

NDIS Support Coordination and Connection Reform

**Making food, nutrition, hydration, eating and drinking
explicit quality and safeguarding requirements**

Response
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Recipient

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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 9,000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

The Accredited Practising Dietitian (APD) program is the credentialling program of Dietitians Australia. It provides an assurance of safe and quality dietetic practice and is the foundation of self-regulation of the dietetic profession in Australia. APDs assess and manage disability-related nutrition and hydration needs, malnutrition risk, tube feeding, allergies and intolerances, therapeutic diets, sensory and functional barriers to eating, and mealtime support in collaboration with participants, their families, support workers, other health professionals and support coordinators.

This submission was prepared by members of the Dietitians Australia Policy and Advocacy team. Members of Dietitians Australia and the Disability Expert Reference Group contributed to this submission, following the Conflict-of-Interest processes approved by the Board of Dietitians Australia. Contributors include APDs who are NDIS registered providers.

This submission answers the paper's 12 questions about service provider models and approaches, from the professional experience of APDs working in food, nutrition and mealtime support. Question numbers refer to that set. The seven participant questions are not answered separately. Participant question 5, on the experience, skills and knowledge of an SCC worker, is covered under question 7.

Executive summary

When nutrition and mealtime risk is missed, participants can choke, become malnourished, be admitted to hospital or die. In January 2025, a registered NDIS provider was ordered to pay a civil penalty of \$1,916,250.00 at that time the highest imposed on an NDIS provider, after failures that led to the death of a participant known to be at risk of choking. The failures included not following the requirements of participants' dietitians' plans (NDIS Quality and Safeguards Commission [NDIS Commission], n.d.-b). Mealtime management has its own NDIS Practice Standard (NDIS Commission, n.d.-a), and the NDIS Commission ran a national compliance campaign on it in 2025 (NDIS Commission, 2026). The regulator already treats mealtime risk as a distinct safeguarding risk. The SCC service should do the same.

NDIA data for the six months to December 2025 show that 23,429 participants received dietetic supports, about one in twenty of those receiving therapy supports (National Disability Insurance Agency [NDIA], 2026, p. 63).

Dietitians Australia recommends that the new Support Coordination and Connection (SCC) service explicitly recognise nutrition, hydration, eating, drinking and tube-feeding needs in service specifications, workforce competencies, referral pathways and performance measures. Participants need coordination that results in access to appropriate dietetic supports and helps the people supporting them implement that care safely.

Accredited Practising Dietitians (APDs) assess nutrition needs, provide individualised dietetic supports and support their implementation. SCC providers must understand when this expertise is required, connect participants with an appropriately skilled APD, and be able to solve problems such as when funding, service availability or communication problems prevent service delivery. The new arrangements should preserve participant choice of independent APDs and create opportunities for APDs to contribute specialist advice, education and service improvement.

We support a capable, accountable SCC workforce and sustainable commissioning. Of the two commissioning approaches under consideration, Dietitians Australia prefers the multi-provider model because it offers greater scope for specialist and small providers to participate, supports participant choice and helps preserve established practitioner relationships. Relying on a single regional lead organisation risks concentrating referral and contracting decisions within one organisation, potentially restricting access to APDs outside its preferred network.

Key recommendation

Dietitians Australia recommends that the future SCC model establish an accountable pathway for identifying disability-related nutrition, hydration and feeding risks as a named safeguarding risk. SCC workers should be required to recognise that risk, connecting participants with Accredited Practising Dietitians (APDs), coordinating team-based care, supporting implementation of their recommendations and following up unresolved barriers to care. This pathway should be embedded in SCC service specifications, workforce competencies, funding arrangements and performance measures, while protecting participant choice and access to dietetic care.

Supporting recommendations

1. **Identify and respond to nutrition risks (Questions 7 and 11):** Require SCC services to identify food, nutrition, hydration and mealtime concerns, facilitate timely referral to an appropriately skilled APD, confirm that care has commenced and escalate unresolved barriers to accessing or implementing nutrition support.
2. **Enable participation by specialist and small providers (Questions 1 and 2):** Provide viable commissioning and contracting pathways for specialist providers, including independent APDs, sole traders and small practices. Protect participants' access to clinical APDs outside the SCC organisation's preferred provider network.
3. **Make SCC and SCC+ access transparent and responsive (Question 5):** Publish clear eligibility, reassessment and escalation arrangements that recognise complex nutrition and mealtime coordination needs. Fund timely increases in coordination during hospital discharge, provider transitions, interrupted nutrition supplies or rapid deterioration, without requiring participants to wait for a formal move between SCC and SCC+ or making access depend on a provider's remaining contract budget.
4. **Fund the full cost of coordinating nutrition care (Question 6):** Fund specialist consultation, preparation, provider liaison, case conferences, travel, supported communication, documentation and follow-up. Protect separate funding for participant-specific dietetic assessment, intervention, support-worker training and review.
5. **Build workforce understanding of APD expertise (Question 7):** Require SCC staff to understand the APD's role and the distinct contributions of allied health professions within multidisciplinary nutrition and feeding care. Establish role-specific competencies, recognise allied health professional safeguards and assess existing coordinators' nutrition-related knowledge and training needs before transitioning to the new system.
6. **Commission APD-led nutrition education (Question 8):** Commission an APD-led nutrition referral and education component for SCC staff and relevant stakeholders, co-designed with people with disability. Build on the Department's previous investment in Dietitians Australia's disability resources, education and supervision programs. (<https://dietitiansaustralia.org.au/advocacy-and-policy/capacity-building-disability-dietitians>)
7. **Provide practical access to nutrition expertise (Question 9):** Support a maintained referral directory identifying APDs' relevant disability experience, service availability and delivery options, alongside a staffed advice hotline to help SCC staff identify appropriate expertise and escalate nutrition-related concerns.
8. **Protect participant choice and continuity of dietetic care (Questions 3 and 12):** Preserve relationships with participants' chosen APDs and other practitioners during transition to SCC and subsequent service

changes. Require independent referral processes and transparent conflict-of-interest arrangements so organisational changes do not unnecessarily disrupt established nutrition care.

