Submission No 14

INQUIRY INTO THE EXERCISE OF THE FUNCTIONS OF THE LIFETIME CARE AND SUPPORT AUTHORITY AND THE LIFETIME CARE AND SUPPORT ADVISORY COUNCIL - FOURTH REVIEW

Organisation: NSW Agency for Clinical Innovation

Name: Mr Hunter Watt

Position: Chief Executive

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(2) attachments

ACI NSW Agency for Clinical Innovation

15 August 2011

Our Ref: ACI/D11/5291

Ms Rachel Callinan
The Director
Standing Committee of Law and Justice
Legislative Council
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Callinan

Submission to the Fourth Review of the LTCSA

Thank you for the opportunity to provide comment to the Standing Committee on Law and Justice of the Legislative Council in relation to the fourth review of the Lifetime Care Support Authority (LTCSA) under section 68 of the Motor Accidents (Lifetime Care and Support) Act 2006. Our response reflects the issues raised by the clinical networks involved with the Lifetime Care Support Scheme (LTCS), these being the NSW State Spinal Cord Injury Service (SSCIS) and the Brain Injury Rehabilitation Directorate (BIRD). The State Burn Injury Service has no issues for the fourth review to consider.

The NSW Agency for Clinical Innovation (ACI), previously the Greater Metropolitan Clinical Taskforce (GMCT), a board governed statutory authority that engages clinicians and consumers in health planning and works closely with NSW Department of Health, Local Health Districts, public health /non government organisations and researchers. ACI uses the existing clinical network model to involve clinicians and consumers in continuous clinical redesign to deliver improved outcomes for patients.

The ACI NSW State Spinal Cord Injury Service (SSCIS) is responsible for providing multidisciplinary health services for adults and children with acquired spinal cord injuries (SCI) where the cord lesion is non-progressive, and there is persistent neurological deficit arising from either traumatic or non-traumatic causes.

The BIRD builds on the existing network of 14 specialist rehabilitation services of the ACI NSW Brain Injury Rehabilitation Program (BIRP) in metropolitan and rural NSW for adults, young people and children following traumatic brain injury (TBI). The BIRD provides support to clinicians and consumers to develop and implement best practice treatment across inpatient, transitional and community settings.

ACI and its networks are in support of the 12 recommendations of the third review and look forward to the response from government. Support of these recommendations will improve the exercise of the functions of the LTCS Authority and LTCS Advisory Council, and will address many of the issues highlighted by clinicians during the third review. The issues addressed by recommendations 2, 6, 7, 8, 9, 10 and 12 continue to be areas that require improvements and consideration in the fourth review.

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Despite the delay in the release of the government response, our networks have continued to work collaboratively to resolve the issues with the following positive outcomes:

- LTCS remain open to ongoing review of the processes and procedure and agree to hold meetings to discuss issues with a view to improvement. We have been successful in our request to meet with LTCS management to try and problem-solve some difficult scenarios. Outcomes of these are available.

- The LTCSA newsletter remains an informative and effective way of keeping service providers up to date with developments and we recommend this continues.

- Establishment of working groups involving service providers to review models of care and service delivery for people with very high support needs.

- Establishment of supported accommodation group home at Blacktown for people with high care needs has been a great initiative.

- Ability to change interim participants into lifetime participants of the Scheme before the 2 years following injury. This has had beneficial effects in allowing participants to access settlement monies from their CTP claims at an early stage.

- Attendant care programs and the clearer criteria around the role of the Registered Nurse, less rigidity around the timetables included in the Care Needs Assessments (CNAs) and the increased pool of care agencies to draw on.

- Implementation of the vocational In-Voc pilot program in the spinal cord injury (SCI) units. The pilot program is seen as an excellent strategy to support the individual with a SCI to develop a positive attitude to their abilities and confidence in returning to work following their hospitalization.

As the Scheme continues to expand and mature a new issue has developed highlighting anomalies and inequities in the assessments for meeting entry and exit criteria. This issue is discussed more fully in the BIRD comments.

Additional comments are provided by SSCIS (Attachment 1) and BIRD (Attachment 2).

Once again, thank you for the opportunity to provide comment. Please do not hesitate to contact if further information or clarification is required.

Yours sincerely

Hunter Watt
Chief Executive

ACI NSW Agency for Clinical Innovation

ATTACHMENT 1

Submission by the ACI State Spinal Cord Injury Service (SSCIS)

Prepared by: Frances Monypenny, Network Manager, ACI SSCIS on behalf of the SSCIS Directorate and spinal clinicians and services.

1. Annual Review of LTCSA

We acknowledge the requirements under the Motor Accidents (Lifetime Care and Support) Act 2006 that an annual review be conducted of the LTCSA, however, it is our view that not enough time has elapsed since the publication of the Report on the Third Review for the implementation of its recommendations and the evaluation of the impact of the strategies and changes made as a result of these recommendations, to take effect. In addition, no feedback has been received by our organization in relation to the recommendations made by the third review.

The issues addressed by recommendations 4, 6, 7, 8, 9, 10 and 12 of the Third Review continue to be areas that require improvements and consideration in the fourth review. However, SSCIS will not provide additional comments related to these recommendations as our issues were clearly outlined in our submission to the third review. We look forward to receiving the government response to those recommendations.

2. Overall feedback by spinal specialist services.

The overall feedback from the spinal specialist services with regard to the relationship, communication, processes and procedures between the LTCSA and the specialist services is positive with reported improvement in all these aspects. We commend LTCSA for acknowledging the issues raised by the specialist services and working towards addressing these issues through improving their communication, process and procedures. However, work is still required to further streamline and reduce the administrative burden for clinicians in relation to the preparation and processing of applications and the need to provide additional information as a result of variability and inconsistencies in the response of LTCS Coordinators to the information provided. The need for greater clarity, transparency and consistency in requirements and processes, greater recognition of equipment essential for discharge for a person with a spinal cord injury (SCI), the acknowledgment that this equipment requires customization for the individual applicant, and acknowledgment of the extensive expertise of specialist clinicians who are prescribing the equipment, is ongoing.

3. Increasing the understanding by LTCS Coordinators and Case Managers of the key issues related to SCI and their impact on the individual's life, health and community living, and the need to use a risk management and wellness approach to their lifelong planning and support strategies.

SSCIS previously highlighted the need for LTCSA Coordinators, Case Managers and private therapists to have a better understanding of the health problems arising in spinal cord injury which are often not body system specific, but inter-related systems which require a range of approaches and professional disciplines working together. The lack of understanding of these issues limits their ability to identify problems early and to use a wellness, health maintenance and risk management approach in their work with people with a spinal cord injury.

It is the view of SSCIS members that there should be a greater emphasis on health monitoring and promotion, and illness prevention included in the support and monitoring processes provided by Case Managers. The impact of SCI on the individual does not only result in physical disability related to mobility. SCI also affects many of the body's normal physiological processes, in particular those associated with the normal functioning of the skin, the respiratory, bowel and bladder systems, blood pressure control, and muscle tone, and in a reduction in the body's natural resilience to respond and protect against noxious stimuli to these normal bodily functions and systems. SCI is a catastrophic injury with damage or loss of control and regulation over multiple systems of the body. These dysfunctions become lifelong conditions which need to be managed using a chronic diseases self management approach.

SSCIS does not expect LTCS Coordinators and Case Managers to become expert clinicians in the management of people with a SCI. However, SSCIS will continue to advocate for increased acknowledgment by LTCS of the need to use this health promotion, illness prevention approach and for a more coordinated approach to the health surveillance of people with a SCI who are LTCSS participants. SSCIS suggests that the involvement of specialist health care services in providing regular review, monitoring, advice, and support of health maintenance and promotion and illness prevention are a key goal for people with SCI who are LTCSS participants and that ensuring this goal is included in the individual's life plan is a key responsibility of Case Managers. The current approach of using local clinicians on a needs basis does not ensure a comprehensive approach which considers the interrelated nature of physiological changes as a result of the SCI.

Understanding of these changes, how they should be monitored for signs of deterioration, and the strategies that need to be implemented without delay to prevent further deterioration and return to optimal status, are an essential component of the lifelong management of a person with SCI. The prevention and deterioration of physical, physiological and psychological gains and skills learnt during rehabilitation are also essential aspects of the support of the person with a SCI returning to community living. For this reason spinal specialist clinicians have and will also continue to advocate for the approval and supply of exercise equipment to support these gains where the individual does not have access to community based accessible physical fitness and muscle strengthening equipment.

