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| Document Metadata |
| **Target Audience** | All Clinical Employees |
| **Jurisdiction** **Jurisdiction Exclusions** | NT HealthN/A |
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| **PGC/SharePoint ID: HEALTHINTRA-**1880-8255 | **PGC/Content Manager ID:** EDOC2018/42418 |
| **Version Number:** | Version: 4.0 |  | Approved Date: 01/02/2021 | Review Date: 01/02/2024 |
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# Purpose

The purpose of this guideline is to specify Territory Equipment Program funding criteria for this group of assistive technology, items provided, eligible prescribers and to provide a basis for consistent and transparent decision making.

# Guideline

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| **Includes** | **Eligible Prescribers** |
| **Communication Software** |
| **Level 2 General Equipment****Examples:*** Grid 2
* Speaking Dynamically Pro
* iPad applications
* Other applications
 | Speech Pathologist with:* More than 1 year clinical experience; and either:
* 3 previous prescriptions for Level 2 General Equipment of the specified Equipment Type

OR* Prescriptions must be co-signed by Approved Prescriber

Speech Pathologist with 5 or more years of experience |
| **Speech Generating Devices**  |
| **Level 1 General Equipment****Examples:*** Single Message Devices
* Sequenced Message Devices

iPad applications | Speech Pathologist  |
| **Level 2 General Equipment*** Static Display Devices
* Dynamic Display Devices
* Text-to-Speech Devices
 | Speech Pathologist with:* More than 1 year clinical experience; and either:
* 3 previous prescriptions for Level 2 General Equipment of the specified Equipment Type

OR* Prescriptions must be co-signed by Approved Prescriber

Speech Pathologist with 5 or more years of experience |
| **Voice Related Communication Device** |
| **Level 1 General Equipment*** Voice Amplification Device
 | Speech Pathologist  |
| **Level 2 General Equipment*** Electrolarynx
 | Speech Pathologist with:* More than 1 year clinical experience; and either:
* 3 previous prescriptions for Level 2 General Equipment of the specified Equipment Type

OR* Prescriptions must be co-signed by Approved Prescriber

Speech Pathologist with 5 or more years of experience |
| **Access Hardware** |
| **Level 2 General Equipment*** Switch
* Pointing systems
 | Speech Pathologist with:* More than 1 year clinical experience; and either:
* 3 previous prescriptions for Level 2 General Equipment of the specified Equipment Type

OR* Prescriptions must be co-signed by Approved Prescriber

Speech Pathologist with 5 or more years of experience |
| **Level 2 Seating Equipment*** Head control
 | Occupational Therapist or Physiotherapist with:• More than 3 years’ experience; and• 3 previous prescriptions for Level 2 Specialised Seating Equipment of the specified Equipment Type; and• Prescription of any complex mounting equipment should include clinical consultation with the Seating Equipment Assessment and Technical (SEAT) Therapist |
| **Mounting Systems**  |
| **Level 2 General Equipment** | Occupational Therapist* More than 1 year clinical experience; and
* 3 previous prescriptions for Level 2 General Equipment of the specified Equipment Type
 |
| **Level 2 Seating Equipment** | Occupational Therapist or Physiotherapist with:* More than 3 years experience; and
* 3 previous prescriptions for Level 2 Specialised Seating Equipment of the specified Equipment Type; and
* Prescription of any complex mounting equipment should

include clinical consultation with the Seating Equipment Assessment and Technical (SEAT) Therapist  |
| **Excludes:*** Items under $100
* Commercially available IT devices eg. iPad, iPhone
* Aids and equipment which can be funded by other sources
 |
| **Alternate Funding Sources for Aids and Equipment**Availability of equipment funding from other sources must be investigated. This list should not be considered exhaustive as further alternative funding sources may be available. | Items for childcare may be provided through the Inclusion Support Program (ISP)Items for school or TAFE may be provided through the Department of Education Items for the workplace may be provided through Job AccessItems for aged clients may be provided through a Commonwealth Home Care Package 1, 2,3,4 or a Residential Aged Care facility Items may be funded through an approved National Disability Insurance Scheme (NDIS) PlanCompensable and private funding such as Department of Veterans Affairs (DVA), Motor Accident Compensation (MAC)or other Insurance schemesPublic/community housing organisations eg. Department of Housing and Community Development, Housing Co-operatives |
| **Contracts in place:** TBC |
| **Identification of Need/Clinical Criteria** |
| **A Communication Aid or Device may be funded where:**1. The client will use the device in order to participate in required functional activities **AND**
2. The item facilitates the client’s primary means of communication **OR** client uses a variety of modes including the device **AND**
3. Full participation cannot be achieved without the device **AND**
4. A plan for training and support for the device use is in place.