9. **Require safe handover of nutrition support (Question 12):** Make documented, consent-based transfer of nutrition plans, supply arrangements, outstanding actions and review requirements a condition of implementation. Give particular attention to participants requiring tube feeding or complex mealtime support, those in rural areas and those with unstable support networks.
10. **Ensure equitable access across health and disability services (Questions 10 and 11):** Address rural and remote gaps in APD availability, cultural and communication needs and supported decision-making about nutrition care. Require SCC staff to clarify responsibilities across services, follow up referrals and escalate unresolved funding or access barriers until an appropriate nutrition support pathway is in place.
11. **Clarify the health and disability interface (Question 5):** Set clear protocols so SCC workers know when APD assessment addresses disability-related needs, apply the NDIA's nutrition supports guideline, and escalate unresolved questions of responsibility. A referral should not be refused because responsibility is unclear (see Box 1).

About this submission

What coordinators need to understand about APDs (Appendix A and Appendix B).

Dietitians Australia's published Disability Role Statement describes nutrition assessment, diagnosis, intervention, monitoring and evaluation; disability-specific knowledge; and collaboration within interdisciplinary teams. Capability varies with experience and further training. SCC coordinators should understand that experienced disability APDs can mentor and supervise early graduates to safeguard participants and the quality of care (Dietitians Australia, 2021).

Specialist disability-related nutrition care

Accredited Practising Dietitians (APDs) provide specialist assessment and intervention where a person's disability affects their ability to eat, drink, meet nutritional requirements or safely and effectively implement nutrition recommendations. Dietetic care in disability can be clinically complex because nutrition needs may be affected by the nature of the disability itself, multiple health conditions, medications, dysphagia, gastrointestinal issues, food aversions, cognitive or communication impairment, behaviours of concern, fluctuating health, dependence on others for food and mealtime support, and the person's living and support environment.

Comprehensive assessment and individualised intervention

APDs undertake comprehensive nutrition assessment and develop individualised interventions that take account of the person's disability, functional capacity, communication needs, preferences, goals and available supports. This may include management of malnutrition or unintended weight change; food fortification; allergies and intolerances; food aversions and restricted dietary intake; mealtime management; nutrition-related consequences of medications and health conditions; and enteral nutrition. APDs also assess whether recommendations can realistically be implemented by the person, family, carers or support workers and modify the intervention accordingly.

Enteral nutrition and tube-feeding management

For people requiring enteral nutrition or tube feeding, dietitians have an important clinical role across the continuum of care. This includes assessing whether enteral nutrition is appropriate, determining nutritional requirements and the appropriate feed or formula, developing and adjusting feeding regimens, monitoring nutritional adequacy and tolerance, managing nutrition-related complications and supporting people who

receive enteral nutrition at home or in supported accommodation. Enteral nutrition may provide all or part of a person's nutritional requirements and requires ongoing professional monitoring because complications can include aspiration, gastrointestinal symptoms and problems associated with the feeding tube.

Multidisciplinary and implementation support

Disability dietetics is collaborative. APDs work with the person, family and carers, disability support workers, supported accommodation providers and interdisciplinary health teams. They may provide disability-specific recommendations, develop mealtime or nutrition plans, advise residential and respite services, train or support those responsible for implementing nutrition recommendations, coordinate referrals and contribute to multidisciplinary management. More experienced disability APDs also manage people with multiple or complex comorbidities and provide specialist input into disability-related nutrition protocols, service development and policy.

Clinical complexity beyond general nutrition advice

The dietitian's role is not interchangeable with general nutrition information or routine food support. It involves clinical assessment, diagnosis of nutrition-related problems, evidence-informed intervention, monitoring and review, and adaptation of care to the interaction between disability, health conditions, function and the person's support environment. For people with complex disability, effective dietetic intervention may therefore require substantial assessment, liaison, implementation support, monitoring and coordination in addition to direct consultation time.

Question 1 Commissioning arrangements

What commissioning arrangements would best balance participant outcomes, quality, sustainability and choice and control?

Of the two commissioning approaches under consideration, Dietitians Australia prefers the multi-provider model. We recommend commissioning against demonstrable access and outcomes, with viable routes for multiple providers and specialist partnerships. The tender should name nutrition and dietetic expertise among the capabilities that every SCC service **must** be able to access. Providers should explain who will respond to an identified nutrition concern, how quickly, how the participant will choose their APD and what happens if no suitable service is available.

Commissioning could risk excluding specialist providers. Member feedback is that participants should retain access **to independent APDs and existing relationships**. A trusting relationship can take years to build. DA asks that these existing trusted relationships are not broken due to a new system of support coordination. We recommend permitting appropriately governed consortia and specialist contracts, with proportionate tender requirements, transparent fees and timely payment. Contracts should prohibit exclusive referral arrangements to 'lead organisations' that unnecessarily restrict participant choice.

Procurement should distinguish three funded functions: SCC coordination; specialist advice and workforce education commissioned by the SCC organisation; and the participant's individual clinical dietetic care. Record the purpose, consent and payment source for each function so clinical work is not absorbed into an underfunded coordination contract or charged twice.

