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Transitional arrangements for the NDIS

August 2017

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 members. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the *Transitional arrangements for the NDIS* by the Joint Standing Committee on the National Disability Insurance Scheme.

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DAA interest in this consultation

DAA supports the implementation of the NDIS and acknowledges the potential of the NDIS to greatly improve the wellbeing of people with disability. DAA considers that the various nutrition needs of people with disability have not been well recognised in the past and that improved access to nutrition products and services through the implementation of the NDIS will enable people to achieve their goals, to increase their social and economic participation and to develop their capacity to actively take part in the community.

The Accredited Practising Dietitian (APD) program administered by DAA is the platform for self-regulation of the profession and provides an assurance of quality and safety to the public. APDs are food and nutrition experts who translate the science of nutrition into practical solutions for healthy living. APDs assist people with disability to make positive lifestyle changes tailored to their unique needs.

Key messages

DAA recommends that

- more training of planners is undertaken, at entry to the NDIA and on a continuing basis.
- the NDIA employ allied health professionals, including APDs to provide guidance to planners and other NDIA decision makers.
- effective resolution mechanisms for interface issues be implemented in each jurisdiction during the transition to full rollout. Such mechanisms need to be effective locally, at the highest State level and at the Commonwealth level.
- safeguarding and quality frameworks should not create cost burdens and administrative red tape which will act as deterrents to entrants to the NDIS workforce.

Discussion addressing Terms of Reference

a. Boundaries and interface

The common interface issue for APDs and NDIS participants is the health: disability interface. One reason this arises is that planners deny inclusion of access to APDs in NDIS participant plans, or that they include fewer hours than is necessary to meet participant goals. We assume that this is largely an issue of planners having a poor knowledge of the importance of nutrition across the spectrum of disability, and the role of APDs (see reference 1 and 2 for more information about nutrition and disability, and the role of dietitians in disability).

Health services

In complex cases APDs have observed stand-offs which place the NDIS participant at risk of harm and often causes the practitioner to spend considerable unpaid time in advocating for the needs of the NDIS participant. An example from an APD in NSW illustrates such a situation.

> *16 January 2017*
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> *"I have a case study for you regarding an NDIS client with Huntingtons Disease who has been refused service by NSW Health dietitians (documented in emails to Speech Pathologist) and whom NDIS has also refused to fund dietetics. I have cc'd the case manager [name of service provider worker] from Service Provider who has been liaising with NDIS and requested funding multiple times only to be denied again and again.*
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> *… This lady has deteriorating swallowing function and is at high risk of aspiration. She is currently being considered for enteral feeding. She lives with her elderly stepfather who provides most of her care as well as support staff who visit daily. I have had 2 other cases that I can remember of clients with the same diagnosis and risks who were funded for dietetics without question. The only difference I can see is the lack of capacity of the stepfather to advocate on her behalf due to his own failing health.*
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> *This issue is making me quite angry as it is clinically justifiable to fund dietetics, there is precedence of other clients being funded, and no one wants to take responsibility for this lady's dietetic management.*
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> *… NDIS can't expect Health the keep picking up these clients when they've lost all of their ADHC funding for their HACC services. And I can't keep bulk-billing hour long home visits because I'm concerned about these client's wellbeing."*

The advice by planners to access an APD from a health service is generally not helpful because health services may never have provided the service required and may not have the number of staff or the skill mix to meet the needs of people with disability. Even health services that have provided services in the past may now refuse services believing that people with disability can access services through the NDIS.

When APDs have raised specific cases of boundary issues between health and the NDIA it seems to have taken a long time because of the lack of resolution mechanisms. This exposes the client to risk of harm which is unacceptable given

the NDIS is aiming to improve the experience for people with disability who are often in very vulnerable situations. We understand NSW is implementing resolution mechanisms between NSW Health and the NDIA and we hope that every jurisdiction takes similar action.

Medicare Chronic Disease Management items

Another scenario is that NDIS participants are advised to see their General Practitioner for a referral to an APD in private practice to be seen under Medicare Chronic Disease Management items. The suggestion that people with disability should use Chronic Disease Management items is done without recognising the complex needs of the person with disability, as indicated by the Australian Institute of Health and Welfare[3]

> *'In 2011–12, people aged under 65 with severe or profound core activity limitation had a higher prevalence of various types of long-term health conditions and were 3.3 times as likely as those without disability to have 3 or more long-term health conditions (74% versus 23%).'*

The NDIS participant is likely to require more time and greater frequency of service from a suitably skilled APD. However, Medicare Chronic Disease Management items are capped at five consultations per year across all eligible allied health providers. The remuneration is less than market rates and is for a minimum of 20 minutes. This is not a suitable consultation scenario for quality service provision in disability. Cases related by APDs which illustrate these issues are included below.

> *April 2017*
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> *"…The Client's case manager contacted me requesting a nutrition assessment for a 30 yo gentleman with autism, pica, intellectual disability and hyperactivity. I wrote a letter of support to NDIA to consider the addition of dietetics to be added to his NDIA plan. I have now received a chronic disease management plans (sic Medicare Chronic Disease Management plan) prior to adding these services to their NDIA plan. I am under the impression that this client is not able to afford the gap and charges for travel time, as appointments need to occur at his residence…."*

b. Consistency of plans and delivery of NDIS and other services across Australia

The experience of APDs is that there is a high degree of variability in whether nutrition services are included at all, and in the hours included in participant plans.

The following case from an APD in NSW illustrates the variability in access to services by NDIS participants who may be vulnerable and in no position to

advocate for 'reasonable and necessary supports' according to their 'choice and control'.