The client must have a diagnosed communication impairment and must be able to use the device to facilitate communication.Voice Related Communication Devices prescribed as a replacement for eligible clients no longer attending as hospital patients (replacement batteries will not be supplied under a 12 month period). |
| **Other Considerations** |
| * The TEP will assist toward the purchase of a speech generating device that is the primary means of communication for someone with diagnosed communication impairment.
* Trialling or investigation of equipment is essential and the client must agree to a training and review process.
* A non-verbal person may also require equipment to access other communication systems such as telephones and computers.TEP does not fund these items.
* Additional prescriptions may be considered if there is significant functional change in the client’s assessed communication needs.
 |
| **Clinical Priority** |
| While a person may be eligible for TEP, it does not guarantee that a particular aid or item of equipment will be provided. This decision is dependent on the clinical priority and the availability of funds. New or re-issue stock items will be issued as soon as possible following approval and the processing of the prescription. To ensure clients most in need are assisted, each prescription item will be clinically prioritised using the following criteria.This is an indication of the clinically assessed priority for the prescribed item and should be clearly justified by the prescriber within the prescription. |
| 1. **High Urgency Category**
 | The provision of aids or equipment which are ***essential***to :* The safety of the client/carer in the home
* The continuation of the current care/living arrangements

The client’s independent functioning in the home |
| 1. **Medium Urgency Category**
 | The provision of aids or equipment which will ***improve*** the:* Safety of the client/carer in daily living activities
* The client’s independent functioning in daily living activities

The provision of aids or equipment that will ***maintain*** the client’s current care/living arrangements. |
| 1. **Low Urgency Category**
 | The equipment is ***therapeutic based*** equipment that increases the client’s mobility and communication abilities in the long-term.The equipment ***contributes*** to the client’s quality of life but is not essential for their current care/living arrangements. |
|  **Equipment Decision and Justification** |
| **Client Factors**  |
| **Provide*** The client’s diagnosis and/or details of functional disability
* A measurable functional goal in relation to the device
* Information from the clinical and functional assessment of relevant skills including: physical, sensory and cognitive skills, communication skills and need for additional access equipment

**Confirm*** That the device will be required for ongoing, long term (>12 months) use by the client
* That the client has the need, opportunity and motivation to use the device
* That the device is the client’s preferred means of communication for the stated goals
* That the device is the client’s primary means of communication or is an essential adjunct or enhancement to an existing communication system
* That the client has the ability to use the device to fulfil the stated functional goals
* That the skills of the client match the features and specifications of the device
* That a specific training plan is in place for the device across all appropriate environments for systems requiring complex navigation, and that the client has the cognitive skills necessary to achieve this

That opinion from a specialist Alternative and Augmentative Communication (AAC)/Speech Generating Device (SGD) provider has been sought in assisting with investigation and/or trial selection and prescription**Consider*** Can the device be adapted for ongoing use, if the client has a degenerative condition
* Will the device be flexible enough to suit the changing needs and abilities, if the client is developing or expected to develop further cognitive and language skills
* Does the client have an alternative communication strategy in case of breakdown or unforeseen inability to use the device
* Will the client be able to use the device across most of their communication environments
* The level of support the client requires to position and access the device
* If a commercially available device or feature is more suitable for the client

Whether alternative modes of communication have been explored and the method chosen is the client’s method of choice |
| **Social/Carer Factors** |
| **Confirm*** That the client’s carers and primary communication partners are able to support the client’s use of the device
* That the client and/or the support people who assist the client will be trained to operate, program, charge and maintain the device appropriately
* That if applicable, the client and/or support people will be able to use mounting systems for the device and/or access method accurately
* That the client and/or the support people who assist the client have adequate resources to prepare material and to program the device appropriately for functional use
* That the client and/or the support people who assist the client have adequate resources to familiarise new communication partners with the device
* That a plan for training has been made for the client, and if applicable the carer, regarding the use of the equipment, maintenance, cleaning and ongoing review
* That a plan for training has been made for the client, and if applicable the carer, regarding equipment trouble shooting
* That the carer is able to hear and/or understand the speech output when the device is being used

**Consider*** Whether training is required for carers
 |
| **Environmental and Equipment Factors** |
| **Confirm*** For communication software that the client owns a device such as a laptop/PC/iPad/tablet with the minimum requirements required to run the software
* For systems with complex access, positioning or mounting requirements, that input from an Occupational Therapist and/or Physiotherapist has been obtained
* That a plan is in place for ongoing clinical support
* What technical support is available for maintenance and repairs eg. iPad applications may not have support services available