SCC contracting requirements should also explicitly list APDs as being eligible to become an SCC Coordinator, subject to the separation rule discussed under question 3.

The NDIS Commission's 2024 inquiry action plan supports stronger standards, market stewardship and independence for intermediary supports (NDIS Quality and Safeguards Commission [NDIS Commission], 2024). We propose testing commissioning options in different markets before scale-up, comparing participant choice, unmet need, access to specialist care and the viability of smaller providers.

Question 2 Lead organisation capability

What provider types would be best placed to be a lead organisation? Why do these characteristics matter?

You should not have to be a large provider to be a lead organisation

No single organisational type should be presumed best placed. Selection should assess disability-led governance, accessible communication, cultural safety, local relationships, financial capability, independent referral processes and the capacity to respond to complex needs. A specialist organisation or consortium should be able to demonstrate these capabilities without first becoming a large generalist provider.

Coordinator capability should match the role, with clinical expertise available for SCC+

Complex disability needs allied health expertise and coordination across systems. Member feedback suggests that coordinators with allied health qualifications are particularly effective at assembling appropriate teams:

“They maintain contact with a range of Allied Health professionals and are able to put together a team, such as a feeding team, to address the complex experience of disability.”

Use practical scenarios to assess lead organisations

We recommend assessing lead organisations using practical scenarios, including:

1. a participant with tube feeding leaving hospital and
2. a participant whose nutrition plan is not being implemented at home.

Tenderers should demonstrate referral, consent, case conferencing, funding escalation and accountability across organisations.

Lead organisations should have access to APDs

Require access to an experienced APD for nutrition-related service design and staff advice, through employment or a funded external arrangement.

Question 3 Lead organisation advantages and risks

What are the advantages and disadvantages of the lead organisation model?

Dietitians Australia prefers the multi-provider model. If the Government proceeds with a lead organisation, the conditions set out below should apply.

Strengthening coordination of nutrition and dietetic care

A lead organisation could provide clear responsibility for coordinating APD referrals, supporting implementation of nutrition and mealtime plans, and developing staff capability to recognise nutrition risks. Common systems could improve communication between APDs, support workers and other providers, including during hospital discharge of people with disability. These benefits should be demonstrated rather than assumed from organisational size. Risks include delayed APD referrals, restricted access to specialist dietetic expertise and disruption of established trusted relationships with participants.

Protecting participant choice and access to specialist APDs

Dietitians Australia remains concerned about specialist exclusion. Any lead model should require an accessible pathway to specialist APDs, published referral criteria, conflict-of-interest controls and a process for obtaining an alternative coordinator. Participants should retain access to their chosen clinical APD even when that APD has no commercial relationship with the lead organisation. Regional contracts should

include contingency arrangements to maintain coordination of nutrition care, particularly for participants requiring tube feeding or complex mealtime supports, if the lead provider exits or cannot meet demand.

Dietitians Australia supports the paper's proposal that SCC services and workers cannot provide other NDIS supports.

Maintaining accountability for nutrition plan implementation

The lead organisation should remain accountable for coordinating action and escalating unresolved barriers when an APD's nutrition plan is not being implemented, including where coordination functions are subcontracted. Contracts should specify responsibilities for arranging case conferences, clarifying implementation tasks and escalating gaps in funding, supplies or staff capability. This would help prevent participants being passed between organisations while essential nutrition supports remain unresolved.

Preserving APD clinical judgement

Commissioning and purchasing arrangements should respect the treating APD's clinical recommendations. Where clarification is needed, the coordinator should seek advice from the treating APD, with review by a suitably qualified practitioner where required. Recommendations about nutrition support, including enteral feeding regimens and oral nutrition support products, should not be changed solely to suit a provider's purchasing preferences or commercial arrangements.

Question 4 Regional service areas

What would be appropriate regional areas to use for SCC service areas?

Primary Health Network and Local Hospital Network boundaries should allow flexibility in access to APDs and multidisciplinary feeding teams, particularly for participants in border communities. SCC service areas should support existing practitioner relationships and access to appropriate expertise across regional boundaries. Commissioning and referral arrangements should provide fair opportunities for independent APDs, sole traders and small practices, including those without established links to regional networks. Arrangements should be flexible and allow participant choice, irrespective of the SCC location or SCC Provider geographical responsibility.

Commissioning should permit cross-boundary specialist arrangements and continued care where a participant moves a short distance or receives hospital care outside their SCC region. In large rural regions, require local access points and an outreach plan supported by funded specialist telehealth. Publish an assessment of likely travel, waiting times and specialist access before finalising each region.

Question 5 Variable need and SCC plus access

How might SCC providers manage variable need among the participants it supports? Which workforce, caseload, and service capacity factors should be considered?

It is unclear how and when access to SCC+ will be determined, including how complex nutrition and mealtime needs will be recognised. The paper lists seven eligibility factors. Complex nutrition and mealtime needs fall under at least three of them: safety risk, engagement with multiple support systems, and the stability and predictability of support needs. The eligibility criteria should say so.

Caseloads should reflect the coordination required to access APD care and implement nutrition plans, including multidisciplinary involvement, communication adjustments, carer capacity, travel and safeguarding concerns. Diagnosis alone should not determine intensity. Tube feeding may be stable with skilled support but require intensive coordination during hospital discharge, supply disruptions or changes in support providers.

Providers should maintain funded capacity for temporary increases in coordination, including APD contact, case conferencing and resolving implementation barriers. Participants should not have to deteriorate while awaiting a move between SCC and SCC+.