> *18 January 2017*
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> *"If NDIS can hand me a standard bunch of money for my son just because he has ASD, then they should be able to do the same for people with the same diagnoses. There's nothing individual or person-centred about NDIS. There was no rhyme or reason why this lady couldn't get funding but my other 2 Huntingtons clients could. We need guidelines around this and we need clarity with responsibilities."*

There is an inconsistency in the inexplicable exclusion of APDs from the Early Supports for Early Intervention Professional Registration Group (Provider Toolkit Module 4) in contrast to the inclusion of most other allied health professionals. This has placed participants aged 0 – 6 years and their families at a disadvantage in accessing team based integrated care which meets the needs of children who are not growing well, who have difficulties with eating and drinking adequate amounts safely, who have food related behaviours etc.

Where a dietitian is requested by the family of a child with disability, they must ask to get that funded separately. This presents problems if the participant plan has already been signed off.

d. Any other related matters

Provider registration

The registration process for APDs as providers has been difficult for some practitioners, with some States requiring compliance with onerous processes. Some States have amended their processes to make the process easier, but there continue to be difficulties.

APDs have provided the following feedback

> *"I found registering with the NDIS quite difficult. I'm not even sure if I've done it correctly or not to be honest. I'm having trouble adding outlet details and will probably have to call them to get help with this. Really not user friendly." (QLD)*
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> *"I signed up to the NDIS about 6 months ago and it was quite laborious and even when I had completed all of the requirements I still wasn't sure if I was registered or what to do next. At present I am yet to see any NDIS clients and I still don't know much about what to do if I actually get a client or how they find me. So in short the portal system isn't particularly user friendly." (TAS)*

DAA and other allied health professionals attended a workshop recently to test the process of verification within registration to be implemented from July 2018. We are concerned that the proposed 11 point process presents a considerable burden to providers compared to the current allied health application for provider number with Medicare, which essentially requires completion of an online form, submission of qualifications and statement of compliance with the Health Insurance Act 1973. Whereas there is no cost to register with Medicare, it is likely that the NDIS verification process and components such as police checks and working with vulnerable person checks will cost some hundreds of dollars. The proposed process is bound with red tape which we understood the Australian government was actively working to reduce. The red tape and cost of verification will be a deterrent to entry to an already thin market.

We conclude that verification for APDs and other allied health practitioners will not be a proportionate and risk responsive component of the registration system. Many allied health professions have already been deemed to present a low risk to public safety[4] as demonstrated by their exclusion from registration under the Australian Health Practitioner Regulation Agency. Even those allied health practitioners who are registered under the Australian Health Practitioner Regulation Agency have demonstrated a low risk to public safety by the low number of complaints received as reported in the first review of the Australian Health Practitioner Regulation Agency.

We also draw the attention of the Committee to the requirement for some professions to be compliant with no less than three codes of conduct. Self-regulated professions such as dietetics will have to comply with the code of the Dietitians Association of Australia, the code for unregistered professions and the NDIS Code of Conduct. We recommend that mutual recognition be instituted such that professions have only to comply with one code of conduct.

Communication

It has often been difficult obtaining information from the NDIA on particular issues in a timely manner to inform members. There is a reluctance to put information in writing for example, which has been delivered verbally in a public forum by NDIA staff, even though it would assist professional bodies to disseminate information to members.

Engaging with the NDIA has proved difficult for practitioners and for DAA alike. It appears that there is some change in the NDIA culture of doing business with professional groups, which are genuinely interested in developing systems which work well for participants, providers and other stakeholders.

Disruption to supply chains of nutrition support products

Prior to the NDIS commencing, arrangements for accessing nutrition support products by people unable to eat and drink adequate amounts of ordinary foods and fluids safely varied greatly between and even within States and Territories. People were able to able to access their products at no charge in some states, or at state contract prices in others and so on. Despite the lack of equity and national consistency, there were well functioning systems in place at a local or State/Territory level.

With the NDIS, disruptions to previous arrangements have led to failure in supply of items, increased pricing in supply, and confusion amongst participants and providers about how to access products and where to get reliable current information. An example of price changes is provided below. One APD wrote

> *February 2017*
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> *"I work across a number of group homes. Some are still run by ADHC and some by an NGO. I am struggling with getting a particular feed for 4 different people at an affordable price.*
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> *I just wanted to check if anyone has a clear idea about how people who are eligible for them, access tender prices. What I am finding tricky is that group homes are often the account holder with a supplier as opposed to an individual or the NGO (overseeing a group of group homes) is registered with a supplier. The issue I am trying to resolve currently is accessing tender price on a low energy feed. The price difference for one feed is large. 4 x the price depending on supplier."*

In response to these disruptions, APDs, dietitians from State and Territory Health Departments, medical nutrition companies, medical nutrition product distributors, nurses and other stakeholders met on 28 June 2017 to discuss these issues. Stakeholders considered that there are a number of solutions which might be needed. Key to finding solutions is better communication of information for all parties who contribute along the pathway of accessing nutrition products and services. Also required is greater engagement by the NDIA to work with various stakeholders to improve both participant and provider experience in accessing services and products.

Payment difficulties

APDs were significantly disadvantaged by the outages in NDIS portal and transition to new digital payment arrangements during 2016. While the major problems seem to have been addressed, APDs report interaction with the portal is still not easy, and that the administrative burden impacts significantly on their productivity.

References

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3. AIHW 2016. Health status and risk factors of Australians with disability 2007–08 and 2011–12. Cat. no. DIS 65. Canberra: AIHW.
4. Intergovernmental Agreement for a National Registration and Accreditation SCHEME for the Health Professions http://www.coag.gov.au/sites/default/files/agreements/iga_health_workforce.pdf