ALLIED HEALTH PROFESSIONS AUSTRALIA

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The Peak Body Representing Allied Health in Australia
Incorporating AHPARR (Rural & Remote), National Allied Health Classification Committee and National Alliance of Self Regulating Health Professions

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AHPA Response to discussion paper 'Towards Solutions for Assistive Technology'

Allied Health Professions Australia (AHPA) appreciates the opportunity to comment on the National Disability Insurance Agency (NDIA) discussion paper 'Towards Solutions for Assistive Technology'.

AHPA has developed this broad allied health response to the discussion paper (in comparison to the profession specific responses) drawing particularly on the advice of its AHPA NDIS Reference group. AHPA commends the profession specific responses provided by a number of AHPA's Member Organisations. This AHPA response needs to be read in conjunction with the profession specific responses – it is not a compilation or summary of those responses.

AHPA is the national peak body speaking for the allied health professions. Collectively, the 18 national organisations within AHPA represent over 77,000 allied health professionals. Each organisation has internal systems and networks for liaising with its members, ensuring that AHPA has input from health professionals right across Australia who together provide extensive expertise. AHPA member professions with a long term commitment to working with people with disabilities and their carers are primarily those for: Dietitians, Exercise Physiologists, Occupational Therapists, Orthotist/Prosthetists, Physiotherapists, Podiatrists, Psychologists, Social Workers and Speech Pathologists.

Within the current systems for Assistive Technology (AT) provision, allied health professions represented by AHPA provide support for individual participants who use AT to develop capacity within a dynamic and person centred assessment, trialing and prescription process. They also build capacity in family, carers and community through the provision of information and training.

Allied health practitioners (AHPs) are adept at managing the tensions between supporting choice and control for participants with providing what is 'reasonable and necessary'. Managing this tension will be a critical part of practice for AT mentors, newly skilled

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participants, and any other 'expert advisors'. AHPs have also played an important role in contributing to governance activities around AT provision, including providing sign off on prescriptions of items which carry greater financial or outcome related risk.

AHPA recognises that the philosophies of participant empowerment and choice are fundamental to the NDIS, and that service systems and the role of professionals will need to change in order to enact such philosophies when delivering supports such as AT. AHPA supports the key objectives outlined in the discussion paper, and believes allied health professionals have a critical role to play in achieving these. AHPA also welcomes a move away from the fragmented and bounded AT funding schemes currently in place.

AHPA notes however that the success of any new AT delivery system will depend upon:

- Robust systems to evaluate the efficacy of any new innovations (such as procurement panels)
- Retention, in some form, of essential AT best practice elements

Overarching Comments

The strategies proposed to achieve many of these objectives are aspirational; that is, they are untested and likely to have areas of risk which will not be apparent until implementation commences. While many areas would benefit from evidence or research work, AHPA strongly recommends that the NDIS facilitate a review of the available evidence regarding the role of AHPs in AT provision to contribute to the design of the scheme, and also that a participatory action research model is used as part of the implementation process. Use of an action research approach will enable review and analysis of the scheme and its outcomes as it is put into practice, helping ensure that the anticipated outcomes are achieved as well as providing the opportunity to identify unanticipated and unwanted outcomes and take appropriate corrective actions. Critical aspects of 'operationalisation' include:
* What does 'the right support at the right time' comprise?
* What is the role of allied health professionals in providing this, and how can access to this expertise be ensured and enhanced?
* Are there any unintended impacts on product development and innovation in the small and emerging AT equipment industries in Australia resulting from the procurement model?
* Which types or items of AT equipment don't 'fit' with the procurement model proposed?
The opportunity exists to use this approach to trial different versions of the scheme in different trial sites, with a different focus across the sites.

We note the Discussion Paper does not have a significant focus on the role of AHPs in AT provision. It is now opportune to seek information about and incorporate within the model the important role of the AT expert team e.g. matching a range of devices/device features to individual participants' needs and abilities, in order then for participants to choose from amongst appropriate options; providing professional advice to participants and their supports about the options and opportunities offered by AT, to help to raise expectations and aspirations; supporting participants to identify and prioritise device features that are important to support their participation; developing and providing access to information which participants identify they need in order to utilise their AT to support participation.

It is pleasing to see liaison with AHPA recommended as a next step, acknowledging the critical role of AHPs in contributing to participants' ability to exercise choice and control to successfully select the item of equipment that is 'fit for purpose'.

AHPA recommends that as part of this process, the NDIA provide support for AHPA to:
Undertake an evidence review of the available literature on best practice in AT service provision, to ensure development of the best NDIA AT provision system possible.

