making aid is proposed, and there is potential for DisabilityCare and other funding schemes to incorporate credentialing and accreditation into their contractual arrangements with AT practitioners and suppliers.

Issues of scope are not dealt with in detail, as much of this will be determined by different AT funding agencies (such as DisabilityCare). However, the range of AT in relation to issues of complexity, risk and the concomitant competencies required is canvassed broadly in Table 2 of the paper. There was strong support in the consultation for a single system to cover both AT practitioners and suppliers.

Several options are proposed for governance and board composition. In the consultations half of the respondents supported utilisation of an existing body, particularly one already involved in credentialing/ accreditation (such as AHPRA) or in the sector (ARATA and ATSA) to provide governance and/or to auspice the System. This was seen as cost efficient, enabling utilisation of existing structures and expertise. The other half argued for a new independent board and organisation to minimise conflicts of interest and ensure a strong focus on AT credentialing/ accreditation. Few people supported the idea of a representative board, with the vast majority arguing for a skills-based board or a combination of the two.

Credentialing AT practitioners

Fundamentally, the purpose of credentialing AT practitioners is to provide a robust and clear evidence-based assessment of their competence. To develop appropriate structures and processes to achieve this, the paper considers a wide range of issues including those summarised below.

Requirements for AT practitioner competence must be closely linked to the risks and complexities of the AT involved. Four levels of AT risk were identified, ranging from simple everyday items that most consumers would be confident and able to select for themselves (Level 1), up to highly complex AT solutions that will typically be unique to the consumer and often require a team of practitioners and suppliers to develop in conjunction with the consumer and their family.

With the four levels of AT in mind, three options were developed. All three are the same for Level 1 and Level 2 AT. It is proposed that no credential be required for Level 1 AT. Across all options it is proposed that for Level 2 AT a relevant undergraduate degree and credentialing evidenced through registration (where that exists) and/or good standing with the relevant professional association is likely to be sufficient and appropriate.

The major differences between options, and the major challenges, are in Levels 3 and 4 AT:

- Option 1 proposes that there are additional AT competency requirements, and therefore additional (secondary) AT credentialing, only at the highest level of AT risk, Level 4.
- Option 2 is similar to Option 1, except that it identifies the need for additional competencies and (secondary) AT credentialing that covers both Levels 3 and 4 AT.
- Option 3 proposes that there are additional competencies required at Level 3, and still more at Level 4 AT, with each of these requiring credentialing (secondary and then tertiary).

In relation to eligibility for 'secondary' credentialing, several pathways are suggested including (a) professional qualifications; (b) Cert III plus experience; (c) minimum 3 years equivalent full-time experience. This proposal is based on awareness that there are some very experienced and extremely capable practitioners without professional qualifications. Some concerns were raised in the consultation about allowing people without professional qualifications to apply. It was also proposed that after three years of operation, requirements be increased.

Similarly, there were several pathways proposed for meeting credentialing requirements, including: attainment of AT credentialing through a recognised system (e.g. RESNA ATP, and potentially equivalents in relation to 'advanced AT practice' if these are implemented in the future by relevant professional bodies such as Australian Physiotherapy Association); or a postgraduate qualification in AT practice; or a portfolio of demonstrated AT practice competence; or completion of an approved written examination.

Additional potential requirements include: a structured interview with an expert AT consumer and advanced AT practitioner canvassing essential practice dimensions; and agreement to abide by other elements including professional/association codes of practice, and participation in ongoing professional development, including an insightful/reflective practitioner requirement.

In the consultations there was strong support for the interview process and the insightful practitioner concept, but major concerns were raised by many of the feasibility and cost of these.

Significantly, one of the biggest issues raised throughout the consultation process was the intersection of additional AT credentialing requirements and existing professional credentialing through relevant professions, including occupational therapy, physiotherapy, speech pathology, rehabilitation engineering, and orthotics and prosthetics. The options described above reflect this intersection, and the next stage of this process will need to involve extensive work and negotiation to resolve these issues. In these existing professional credentials requirements regarding AT competencies vary widely. There are several different ways to proceed in relation to the roles of professional bodies and AT credentialing, including:

a. set up a national accreditation agency (independent, or part of an existing organisation) to establish and run a credentialing system, or
b. establish a national working group to develop AT competency standards/requirements and work with the registered and self- regulated professions to establish and manage their own 'advanced AT' practice credentialing programs, or

c. A combination of (a) and (b) with a single national AT accreditation framework that incorporates recognition of the advanced AT credentialing done by the professions.