An Australian scoping review identified 15 publications evaluating healthcare models for people with intellectual disability (Downs et al., 2026). It found promising results for cross-sector coordination (Downs et al., 2026). The authors found evidence of effectiveness and cost-effectiveness in models using cross-sectoral care coordination, supporting more structured and standardised approaches to delivery and evaluation. We recommend that SCC commissioning support structured relationships with health services while evaluating whether these arrangements reduce unmet need and participant burden.

Dietitians Australia recommends clear protocols at the health–disability interface so coordinators understand when APD assessment addresses disability-related functional needs, how responsibilities are shared and where to escalate uncertainty. Access to assessment should not be blocked because a coordinator assumes all nutrition needs are solely a health-system responsibility. The NDIA’s operational guideline states that nutrition supports are disability-related health supports, and that these may include a dietitian, enteral feeding equipment and prescribed nutritional supplements related to the participant’s disability (National Disability Insurance Agency [NDIA], 2026). SCC workers should know and apply that guideline. Where responsibility is unclear, coordinators should seek APD advice and facilitate resolution with the relevant agencies, rather than refuse referral or leave participants to navigate the gap. These arrangements should be evaluated for timely assessment, continuity of nutrition care and reduced participant burden. Coordinators need case examples and education on disability-related nutrition supports that can appear to be health-system responsibilities.

Box 1 Supporting recommendation 11.

Question 6 Payment and funding

Which payment and funding approaches would best support participant outcomes, workforce sustainability and innovation?

One of our funding concerns is particularly relevant to SCC+. Any adjustment for coordination intensity must avoid arbitrary categories that reward easy-to-serve caseloads.

DA recommends a transparent cost model that recognises the work required to coordinate complex nutrition, hydration and mealtime supports. If block funding is used, it should cover core service availability, with additional payments for evidenced increases in coordination demand. Adjustments should reflect actual complexity, including hospital discharge, tube feeding, multiple providers or disrupted nutrition supplies, and avoid incentives to select participants with less intensive needs.

An organisation’s or participants’ exhausted budget should trigger NDIA action, rather than an unrecorded reduction or cessation of participant support.

SCC contracts should fund preparation, case conferences, supported communication, APD liaison, records, travel and follow-up. APDs engaged to advise or train SCC staff should be paid for preparation, delivery and review, including reasonable overheads. Referral arrangements should not depend on discounted or unpaid dietetic work.

Funding should distinguish SCC coordination from APD assessment, intervention, participant-specific training and review, and from prescribed oral nutrition support products, enteral formula, equipment and consumables. Coordinators should have clear pathways to resolve funding responsibilities where nutrition or hydration supports span health and disability services. Neither coordination nor clinical care can be effective if the supports needed to implement an APD’s plan are unavailable.

Monitor delayed APD referrals, interrupted nutrition supplies and unimplemented plans, alongside waiting times and reduced contact.

Payment assumptions should be tested through time-and-cost studies involving APDs and participants, with indexation and scheduled review. Outcome measures should recognise timely APD access, continuity of nutrition and hydration supports, and prevention of avoidable deterioration. For participants with progressive disability, maintaining comfort, function and stability should be valued.

Question 7 Quality workforce and safeguards

What quality, workforce and safeguarding requirements should apply to commissioned SCC organisations?

SCC workers should be able to recognise when food intake, hydration, feeding arrangements or access to supplies may be inadequate, and seek appropriate assessment. They should know how APDs, speech pathologists, occupational therapists, nurses and medical practitioners contribute to care.

Dietitians Australia's 2025 Supports Rules submission records member reports of dietetic funding being denied and APD work being incorrectly considered interchangeable with other disciplines, including for sensory-based eating difficulties (Dietitians Australia, 2025). We recommend training that explains each profession's contribution to feeding care and includes practical referral scenarios. **Shared goals do not make distinct clinical assessments duplicative.**

Member feedback includes instances of participants with tube feeding being referred to inappropriate professionals who advised restrictive dietary advice. This feedback illustrates a question the service specification must answer: how will SCC workers verify that the practitioner they recommend has the relevant qualifications and competence? We recommend requiring APD referral for clinical dietetic needs and documenting the rationale for specialist referrals, with escalation when advice may create risk.

Members proposed allied health qualifications for all coordinators and planners. Dietitians Australia supports the underlying concern about capability and recommends requirements matched to the actual role. SCC+ work involving substantial clinical complexity should require relevant professional expertise or direct access to supervised specialist input. Qualifications should sit alongside demonstrated disability practice, lived-experience knowledge and cultural capability. Decisions about planner recruitment are outside this commissioning process, but role boundaries and communication with planners must also be explicit.

The existing mealtime management indicators address qualified assessment, participant involvement, accessible plans, staff training and review when needs change (NDIS Commission, n.d.-a). SCC specifications should support access to these safeguards without transferring the direct provider's responsibilities to the coordinator.

Question 8 Attracting and retaining capability

How can the future SCC model attract, build and retain workforce capability, including retaining participant relationships?

The future SCC model must retain existing workforce expertise and the participant relationships that are often built over years, while ensuring participants can access the allied health services to which they are referred. Many APDs are already reporting pressures that may force them to reduce services, close their books, withdraw from NDIS work, or cease operating altogether. This would further reduce access for participants who already face long wait times and limited service options. Dietitians Australia is concerned about the sustainability of the dietetic workforce in the disability sector. This risks a significant reduction in NDIS service delivery capacity, leaving participants with fewer safe and qualified providers and disrupting established therapeutic relationships.