As a first step, develop clearer operational definitions (e.g. of 'choice', AT 'service', AT 'solutions', AT 'products') to help provide improved clarity and shared understandings.

Access AHP with expertise in AT provision across a range of different types of equipment i.e. Augmentative and Alternative Communication (AAC) AT, complex AT, to further describe the system required to support effective, efficient and successful provision of AT within the NDIS.

Guiding Question 1

Do you think the participant capacity building framework (Attachment 2) will help participants reach their own decisions and give them better control over choices about assistive technology solutions?

AHPA agrees with the principle of participant capacity building, and notes the proposed framework offers great potential.
However there is a need for considerable additional exploration of how the model will work, how it will interface with processes to build participants' capacity, and how it may be impacted in areas of prescription where there is significant risk of any kind. It will be critical to explore and identify processes that may contribute to the development of knowledge and skills in participants.
As has been identified above, 'expert' service hubs can offer an important contribution to the development and transfer of competencies in the provision of AT, including in participants and their supports and community.

How useful would it be to have access to peer support people, such as Assistive Technology Mentors?

Peer supports, such as the pilot AT Mentors, potentially enables participants and AT users to inform and drive continuous improvement in AT provision. Additionally, AT mentor roles may contribute to creating open expectations amongst participants and their supports for the role that AT can play in facilitating true participation, and provide participants with the knowledge and skills to feel confident to actively engage in the process and decision making around AT provision, and to believe that this is their right.

This aspect of the model will also benefit from use of a participatory action research approach, as the area is currently underexplored in the literature on consumer participation and so uninformed by any real experience. Key questions to be answered include:
* What kind of supports do participants seek from a mentor, and in which parts of the process of AT provision (i.e. identification of need for or benefits of AT, or assessment, or

prescription of the appropriate solution, or implementation etc)? Are there differences for different types of equipment, or in different contexts?
* What information, training and review processes may AT mentors require to augment the knowledge and skill acquired through their own experiences?
* What is needed, to enable them to provide information and support that is appropriate for a broad cross section of people with disabilities in a way that encourages and facilitates knowledge transfer?
* How is this best developed, organised and made available?
* What are the associated costs and how will these aspects of service delivery be funded?

AHPA notes the relationship between AT mentors / 'expert advisors' is underexplored, and offers the following comments in relation to this :
* The Discussion Paper focuses on information provision as the essential factor for participant empowerment and thus increased self-management of AT requirements. AHPA would suggest that the simple provision of information is inadequate to support the development of the competencies required.
* Allied health professional training is extensive and addresses, among other things, human development and pathology, AT devices, and the psychology of adaptation. Evidence suggests this knowledge is key to good outcomes in AT provision. In what ways might this competency set be shared with the proposed new workers?
* In what ways might peer mentors (and others) learn from, intersect with and refer to allied health practitioners?

How important do you think "expert advisers" will be in assisting with assistive technology solutions and decision-making? What are the main skills and attributes you think they should have?

There is significant variation in the need for and value of expert support within and across different types of AT equipment.
The prescription of some types of AT is recognised as being a complex area of AHP intervention, based on a broad range of professional knowledge, and requiring complex clinical reasoning.
For some AHP professions, AT provision is a core part of their profession's scope of practice, (e.g.prosthetists and orthotists). Other professions may graduate with the competencies to be able to provide some or most items of equipment within their professional scope of practice, but this may be a small part of their total role. The ability to provide some types of AT or where there are complex clinical issues, may require significant clinical focus and development of competencies on behalf of practitioners to enable them to provide high quality supports, including transfer of information, knowledge and skills to the 'primary supports' in a participants life There is some degree of recognition of the complexity of the process as well as the financial and outcome risks, with the current expectation for sign off by Allied Health providers on a range of different equipment items in a number of the schemes. The development of the NDIS, with its focus on participants and their ability to exercise choice and control, provides an exciting opportunity to develop a model that will facilitate provision of access to the right supports at the right time and provided in the right way.

This may include, for example: consideration for a new and different workforce profile to ensure that services are efficient , flexible, and responsive; data collection to inform service evaluation and outcome measurement; processes for review and continuous improvement; services provision which has as 'light' a touch as possible, as well as being client centred. AHPA suggests that AHPs who have knowledge and experience with AT assessment and prescription as well as person centred service provision, offer a crucial contribution to both the design and development of the model. This includes identifying the additional information, linkage and capacity building supports needed as part of ensuring successful AT provision.

Recommendation: That in the development of the new model for AT service provision, NDIS ensure that service pathways and funding is structured such that information, linkages and capacity building supports are put in place and available, as well as individualised supports that participants may require as part of the AT provision process.
It is also important to recognise that within the current processes of AT provision in Australia, suppliers are part of the expert supports available (for example, as employers of skilled and knowledgeable allied health and technical support staff, provision of information and training resources, demonstration, trial and loan devices).

Recommendation: That the NDIS facilitate a greater engagement with suppliers and others in order to explore and evaluate the costs and benefits of a procurement model , including identifying whether and which items or types of AT may be impacted differently by the application of such a mode. Consideration should also be given for potential impacts on supports currently provided by suppliers at no cost i.e. access to mentors, product or product line specific expertise and support, including information and training.
There are many examples where the involvement of expert allied health advisors is likely to be critical to facilitate timely provision of appropriate AT to meet current and anticipated needs. For example, for people who have had a traumatic brain injury which has impacted on their function across a number of participation domains, or who may be experiencing a rapid decline in ability due to an acquired neurological impairment such as Motor Neurone Disease, they and their supports may need to be involved in a managed introduction to identifying the need for and opportunities offered by AT, and what type of AT is required. Expert advisors can bring the evidence from outcome studies for other participants with similar issues and needs and marry this with the focus and preferences of an individual.

Recommendation:
That the NDIS facilitate the development of a model of AT service provision which includes all of the potential roles in AT provision for different types of equipment and different levels of clinical complexity, including AHP expert advisors/teams, primary or local AHP supports, AT mentors, Allied Health Assistants. Technical supports etc.
That the NDIS ensure that funding is available for all components of a quality AT provision scheme, including for the development and sustainable provision of information, linkages and capacity building supports, 'expert hubs' offering demonstration, assessment, trialing support, individualisation, ongoing support and review, as well as for the necessary supports within an individual participants plan.

Expert advisors will require a range of competencies, including but not limited to:

- Specific allied health profession based knowledge in the relevant areas i.e. communication, activity and occupation, mobility and seating, alternative
- Appropriate profession specific skills in assessment, intervention planning and provision, outcome measurement etc.
- Knowledge of current AT in their activity domain (as above)
- Application of evidence based practice and practice based evidence within AT provision
- Person-centred practices
- Strengths, participation and relationship focused practice
- Systems management skills
- Ability to apply adult learning theories
- Ability to work in a collaborative multi-professional team

A number of questions need to be explored and protocols developed which will provide guidance in decision making around AT provision within the new scheme, for example: balancing long term benefits/savings with increased initial costs; determining the point of diminishing return for maintenance and repair of items versus provision of a replacement item; identifying and prioritising device features according to their potential or measured impact on successful use of AT etc. The guidelines may vary across different types or items of AT.

Recommendation: Develop guidelines for use within the AT provision system, to help guide decisions around equipment prescription, with reference to the available evidence, including expert opinion.
It will be important to clarify the roles and responsibilities of AHPs vis-à-vis planners, and to ensure that the processes for the inclusion of AT provision as part of participants plans and approval for funding is timely and efficient, with sign off for what is 'reasonable and necessary' sitting with the allied health professional who have the expert knowledge and skills to make an informed determination on this. To facilitate this it is recommended that in situations where there is increased risk around AT provision, accountability for determining what is 'reasonable and necessary' sits with approved AHP prescribers.

Expert advisors also have a role in contributing to capacity building in the community, including providing consultancy support, advice, training and information to allied health professionals who will have a role in AT provision, whether that be informing participants about the types and variety of AT that may be useful for them, or the supports that are available, or providing local support for implementation of complex AT etc.

Recommendation: Look at existent evidence around best practice AT provision and the application and value of a 'hub and spoke' model of service, and ensure that funding for the provision of these services is available .

Provide suggestions for processes and/or activities to ensure that assistive technology solutions are identified correctly, with minimal error, and are effective in supporting participants to achieve their goals.

AHPA and its members appreciate the opportunity and have a significant contribution to make on this question, drawing on the literature available from other countries on AT service delivery and its components as well as on specific allied health professional frameworks.

Recommendation:

- Continued liaison occurs with members of the allied health professions.
- AHPs with direct and specific expertise and experience in AT provision across all of the major types of AT (i.e. communication, complex accessing and IT, mobility and seating etc) are included in a process to review and analyse the available literature and consider its application to the design and development of the model for provision of individualised as well as information, lifestyle and capacity building supports for the different types of AT (e.g. AAC AT, complex integrates systems with alternative access option, mealtime equipment for people with dysphagia etc.) .

What do you think of the acquisition and procurement approach (including having a third party entity manage the pricing sourcing and procurement arrangements and contracted supply agreements)?

While an acquisition and procurement approach may be appropriate in the provision of some items of equipment, and offer savings to the scheme, AHPA is concerned that the approach has significant shortcomings if applied across the board to all types and items of equipment.

These concerns hinge around the following:

- This model inherently removes choice for participants as it takes away the choice of AT supplier.
- Within the model, participants are coming to the scheme as 'applicants' for funding, rather than empowered consumers.
- There appears to be an unresolved contradiction between the impacts of bulk procurement on the supply chain (i.e. limiting viability of smaller suppliers) and the desire for an innovative and flourishing supply. If applied across the board, there is a risk that the pool of suppliers in Australia will shrink to that small group who were able to successfully engage in a tendering process, due to the unanticipated impact on supplier's ability to apply strategies to maintain viability.
- Lack of clarity about the identification of and approach to items which may not fit within the model e.g. complex AAC AT, alternative access controls, integrated systems etc.
- Confidence in the robustness of the data informing a cost/benefit analysis, including a nuanced review of the barriers that such a model can provide, such as waiting lists,

delays in provision due to the need for authorisation and sign off on simple and low risk items etc.

- Although a drive to separate assessment from procurement in order to create transparency in the system is understandable, in some instances this is not possible (i.e. provision of orthotics) and in others it is not going to contribute to achieving the stated objectives of the scheme, and can be more flexibly addressed based on an understanding and support for professional ethics in service provision.

Recommendation: provide a series of systematic consultations with AHPs around focal AT device areas in order to ensure access to local knowledge and expertise to inform development of a safe, high quality, accessible, responsive model for provision of the range of AT available, for the range of participants within the NDIS.

What do you think about the use of refurbished items (assuming that all appropriate health and safety procedures and necessary safeguards will be in place)?

AHPA believes that there may be a place for the use of refurbished items for some types of AT which doesn't require significant individual fitting or modifications and/or which is more costly e.g. AAC AT Deciding on which items which can be refurbished and reallocated will no doubt be dependent on the costs of associated activities such as infection control, liability, ongoing maintenance, record keeping and tracking items for return.
While there is an understandable urgency in establishing a consistent national approach to AT provision, it would be unfortunate if the 'hands on' procurement and refurbished provision model was implemented without an explicit process for review and modification.

In what ways could further innovation be introduced and explored so that NDIA participants can have access to the best and brightest technical solutions?

It is important that the scheme recognise that technology is a present and increasing part of all our lives, and is evolving very quickly. It is clear that technology offers opportunities for people with disability to live more connected, independent and autonomous lives with a reduced dependence on direct human supports.

Evidence indicates that in at least some areas of AT provision, individualised funding has the potential to shift the market in ways that will lead to an interest in discovering and meeting the demands for technology of people with disabilities.

Investing in development and provision of high quality individual and information, lifestyle and capacity building supports will impact on and shape the AT market in Australia. AHPs have a pivotal role in contributing to this. Funding development of a network of expert AT 'hubs' offering all or part of the range of services required in quality AT provision, including capacity building to participants and their supports in rural and remote, as well as metropolitan, areas will contribute to the achievement of the key outcomes identified in the discussion paper. Such services should build on and complement existent services which operate in this space (i.e. Independent Living Centres, Communication Access Network auspiced by SCOPE etc).

In addition, AHPA would comment that a feature of the existent programmes is that they have often failed to provide adequate access to and support for equipment that has been known to be available within the sector. An important part of helping ensure that participants have access to the brightest and best technical solutions will be the provision of adequate funding for the establishment and sustainable operation of a coordinated, collaborative and evidence based service provision model, with all the necessary components and features required for the various different types of AT provided.

Recommendation: That available evidence and existent models of best practice are used as the basis for development of the model for provision of complex AT through the NDIS i.e. expert 'hubs' and 'spokes'; advice, information, demonstration and assessment centres for complex AT provision such as AAC or alternative access IT etc

Other strategies that may help provide access to innovative AT options include:

- Review the existent evidence base around approaches to support innovation in and access to AT
- Promote and facilitate research to contribute to the evidence base
- Review the processes for data collection about provision of and outcomes of AT services (including participant perspectives and feedback) to position the NDIS equipment scheme to contribute to the evidence base and to support continuous improvement.
- Ensure that the scheme provides access and funding support to emerging 'mainstream' technologies where these are a critical component of an AT solution that addresses activity barriers arising out of a person's disability, and supports participation.

AHPA appreciates the opportunity provided by the discussion paper to access a broader spectrum of knowledgeable and experienced AHPs who have been involved in the provision of AT, and strongly recommends that continued opportunities are provided for them to comment and contribute, given the historical opportunity presented by the implementation of the NDIA, and the fact that it is a new and 'untested' system.