Finally, an option is proposed to undertake credentialing in two separate streams, separating AT practitioners into those who work within supplier settings and those who do not. The advantages and disadvantages of this option are described in the paper, and it is notable that this was the initial approach undertaken by RESNA, which subsequently combined them into a single stream.

Accrediting AT suppliers

The primary purpose of accrediting suppliers is to provide consumers with a clear indication of which suppliers have the skills and reliability to meet their particular AT needs, especially in relation to more complex AT. It will also assist funding agencies (e.g. DisabilityCare) in relation to identifying appropriate suppliers to be become 'registered providers'.

Eligibility to apply for accreditation includes meeting current Australian business/organisation requirements; and employment of some experienced staff. Concerns were raised in the consultation about how consumers purchasing AT from overseas (such as software) would be affected, and was balanced by recognition that within DisabilityCare consumers are not likely to be restricted in their choice of where they can purchase AT, but that consumers should be aware of the increased risks when purchasing off-shore. It was also noted that accreditation needs to be focused on assisting consumers, not protecting suppliers from competition.

Proposed credentialing requirements include: appropriate premises in Australia; adequate recordkeeping, including complaints systems; agreements and approvals in place (e.g. TGA and product standards); consumer protections (e.g. insurance and protection of deposits); a code of practice (e.g. ATSA code of practice); and capacity for provision of effective maintenance/spares/ repairs; and regular audits.

Supplier accreditation was strongly supported in the consultation, including support for the proposed eligibility and accreditation requirements, with three notable exceptions. One has already been mentioned: concerns about limitations on off-shore purchasing. There were also some important concerns raised about the requirements for suppliers of higher risk AT (Levels 2–4) to have access to AT practitioners that were credentialed for that level of AT risk. Perceptions are that some suppliers could readily meet this requirement, but it may prove difficult for others (e.g. in rural settings). This issue will need more work and investigation. Decisions made regarding credentialing, including the competency requirements for different risk levels of AT and whether a single- or two-stream approach is adopted, will have a significant impact on this issue. Finally, the intersection of accreditation and existing quality systems in use by suppliers such as ISO 9001 will need consideration to ensure costs and red-tape are minimised.

Timelines and costs

Responses in the consultation indicated that the proposed timelines covered the major tasks that would need to be undertaken in time for the initiation of the wide-scale roll-out of DisabilityCare in July 2016. There was also recognition that a great deal of work will need to be done, and it will be challenging to do it within these tight timeframes.

A three-stage process is proposed: Stage 1 Development and establishment July 2013 – June 2016; Stage 2 Early operations and evaluation July 2016 – June 2018; Stage 3 Ongoing operations. Essential tasks for Stage 1 are outlined in detail over the three years. Some of these tasks are:

- secure commitment by the DisabilityCare Launch Transition Authority to support and promote AT practitioner credentialing and supplier accreditation, and work to be undertaken to encourage other funding programs to do the same
- secure funding for Stage 1, and establish a workforce
- develop credentialing levels and requirements, in negotiation with relevant professional associations, consumers/families, suppliers and other stakeholders, and establish links with education/training sources
- develop website and other communication media
- produce economic modelling on the costs of the System and appropriate fees and charges.

Determining costs for Stage 1 will require more detailed consideration of the work entailed and relevant costs of this work. These costs are very dependent on decisions that need more investigation and negotiation. For instance if it is decided to proceed through an existing organisation already involved in credentialing, costs may be substantially lower to establish the scheme than if a new independent organisation is established. Costs for the first year to work through the immediate requirements are likely to be in the order of $150,000 to $200,000.

Finally, in the consultation a range of fee structures were proposed for credentialing and accreditation. In both instances, feedback emphasised the need to keep fees as low as possible while at the same time ensuring that the System is self-sustaining once it is operational. Additionally, several responses emphasised that setting appropriate fees was not possible prior to cost modelling for operating the System, and this in turn could not be done until decisions were made about the details of the System itself.