Over the last two years, Dietitians Australia has conducted surveys amongst Accredited Practising Dietitians (APDs), predominantly sole practitioners and small business owners, to understand workforce sentiment. The findings, together with subsequent member reports, show increasing pressures:

- **June 2024 – Price freeze.** 25% of APDs in the disability sector considering stopping some or all services to NDIS participants due to the ongoing pricing restrictions since 2019 (note pricing was frozen for 5 years prior and not indexed despite rising costs).
- **June 2025 - Price reduction effective 1 July 2025.** 64% of APDs working in disability sector indicated that they were considering ceasing or reducing NDIS services. Dietitians reported business losses.
- **June 2026 - Price reduction effective 1 July 2026.** Some APDs have now informed Dietitians Australia that their businesses are no longer viable and they will cease to accept new NDIS clients. Furthermore, they indicated their intention is to leave the sector completely given that business losses are projected to increase due to ongoing rise in business operating costs.
- **A loss of skilled dietetic workforce within the sector will place participants at risk and diminish the efficiency and goals of the scheme.**

Box 2 Workforce

These pressures are directly relevant to the future SCC model. Effective coordination depends on an available, skilled and sustainable provider workforce. Support coordinators cannot secure timely dietetic support if providers have closed their books or left the sector. Provider departures also mean losing established participant relationships, disability-specific expertise and local referral networks, creating additional work for coordinators and requiring participants to rebuild trust with new providers.

The future SCC model should therefore prioritise retention alongside recruitment.

This requires sustainable funding for coordination, paid training and supervision, manageable caseloads, and funded time for relationship-building, provider liaison and supported handovers. Transition arrangements should preserve existing coordinator and provider relationships wherever participants wish to retain them, with clear pathways for experienced workers and small providers to participate in the new model. Retaining existing expertise and relationships can reduce repeated assessments, avoidable handovers and disruption to participant support.

We recommend stable long-term contracts, manageable caseloads, paid supervision and career pathways that retain experienced practitioners. For APDs, procurement should create funded opportunities to provide specialist SCC advice, deliver nutrition referral training, participate in complex-needs case conferences and review the quality of nutrition pathways. APDs wishing to work as SCC practitioners should have a supported pathway to acquire the additional coordination competencies and meet independence requirements.

Build capacity in undergraduate degrees: Offer paid undergraduate supervised dietetic placements with SCC providers

Collaborate with Universities to embed disability dietetic supports into each University nutrition and dietetic degree. Collaborate with rural clinical schools and universities to build disability capabilities.

We recommend that commissioners map available APD capacity by region, disability capability, employment model, waiting time and willingness to accept new referrals. Collect full-time-equivalent capacity and specialist skills as well as headcount. There is an urgent need to collect national workforce data for APDs.

Build on an existing professional education program

The government-funded Capacity Building in Disability for Dietitians program provides introductory and intermediate courses, practical workshops, webinars and supervision. Its public resources address tube feeding, psychosocial disability, communication, supported decision-making and cultural inclusion. The 2026 supervision program involved eight experienced supervisors over six months (Dietitians Australia, n.d.-a). We recommend funding adaptation of relevant material for SCC workers, co-designed with people with disability and evaluated for quality and implementation. A qualitative evaluation was conducted interviewing 15 participating dietitians and explored reported changes in practice (Thompson & Morris, 2023). The program provides an existing delivery platform that can be adapted and tested. The program's courses and resources are an existing base that can be adapted and tested.

Question 9 Local knowledge and community connection

How should local knowledge and community connection be defined and assessed?

The consultation paper names Aboriginal Community Controlled Organisations, Aboriginal Community Controlled Health Organisations and Remote Community Connectors as sources of community expertise. SCC organisations should work with them to connect First Nations participants to culturally safe nutrition care. Dietitians Australia's First Nations resources, developed with First Peoples Disability Network, are publicly available to support this (<https://dietitiansaustralia.org.au/advocacy-and-policy/capacity-building-disability-dietitians>) (Dietitians Australia, n.d.-b).

A practical way to help coordinators find **an APD whose skills match the participant's needs** would include:

- **Public nutrition information resources:** accessible information to help participants, families and coordinators recognise nutrition concerns and understand when to seek APD advice.
- **An up-to-date local referral directory:** it should identify each APD's relevant experience (including paediatric feeding or enteral nutrition), location, cultural knowledge and face-to-face or telehealth options, with practitioner verification and regular updates.
- **Understanding relevant expertise is critical:** appearing in a directory does not mean an APD has experience with every disability-related need. For example, a participant requiring tube feeding may need an APD with specific enteral nutrition experience.
- **An advice hotline:** so coordinators can contact a trained expert when they are unsure whether or which APD or service is appropriate.

Māori participants and participants from Pacific Island communities living in Queensland may value access to APDs who understand their specific cultural food practices and family contexts. SCC organisations should build relationships and referral pathways with APDs who can provide culturally appropriate nutrition care, guided by each participant's preferences rather than assumptions based on cultural background.

Box 3. Example

Dietitians Australia has a public Disability Legacy and Amplification Pack which can be used to build a quality workforce, train support coordinators in understanding nutrition-related disability and uphold safeguarding requirements. For example, this includes (Dietitians Australia, n.d.-b):

1. a community disability dietitian toolbox
2. a resource connecting the Nutrition Care Process with the International Classification of Functioning

3. a paediatric referral guide (https://dietitiansaustralia.org.au/sites/default/files/2026-03/Paediatric%20care_14.pdf) and
4. First Nations resources developed with First Peoples Disability Network.

Question 10 Rural remote and other thin markets

How can the SCC service best support participants in regional, rural and remote areas, or other thin markets, where support options may be limited?

We recommend funded combinations of local care, outreach and specialist telehealth, chosen by the participant and relevant clinicians. Member feedback emphasises the importance of internet access, equipment and travel support:

“For some participants, this may also mean access to subsidised internet access and computer.”

SCC commissioning should include assistance to use accessible technology and arrangements for an appropriate local support person where needed. The relevant funding responsibilities should be agreed across programs. Telehealth should not become the default when an in-person assessment or practical observation is required. Fund clinician travel and coordination of visits, and help participants access available transport assistance.

We recommend commissioning regional access to experienced APDs who can support local clinicians, advise SCC workers and join case conferences. Where there is insufficient local volume to sustain specialist dietetic availability, assess shared regional capacity funding. Preserve small local practices through fair contracts and avoid tender thresholds based only on scale.

Measure time from identified need to appropriate assessment, unsuccessful referrals and unmet need. A referral sent repeatedly to an unavailable service should remain an unresolved access issue, with an identified escalation owner. Thin markets should include shortages of particular expertise and culturally appropriate care, not only geographic remoteness.

Question 11 Complex and overlapping needs

How can the SCC service best support participants who face additional barriers, including those experiencing complex and overlapping support needs or requiring decision-making support?

Dietitians Australia prioritises access to specialist allied health expertise for complex disability and coordination across multiple systems. Member feedback identifies multidisciplinary feeding teams as a useful approach. We recommend a named coordinator, participant-agreed goals and a shared action plan for people whose nutrition support spans disability services, hospital care, primary care and family or paid support.

Some participants make decisions about nutrition with support, or through a guardian or nominee. A decision about tube feeding is one example. The SCC worker’s role is to see that the participant and their decision-maker have the APD’s advice in an accessible form, and that the decision is recorded and passed to the providers who act on it. The SCC worker should not make or steer the decision.

A systematic review of 11 home enteral tube-feeding service-improvement studies found improved knowledge following education and fewer complications with multimodal interventions, but no significant reduction in unplanned hospital encounters; evidence quality was low (Amaratunga et al., 2023). These findings support testing and evaluating coordinated approaches that combine education and specialist input for participants receiving tube feeding within the new SCC model.

Another systematic appraisal of 15 home enteral feeding guidelines found weaknesses in stakeholder involvement and implementability (Korai et al., 2025). SCC pathways for tube feeding participants should therefore be co-designed with participants, carers, relevant practitioners and support providers, and tested

for feasibility in real service settings. Manduchi et al. (2020) identified only four retrospective studies of feeding and swallowing interventions in adults with intellectual disability, all concerning enteral feeding. This limited evidence base reinforces the importance of individual clinical assessment, participant preferences and ongoing monitoring. SCC should facilitate access to this expertise and follow through on agreed actions, with clinical assessment and treatment remaining the responsibility of appropriately qualified practitioners.

Question 12 Transition arrangements

What transition arrangements would minimise disruption and support successful implementation?

We recommend staged implementation with demonstrated service readiness before each transfer. Map participants with complex nutrition and mealtime arrangements early, identify their current APDs and other practitioners, and preserve those clinical relationships unless the participant chooses otherwise or there is a substantiated safety concern. Establish a clear route for people who will not qualify for SCC to obtain information and connection support.

Not every participant will be eligible for SCC. The paper says those who are not may use other coordination supports, such as Local Area Coordinators and Early Childhood Partners, and that the SCC service will align with other intermediary supports. The expectation to recognise nutrition and mealtime risk and refer to an APD should apply to those intermediaries as well. This includes Early Childhood Partners working with children who have feeding difficulties.

Member concerns about overlapping coordinator and planner roles should be addressed through plain-language role descriptions and agreed escalation procedures. Participants and practitioners need to know who can resolve a funding question, arrange a service and respond when coordination breaks down.

The NDIS Commission reported 184 site visits to 98 providers in its May–August 2025 mealtime campaign. It identified inconsistent information sharing during participant transitions as a preventable risk (NDIS Commission, 2026). These targeted visits are not a representative estimate of non-compliance. They provide a direct reason to require a documented, consent-based handover of current plans, outstanding referrals, supply arrangements and review dates.

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Appendix A Disability Role Statement for APDs.¹

This role statement was developed by members of the Disability Interest Group.

It lists the knowledge and skills of an Accredited Practising Dietitian (APD) working in the disability area.

Knowledge

- Nutrition-specific evidence relating to a specific disability and implementation of evidence informed practice including regular review and reflection on outcomes.
- Impacts, interactions and side effects of medications, diet modifications, particular foods, fluids, nutritional supplements and thickeners that may be commonly used in the care of people with a disability.
- Popular diets and nutrition misinformation relating to specific disabilities.
- Policies, procedures and guidelines relating to health care in disability in line with the mandatory organisation/site specific, state and federal policy directives (for example, use of restricted or restrictive practice).¹⁻⁴
- Disability-related funding that may impact an individual's access to health and dietetic care (for example, National Disability Insurance Scheme) and requirements of dietitians in relation to this including realistic implementation within community settings.⁵
- Awareness and utilisation of the International Classification of Functioning to inform nutrition assessment, care plans and decision making.⁶

Skills

- Consideration of accurate and relevant data, unique features of the client's disability, and related nutrition impact symptoms, physical and cognitive limitations, and communication difficulties when conducting a nutrition assessment and developing a plan.^{7,8}
- Ability to determine health priorities for complex disability clients with multiple comorbidities using evidence base and clinical experience to inform practice.
- Ability to ethically work with clients with a disability who have intellectual/cognitive/memory impairments, behavioural disturbances and mental health co-morbidities. For example, working within scope of practice as part of an interdisciplinary team, delivering person-centred care using social justice principles, understanding informed consent and supported decision-making, and that behaviours are a form of communication.
- Assess the capacity and capability of people with a disability and/or their carers to follow dietetic recommendations and adjust interventions accordingly.
- Collaboration with clients, families, group homes, client support networks and interdisciplinary disability related health teams working within the person-centred practice paradigm, considering the individual's needs, abilities, preferences, choices and aspirations.
- Confident identification of the most appropriate method to effectively communicate with clients, families and/or support workers with a range of cognitive abilities to deliver disability-specific nutrition recommendations using evidence-based reasoning.

Activities entry level APDs would conduct

- Nutrition assessment utilising the most appropriate methods, intervention and monitoring considering key disability-specific issues (For example, dysphagia, mealtime behavioural issues,

¹ <https://dietitiansaustralia.org.au/working-dietetics/standards-and-scope/role-statements/disability-role-statement>

menu choice, supports in day-to-day life, cognition, fluctuating health, level of intellectual impairment and client capacity to self-monitor, client access to services, communication or environmental stressors).

- Provide nutrition therapy for individuals with disabilities without complex comorbidities (For example, enteral feeding regimens, food fortification, healthy eating, food aversions, food allergies, mealtime management plans).
- Referral to and coordination with specialist/support services available for people with disabilities.
- Ability to work within scope as part of an interdisciplinary team, and appropriately identify when to refer on and/or be guided by more experienced clinicians (For example, inborn errors of metabolism or management of a ketogenic diet for epilepsy).
- Provide consultation and recommendations for meal planning in disability-related residential and respite facilities.

Activities APDs working at a higher level would conduct

- Provide nutrition therapy for individuals with disabilities who have complex comorbidities (For example, eating disorders, psychiatric illness with behaviours of concern, metabolic conditions including phenylketonuria (PKU)).
- Intuitively utilise advanced nutrition and dietetic skills acquired, and recognise other clinicians' knowledge and skills to successfully problem solve and implement effective interventions.^{7,8}
- Facilitate a transdisciplinary approach when working with individuals with disabilities to implement holistic strategies that promote wellbeing.
- Design, develop and actively participate in research that informs policies and best practice for people with disabilities.
- Ability to confidently communicate at organisation and government levels to advocate for disability-specific nutrition priorities with evidence-based reasoning.
- Act as a nutrition resource to dietitians and members of the interdisciplinary team on application of disability related nutrition protocols and guidelines to an individual client or population. This includes the mentoring/supervision of students or less experienced dietitians as well as other health professionals.^{7,8}

Activities APDs working in this area of practice do not usually undertake

- Assessments of swallowing or making food texture and fluid thickness recommendations.
- Assessments of safety and functioning while cooking.
- Assessments of physical activity capacity.
- Assistance with feeding at mealtimes.

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Appendix B Enteral feeding ²

Key points

- Enteral nutrition is used when a person has trouble meeting their nutrition needs orally.
- Enteral nutrition comes in the form of liquid formulas given through a feeding tube.
- Tube feeding delivers nutrition directly into the stomach or small intestine.
- Common reasons for tube feeding include swallowing problems, critical illness, and treatments affecting the ability to eat like radiotherapy to the head and neck area.

Details

Enteral nutrition or tube feeding is a method of supplying nutrition through a feeding tube. This tube goes directly into the stomach or small intestine, bypassing the mouth and oesophagus.

It is an option when adequate nutrition cannot be taken by mouth. But otherwise, a person's gut is still working normally to digest and absorb food.

Enteral nutrition may make up a person's entire nutrition needs or can supplement what they eat and drink by mouth.

Enteral nutrition formulas are a liquid food that are high in energy, protein and other nutrients that complement a person's normal diet. There are commercial enteral formulas available and they can also be homemade.

Interest in blenderised tube feeding (BTF) is growing. BTF is feeding by the use of blended foods and liquids given directly into the feeding tube. The food could be homemade, commercial formula mixed with pureed baby food or any of the variety of commercially available ready-to-use BTFs. There are potential drawbacks to the use of BTF including the increased risk of bacterial contamination, greater risk of clogged feeding tubes and more effort involved in the preparation of the feed. This is where dietitians can help advise on the most appropriate type of food or formula for a person and tailor the advice to the needs of the individual.

If a person can't absorb nutrients because of problems such as blockage or disease in parts of the gastrointestinal tract, then nutrition needs to be given directly into the bloodstream. This type of feeding is called parenteral nutrition.

Reasons for enteral nutrition

A person needing tube feeding usually has a condition or injury that prevents them from eating an adequate regular diet by mouth. Common reasons for using this type of nutrition include:

- stroke or other neurological conditions which impair swallowing
- after some types of operations to the head, neck or stomach
- after radiotherapy to the head and neck area
- being unable to consume adequate nutrients
- severe illness or injury which reduces the ability to eat
- poor growth (failure to thrive) or inability to eat in young children or infants.

² <https://dietitiansaustralia.org.au/health-advice/enteral-nutrition>

Types of feeding tubes

There are two different groups of feeding tubes.

Nasogastric and nasojejunal feeding tubes

The first type makes use of the nose to pass a feeding tube into the stomach (nasogastric tube) or small intestine (nasojejunal tube). Specialised liquid nutrition formulas or blenderised tube feeds can then be given through the tube. This type of feeding is generally used for short-term situations where the person is likely to return to oral eating within weeks.

Gastrostomy and jejunostomy feeding tubes

The second type delivers nutrition through the abdominal wall into the stomach (gastrostomy tube) or small intestine (jejunostomy tube). This type of feeding is used when it is likely that a person's ability to eat will not recover quickly or may not recover at all.

Feeding tubes are usually inserted during a person's hospital stay. But feeding through the tube may continue after a person returns home or to a nursing facility. If tube feeding support is provided at home, this is known as home enteral nutrition (HEN).

Dietitians are normally involved in all stages of the enteral nutrition process. A dietitian will assess a person to see if enteral nutrition is suitable for them. Dietitians are also involved in the monitoring of the feeding and supporting the person if they return home and still need tube feeding.

Risks to do with tube feeding

Even when it is medical appropriate to use, enteral nutrition is not without its risks. People with a feeding tube are at risk of complications such as aspiration where the feed goes into the airways.

There can also be the risk of infection of the feeding tube at the place it is inserted. The physical presence of a feeding tube can also be a source of irritation or pain. Diarrhoea, constipation, nausea and bloating are also common problems that a person may experience.

When to see a dietitian

Enteral nutrition needs the help and support of a professional. An Accredited Practising Dietitian (APD) can help you meet your individual needs.

We recommend seeing a dietitian if you:

- would like advice on whether you need tube feeding
- need advice to help ensure you're meeting your individual nutrient needs
- are experiencing problems with your current enteral nutrition regimen
- would like personalised advice and support from a professional.

APDs are university-trained nutrition experts. They can help you with personalised, easy-to-follow and evidence-based advice.

Appendix C Education for Support Coordinators – use real life case studies reported by Accredited Practising Dietitians to train Support Coordinators and NDIA staff.

Real-life case studies reported by Accredited Practising Dietitians can support training on recognising disability-related nutrition needs, understanding APD recommendations and resolving barriers to care.

This case demonstrates the need for SCC staff to recognise nutrition risks, communicate APD evidence, coordinate timely escalation and confirm that an accessible support pathway is in place. Referral to another system should not be treated as resolution while the participant remains without appropriate support

Case study 1: Advanced Huntington's disease and loss of access to prescribed ONS

A 51-year-old man with advanced Huntington's disease has severe dysphagia and malnutrition, with **15.8 kg of unintentional weight loss over three months and a BMI of 16.1 kg/m²**. He has received dietetic support since 2021 and has become progressively more reliant on oral nutritional supplements (ONS) since 2023 to meet his nutritional requirements. Percutaneous endoscopic gastrostomy (PEG) feeding is not being pursued, in accordance with the decision of his Plan Nominee/Guardian.

Following a recent NDIS plan review, the participant's support coordinator was advised that the NDIA would **not fund Fortisip because it was a ready-to-drink preparation and was therefore considered "food"**. The coordinator reportedly advised that the NDIS could fund supports for weight maintenance, but that significant weight loss should instead be managed through a GP prescription and mainstream health pathways.

In contrast, Sustagen was considered fundable because it is added to existing foods and drinks. The dietitian was therefore asked to identify an alternative to Fortisip that could meet the participant's nutritional needs within the funding decision.

Strengthening SCC capability to recognise disability-related nutrition needs and resolve funding barriers

This case illustrates the need for coordinators and NDIA staff to understand the relationship between disability, functional limitations and nutrition support. This case also illustrates the potential consequences of distinguishing nutritional products according to their **form of preparation rather than their clinical purpose and disability-related need**. Both products were being considered as part of the participant's dietetic management of severe HD-related malnutrition and dysphagia. Coordinators need to be educated to understand the differences. The NDIA's operational guideline provides that funding for prescribed nutritional supplements may be included in a plan where the supplements relate to the participant's disability-related health support needs (NDIA, 2026).

For a person with advanced HD who is unable to maintain adequate nutrition through ordinary food alone and is not proceeding with Percutaneous Endoscopic Gastrostomy (PEG) feeding, removal of a clinically prescribed ready-to-drink ONS may further restrict the available options for maintaining nutritional status. The case supports the need for developing pathways that coordinators can use, which clearly recognise **clinically indicated ONS on the basis of assessed nutritional and functional need, rather than whether the product is supplied as a powder or ready-to-drink preparation**.

The coordinator's role should be to help clarify the funding decision, communicate the APD's evidence and escalate unresolved barriers through appropriate NDIA processes. Where health and disability funding responsibilities are unclear, coordinators should facilitate communication between the relevant systems and services and identify a workable pathway to care. Referring a participant to mainstream health services should not be treated as resolving the issue without confirming that appropriate support has been accessed by the participant.

Example learning outcomes are described in figure 1.

Example of possible learning outcomes		
Five nutrition capabilities for SCC and NDIA staff		
Training priorities to support safe, coordinated and participant-centred nutrition care		
1		Recognise and escalate nutrition risks Including reported rapid weight loss, swallowing difficulties and interrupted access to prescribed nutrition support.
2		Seek and communicate APD advice Clarify the disability-related need for ONS and the suitability of any proposed alternative.
3		Distinguish coordination and funding decisions from clinical decisions Product suitability should be assessed by the treating APD, rather than inferred from whether it is a powder or ready-to-drink preparation.
4		Resolve barriers across health and disability services Document actions, responsibilities and follow-up. Confirm an accessible support pathway when referring participants to another system.
5		Support participant choice and decision-making Communicate with the participant and their authorised representative about nutrition care, using appropriate decision-making arrangements.
APD: Accredited Practising Dietitian ONS: oral nutritional supplements SCC: Support Coordination and Connection		

Figure 1. Example learning outcomes for coordinators and NDIA staff