**Consider*** Equipment features to be considered when prescribing a device. Refer to following table.
 |
| **Feature** | **Consideration** |
| **Speech Output**  | * Does the device provide digital (recorded) and/or synthesized (computer generated) speech?
* Does the device have sufficient volume for environments of use?
* Is there an appropriate voice for the client to use?
 |
| **Cell Number and Size**  | * How many cells are required:
	+ Small <16 cells
	+ Medium 16-32 cells
	+ Large >32 cells-unlimited
 |
| **Vocabulary** | * What are the vocabulary requirements:
	+ Pre-programmed vocabulary
	+ Ability to generate novel words, phrases and sentences
	+ Access to text and/or symbols
	+ Ability to access to languages other than English
 |
| **Navigation**  | * How is the device navigated:
	+ How many levels does the device offer?
	+ How are the levels organised?
	+ What is the method of moving between the levels?
 |
| **Display** | * Is the display easy for the user to see?
* Will the user be able to see the screen outdoors?
 |
| **Environments**  | * Is the device compatible with the environments it will be used in ie: outdoors, school, playground, public transport etc?
 |
| **Access**  | * What method of access does the client require?
* Does the device match the access needs of the client?
* Will other equipment be required to enable access to the device?
 |
| **Portability**  | * How will the device be positioned?
* How will an ambulant client carry the device?
* How will the device be protected when it is moved between environments?
 |
| **Mount**  | * Is a mount required for the device?
* Is a switch mount required?
 |
| **Seating**  | * Will the device be integrated into the client’s seating system?
 |
| **Keys**  | * What size do the keys need to be?
* How sensitive are the keys?
* Is a key guard required?
 |
| **Memory**  | * Does the device have:
	+ Adequate memory for needs?
	+ Adequate recording time?
	+ Adequate battery life for needs?
 |
| **Durability** | * How durable does the device need to be:
	+ Does the client have a movement disorder?
	+ Does the client have secretion management issues?
	+ Does the client have any behavioural challenges?
	+ Will the device be used in extreme weather eg. hot, cold, windy?
 |
| **Compatibility**  | * Is the device compatible with other technologies the client uses?
 |
| **Trial or Investigation** |
| **Trial or Investigation of the aid or device is required**Refer to TEP Approved Equipment List.**Provide*** Detailed information regarding all aids or devices trialled/investigated including objective measures of goal attainment
* Objective comparisons of the options considered and trialled/investigated and their client’s ability to participate in functional activities with, and, without, the equipment
* Reasons why comparative equipment were unsuitable
* Information about the client’s functional use of the equipment such as: ability to operate the equipment, change or recharge batteries, clean devices, trouble shoot problems
* Length of trial and environments of trial
* Confirmation that the client’s primary communication partners participated in the trial
* Functional outcomes of the trial

**Confirm** * That the most basic, cost effective aid or device that meets the client’s communication needs has been considered and trialled/investigated
* That the most basic, cost effective aid or device that meets the client’s functional need has been considered and trialled/investigated

**TEP T1 Trial Request Form**Approved Prescribers can request TEP assistance for the trial of communication aids and devices by completing this form. Once notified of the outcome, TEP will liaise with Approved Prescribers for ordering and arranging delivery of approved trial aids. |
| **Plan for Delivery**  |
| **Provide*** Name and contact details of client/carer and any clinicians who must be notified prior to delivery
* Delivery instructions
* If equipment is being delivered to a remote location please provide name of freight company (if known), community clinic or aged care facility, contact person, contact number and an email address.
* If replacement item is being prescribed, a plan to remove/return existing/unsuitable item on the prescription eg. TEP to collect item being replaced or prescriber to arrange return of item being replaced.
 |
| **Plan for Equipment Review** |
| It is the Approved Prescriber’s responsibility to ensure correct fitting and client education for TEP equipment on issue. It is essential that both Level 1 and Level 2 equipment is reviewed within 12 weeks of delivery and use. Prescribers must indicate which mode of follow up they will undertake. Options include: home visit, telephone call, client advised to contact prescriber as needed or the prescriber may need to make arrangements to refer follow up to an alternate provider, where appropriate. |
| **Resources** |
|  |
| **For Reference** |
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| Quality Assurance |
|  | **Method** | **Responsibility** |
| **Implementation** | Document will be available for access via the PGC Notification to staff via email | PGC AdministratorsSEAT & TEP Clinical Lead |
| **Review** | Document will be reviewed within 5 years or when changes in practice occur | TEP Advisory Committee |
| **Evaluation** | Document will be evaluated informally at time of review | TEP Advisory Committee |
| **Compliance** |  |  |

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| Key Associated Documents |
| **Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents** |  |
| **References** |  |

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| Definitions, Acronyms and Alternative Search Terms |
| Term | Description |
|  |  |

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| Evidence |
| **Reference** | **Method** | **Evidence Level (I-V)** | **Summary of Recommendation from this Reference** |
| N/A | N/A | N/A | N/A |

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| **National Safety and Quality Health Service Standards** |
| cid:image001.jpg@01D658ED.D030F090Clinical Governance | cid:image002.jpg@01D658ED.D030F090Partnering with Consumers | cid:image003.jpg@01D658ED.D030F090Preventing and Controlling Healthcare Associated Infection | cid:image004.jpg@01D658ED.D030F090Medication Safety | Comprehensive care iconComprehensive Care | cid:image006.jpg@01D658ED.D030F090Communicating for Safety | cid:image007.jpg@01D658ED.D030F090Blood Management | cid:image008.jpg@01D658ED.D030F090Recognising & Responding to Acute Deterioration |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |