Processes for the assessment of assistive technology applications:

Sometimes assistive technology items are rejected, and an alternative suggested by the NDIA. Other times an assistive technology item is rejected as it is considered a similar/duplicate item to one in place. We feel consideration to the barrier being addressed by the assistive technology item will better inform fit-for-purpose decision making. There could be an argument for the environmental barrier or activity restriction being addressed to be identified at the start of an assistive technology funding request. Replacing the blanket ruling of similar items not being approved, with not funding items that resolve the same barrier or restriction, would reduce the number of appropriate assistive technology requests that are rejected and go on to create undignified, detrimental or dangerous outcomes for participants. A clear way to identify assistive technology requests that are urgent and a responsive pathway for these urgent requests would reduce life-threatening adverse events.

Examples:

Case 1:

Participant Goal: To develop social, communication and education skills to be more involved in activities in the community

AT Funding request for: iPad and ProLoQuo2Go

Background: 18 yr old male with multiple disabilities. AT request was made after the client had trialled the app and was selected specifically because the client was familiar with and used to using an iPad device already. Total cost of both device and app for recommended AT was less than $2000.

The NDIA:

1. Took 12 months to complete and review the application
2. Kept asking for more reports and evidence which took additional time and funds without provided additional funds in the plan to enable this
3. Rejected the AT application
4. Offered the alternative of an Android tablet (which doesn't support ProLoQuo2Go) and a different app the client had not trialled, with an estimated total cost of around $7000

The rationale for application rejection was that an iPad could be used for other apps but this was inconsistent with their recommended alternative which could also be used for other apps/programs. The parent and clinician both agreed that the NDIA suggested alternative was not a wise or effective use of funds, especially considering the NDIA suggested an option that had not been trialled and the client and their primary carer were not at all familiar with this type of device or the suggested software. They decided not to pursue this option because it didn't seem ethical or responsible use of tax payer's money.

Barrier being addressed: Socially acceptable, easy to use and familiar alternative and augmentative communication (AAC) to enhance community participation.

Outcome in the absence of appropriate AT:

Client unable to achieve communication and community participation goals as easily. No access to suitable AAC which is both reasonable and necessary for this participant. The application used up a full year's worth of Improved Daily Living funding due to the additional reports requested by NDIA. This prevented the participant from accessing any other therapy services to assist in achieving their goals. If clinician and parent had consented to the alternative recommended by NDIA then the cost could also have been 3.5 times what the requested AT was and not appropriate to his needs, thereby wasting NDIS funds.

Case 2:
Participant Goal: To increase my mobility at home and in the community
AT Funding request for: Manual wheelchair
Background: A 15-year-old male participant with cerebral palsy GMFCS4. Both a powered and manual wheelchair were requested. A manual wheelchair was not approved. A powered wheelchair was approved and enabled the participant to be independent with his mobility about school and in the community. His powered wheelchair does not allow him to:

1. Travel as a family unit due to the size and weight of the powered wheelchair and restrictions to the type and size of motorised vehicles and accommodation that they can rent/ access.
2. Access outdoor activities such as the beach, boats, bushwalks etc.
3. Access community/ private buildings such as hotels, restaurants, shops and friend's place due to the size and circulation requirements of a powered wheelchair.

Barrier being addressed: mobility in environments not conducive to a powered wheelchair

Outcome in the absence of appropriate AT:
Participant is unable to mobilise in a dignified manner if the powered wheelchair does not fit in private residential houses (e.g., friends/ family) and he is often required to crawl or be carried.

The family report they had both power and manual wheelchair provided under the previous state equipment scheme and that they used the manual wheelchair every weekend throughout the year (and with more frequency throughout the school holidays), to ensure the participant was included in family and community events and outings.

Case 3:
Participant Goal: To have the use of assistive technology to independently move himself between environments in his home.
AT Funding request for: A height-adjustable indoor seating system
Background: A 3 ½ year old male participant with a degenerative muscular condition. Indoor seating system rejected as a powered wheelchair approved. Considered to be similar/duplicate items. Home modifications also rejected as considered to be non-essential.

His home has stair entry and without home modifications his powered chair cannot enter the home (It is 100kg and cannot be carried up the stairs).

Barrier being addressed: To have access to supportive seating indoors to reduce the development of scoliosis and pain and reduce the risk of aspiration when eating and drinking.

Outcome in the absence of appropriate AT: Participant needs to be carried and held when indoors. Postural supports not available once inside the home.

Case 4:
Participant Goals: To have optimal health and well-being to live the life I want. To be more involved in activities in my community and at home.
AT Funding request for: Oxygen Concentrator

Background: 17 yr old male with multiple disabilities. Has been on oxygen for many years due to reduced functional skills as a direct result of his disabilities. Up until he turned 17 was eligible for MASS funding for oxygen cannisters which limit mobility and ability to access the community but was deemed no longer eligible. Without oxygen concentrator couldn't live at home and cannot access community and was hospitalized with no option for discharge until oxygen concentrator could be obtained. Not eligible under health funding for oxygen or oxygen concentrator. Mother contacted NDIA to request urgent review and submit AT application for oxygen concentrator. NDIA staff member reported that no option to review plan as no allowance for AT within current plan. Mother informed "you'll have to find an alternative way for him to breathe". No opportunity to escalate and review requested by mother was refused by NDIA staff member. Participant would have been left indefinitely as hospital inpatient and so mother borrowed money to purchase reasonable and necessary equipment.

Barrier being addressed: Independence, mobility and ability to live at home.

Outcome in the absence of appropriate AT:
Participant was forced to remain as a hospital inpatient. Mother borrowed money against her house to purchase oxygen concentrator to enable the participant to be able to return home.

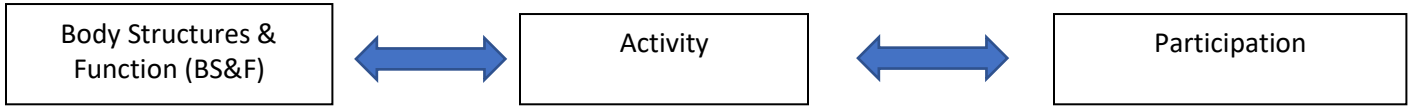
Case 5:
Participant Goals: To have optimal health and well-being to live the life I want.
AT Funding request for: Food pump, giving lines and specialised feeds.
Background: 18 yr old male with multiple disabilities. Has combination of oral and non-oral feeds delivered via a pump. Hospital unable to continue funding for feeds and equipment once turned 18 as transferred from paediatric to adult hospital. After 6 months of appeals and a formal complaint lodged by parent to Canberra NDIA agreed to fund pump and giving lines but not feeds. NDIA reported that the average 18 year old spends $50 per week on food. Parent is spending $200 per week on specialized feeds, supplementary nutrition and oral foods for the participant.

Barrier being addressed: Health and well-being. Ability to live at home.

Outcome in the absence of appropriate AT: No access to appropriate nutrition. Unable to live at home. Undue financial pressure on parent.

A suggested way to triage Assistive Technology (AT) requests:

1. Use the ICF (International Classification of Functioning Disability and Health) to identify the domain in which the need for the AT is occurring. Examples of domains below.



Swallow	sitting	going shopping
Breathing	standing	attending School
Digestion	showering	employment
Skeleton	indoor mobility	socialising
Mental health	eating	attending appointments
Developmental delay in children		

2. Use a scale to identify urgency. The implications prioritization matrix used by SWEP (VIC)[i] for example.
3. Combine the domain and numerical scale to allocate a classification in the subject line of the email containing the AT request. This would allow urgent requests to stand out in the inbox, particularly those in BS&F where serious adverse events can occur.

Examples:

BS&F 9: allocated to an AT application for a participant who urgently needs supportive seating to enable a safe swallow.

Activity 6: allocated to a participant who requires AT in the bathroom to enable them to shower.

Participation 9: allocated to a participant living independently who is unable to leave the house because their powered wheelchair needs repair.

[i] State Wide Equipment Program (SWEP), Priority of Access Guidelines 25th May 2015

The following are 6 recommended changes that will reduce the negative impacts of current AT processes:

1. NDIA staff to rely on, consult with and heed the recommendations of prescribing allied health professional/s.
2. Timely responses to AT applications
3. Separate, transparent and clearly defined escalation pathways for: needs identified during a plan review; needs identified during an active plan; and urgent or high-risk needs regardless of when they are identified.
4. Additional criteria to ensure approved items are fit for purpose, meet identified goal/s and remove an identified barrier. This would join existing checks for cost effectiveness, risk, and the 'reasonable & necessary' criteria
5. Clear processes for reissue, repair and maintenance of purchased AT with associated funding included in plans
6. NDIA to apply the social model of disability, including the ICF in AT decision making to overcomes barriers to participation in everyday life

We have mapped out what is currently happening and identified changes we think would reduce negative impacts and improve outcomes for participants, the NDIA, service providers and the community as a whole.

Recommendation	What's Currently Happening	Suggested Changes
1. NDIA staff to rely on, consult with and heed the recommendations of prescribing allied health professional/s (AHP).	NDIA staff reject or delay applications for: • Reasons that are unclear / not given (ie. not transparent) • Reasons which have already been directly addressed in the AT application from the prescribing AHP • Reasons which show lack of understanding of the purpose of AT for meeting that individual's needs • Reasons that indicate inconsistent interpretation and application of the legislative requirements and NDIA guidelines for different participants or different ways of managing funds Recommendations are being made for inappropriate "alternative" AT by NDIA staff who do not know the participant, have not trialled equipment with the participant and potentially do not have any relevant clinical experience. Best practice use of AT for AAC (Alternative and Augmentative Communication) that is iPad based is not able to be effectively prescribed and utilised for NDIS participants despite being reasonable and necessary, meeting the goals of participants, representing good value for money and not better met under any other funding or system. The use of iPads has been restricted by inappropriate and inconsistent interpretation of guidelines and this is resulting in participants being denied access to reasonable and necessary supports.	1. Ideally, NDIA staff making AT decisions to be qualified AHPs with a background in relevant AT prescription in the age group and clinical area of the participant they are working with. We understand that is not always possible. Therefore, where that is not possible: • NDIA staff consult directly with the prescribing AHP about any questions or concerns. • Consultation occurs BEFORE applications are delayed or rejected and NDIA staff initiate contact with the prescribing AHP if there are any concerns or issues with approving the AT as prescribed. • Communication occurs through a combination of phone, email and in person meetings. • This consultation work is funded non – contact work for the AHP at the request of the NDIA. 2. Cultural change regarding how NDIA staff communicate and interact with and about AHPs. More specifically: 1. Recognise and understand the prescribing AHPs have expertise in AT and the participant's individual needs. 2. Recognise AHPs are happy to coordinate with NDIA staff. 3. Communication may need to occur through multiple avenues not just written applications. For example, AHPs

	Different states have different requirements for AHPs to be recognised as prescribers for different types of AT. Refer to additional case studies for examples of current situation	may use different terms to NDIA terminology but can readily explain further or clarify AT applications if required but won't know NDIA terminology if no-one discusses or explains terms used by NDIA. 4. Understand AHPs are bound by ethics and professional codes of conduct to only prescribe items that meet need, that are most efficient and cost effective. 5. Recognise that prescribing AHPs do not have any conflict of interest with AT suppliers (ie. they do not make any profit from AT prescriptions or recommendations)
2. Timely responses to AT applications	Prescribing Allied Health Professionals often receive: • no response to AT applications • or responses 3-12 months after submission In Victoria, they are processed by SWEP but are then listed as 'pending' with the NDIA for months	1. Responses to applications within 2 weeks 2. Communication of application status and any delays to both prescriber and participant. See recommendation 1 for further details regarding communication by NDIA staff with AHPs
3. Separate, transparent and clearly defined escalation pathways for: needs identified during a plan review; needs identified during an active plan; and urgent or high-risk needs regardless of when they are identified.	One process for AT applications regardless of timing. There are no escalation pathways published on the NDIS website. Plan in development: • Have been able to provide reasoning for AT need and approximate budget in reports, to then have AT items approved 'upon quote' in the NDIS plan. • Now some coordinators in Victoria advise full trials, applications and quotes are required before the plan. This is not affordable for people waiting to enter the NDIS and is discriminatory. • Providers & participants are eager to avoid making changes to plans due to delays experienced (see next point) Within 3 months of new plan: • Complete AT trials, applications and quotes, and apply for 'review of a reviewable decision' which often takes months and sees applications rejected without consultation or a clear reason Within 3+ months of new plan:	1. Mechanism to flag urgent / high risk needs at all stages so these can be prioritised and clear timeframes for responding to urgent or high-risk needs. 2. Separate processes for: • Identifying need for a participant moving to the NDIS (clinical reasoning, budget estimate, but don't require full trials, assessments, applications and quotes) • Identifying need for AT at plan review (provide evidence of trial, applications and quotes at plan review meeting to be included in the next plan, so items can be purchased as soon as plan is active) • Identifying need during a plan (provide evidence of trial, applications and quotes, and receive timely response in less than 2 weeks with provision or urgent / high risk needs within 1 week, and non – urgent needs within 4 weeks) 3. Escalation pathways are transparent, clearly defined and published on the NDIS website, for example:

	• Complete AT trials, applications and quotes, apply for a plan review. In our experience these do not occur, and the need is reviewed at the end of the plan at the scheduled review time. When urgent/high-risk needs arise: • No standard process to accelerate or escalate urgent or high-risk needs • No mechanism or standard process to identify urgent or high-risk needs • Providers and participants repeatedly phone and email their coordinators and the 1800, attempt to file complaints to the NDIA directly (eg local office, feedback@, provider engagement), or to the Ombudsman, or to the local MP or MP responsible for NDIS, or to the media because there are no escalation pathways.	1. LAC / ECIC 2. Local NDIS office 3. A higher up NDIS contact 4. Ombudsman / MP Refer to triage document provided for examples for how risks could be identified.
4. Additional criteria to ensure approved items are fit for purpose, meet identified goal/s and remove an identified barrier. This would join existing checks for cost effectiveness, risk, and the 'reasonable & necessary' criteria	NDIA staff sometimes make changes to prescriptions made by Allied Health Professionals (AHPs). AHPs are legally responsible for their applications and recommendations under professional indemnity insurance, their professional code of conduct (AHPRA and associations such as SPA, OTA, APA). Where changes are made by NDIA staff, this is contrary to professional advice and poses significant risks. Risks include: • The AT item no longer meets the need / is not fit for purpose and does not achieve intended goal • Waste of NDIS funds, no improvement in independence • Adverse events through approval of an unsafe item for the individual's needs • Inappropriate AT being prescribed	1. No changes to AHP prescription without: • consultation with the AHP, who will check with the participant and suppliers. This is funded non–contact work for the AHP at the request of the NDIA and necessary funding should be allocated in participant plans to allow for this to occur.
5. Clear processes for reissue, repair and maintenance of purchased AT with associated funding included in plans	No clear process for reissue, repair and maintenance of AT purchased using NDIS funds. No funding routinely allocated for reissue, repair and maintenance of AT purchased using NDIS funds. This wastes NDIS resources and leads to adverse events, risk, loss of independence, reduced lifespan of equipment and frustration for participants and AHPs.	NDIA to use or replicate existing or past infrastructure and systems in State / Territory based equipment schemes to offer repair and maintenance routinely in plans with AT items, and for reissue of equipment. This prevents or reduces: • NDIS purchased equipment being sold privately once it is no longer needed by the participant

	Prior to NDIS State / Territory based equipment schemes have offered repair and maintenance and reissue of equipment eg SWEP in Victoria. This allowed for: • reuse of Government funded equipment • often shorter waiting times for items if a reissue item is suitable • timely repair and maintenance to enable: risk management; avoidance of adverse events; independence for participant; longevity of item; enhanced safety and effectiveness of prescribed equipment.	• financial loss to the NDIS (having to replace expensive equipment that is not fit for purpose due to insufficient maintenance) • high risk items being openly available without appropriate protections • long delays in provision • participants having no repair and maintenance funding and having to self-fund to maintain reasonable and necessary supports that should be provided by NDIS Reissue of AT that requires replacing to be routinely considered as part of plan review.
6. NDIA to apply the social model of disability, including the ICF in AT decision making to overcomes barriers to participation in everyday life	AT prescription sometimes meets activity-based goals which are not necessarily embedded within the participants everyday environments, and so do not necessarily improve the participants' participation. This occurs in instances where the participant does not have enough funding for AT trial and prescription in the environment/s in which they are using the AT. AT prescription sometimes does not meet ANY form of goal achievement. This occurs when the participants' AT approval by the NDIA is delayed and the participant has grown or put on weight or changed body shape or ability since the AT prescription. The participants AT approval is changed by an NDIA staff member without consulting with the prescribing AT therapist	AT prescription which meets participation-based goals for participants. This would require: • funding for AT trial and prescription in the environment/s in which the participants are using the AT • timely approvals of AT by the NDIA Consultation between NDIA staff person and prescribing AHP before NDIA staff make any changes to the AT prescription (see recommendation 2 regarding timely responses to applications). Consideration of the barriers overcome by prescribed AT in AT decision making not just the function of the equipment (refer to additional documentation regarding ensuring AT is fit for purpose for examples and further detail).