We are pleased to report that the Spinal Outreach Service (SOS) were invited to provide education on the impact and long term management of people with a SCI using a health promotion and risk management approach to a group of approximately 50 LTCS staff. The SOS has expressed interest in continuing to offer this education and expert advice on a regular basis to help LTCS staff maintain and continue to expand on their understanding and importance of the issues related to the SCI.

4. Approval and supply of customised equipment essential for discharge of people with a SCI

People with a SCI require a suite of customised equipment (eg. shower commodes, manual and power wheelchairs) essential for discharge and to enable their return to community living with their newly acquired disability. This equipment requires adjustment to meet the special needs of the individual. Customisation takes into consideration their height & weight, prevention and management of muscle spasm, skin pressure relief, pain minimisation and relief, back, head, arm and foot support needs, postural blood pressure control, ability and physical capacity to mobilise in a manual &/or power wheelchair and to complete their self care needs, to name but a few. During the inpatient period clinicians trial a range of equipment to which adjustments are made in order to determine the most appropriate equipment and necessary customisation required for that individual. This trial

process and education on the appropriate use and maintenance of the equipment takes time and is best completed during their inpatient stay. 'Off the shelf' equipment is rarely appropriate for people with a SCI.

Clinicians report they frequently experience difficulties with the current LTCS process for the approval and supply of customised equipment essential for discharge. The following examples are provided:

- Difficulties in gaining approval for the purchase of customised equipment when an individual is to be discharged to transitional or interim accommodation prior to moving to their definitive home destination. In these situations approval is given for the hire of equipment which cannot be customised.
- The requirement that hire equipment be supplied prior to the approval and supply of customised equipment creates the following difficulties:
    a. It is very difficult to hire specialised equipment (wheelchairs both power and manual) that meet the very specific and individualised needs of this client group.
    b. The supply of interim hire equipment in addition to the customised equipment requires extensive additional, duplicate and time consuming paperwork to be completed by the prescribing clinicians. This takes the clinician away from direct therapy contact with the client reducing the therapy time required by the client to achieve all functional goals, further extending inpatient stay and delaying discharge.
    c. Customised equipment (shower commodes, manual and power wheelchairs) take on average 12 weeks from the time of order to delivery. The clinicians make every effort to ensure the appropriate equipment is trialled in a timely manner to enable delivery, set up and fine tuning of customisation prior to planned discharge date.
    d. When hire equipment is supplied, clients typically are required to return to the spinal specialist hospital for assessment and final set up of their equipment when it is finally delivered to them. This often requires stressful and avoidable long distance travel for the individual and their family / carers.

We recognise the need to ensure the equipment is appropriate for use by the individual in their definitive home destination and to enable them to access the community, and in doing so prevent waste through the supply of inappropriate equipment. However, delaying the approval and supply of the equipment which is essential for discharge not only places the client at risk of developing complications as a result of inappropriate equipment (eg pressure sores, pain, etc) but also leads to additional stress and anxiety in the client and their family.

We also acknowledge that LTCSA uses a case by case basis approach for the approval of equipment requests. However, clinicians report considerable inconsistencies in the approval processes and receive little information, explanation or feedback to explain the rejection or lack of approval of the request.

We seek consideration by LTCSA of the problems encountered as a result of their current approval process for the supply of customised equipment essential for discharge.

5. Supporting transitional accommodation

In situations where the client is unable to return to their home (definitive discharge destination) they may be discharged to interim accommodation (transitional accommodation). Support for discharge to transitional accommodation allows the client to return to community living and in so doing commence the slow process of adapting to their new disability in the community environment. However, clinicians report the following difficulties in relation to the discharge of LTCS participants to transitional accommodation:

- LTCS will not support the process of finding and assessing the appropriateness of transitional accommodation until the approval for the long term discharge destination has been completed, even though the client has completed their rehabilitation goals and are ready for discharge. This practice of delaying approval to search and find transition accommodation leads to an extended length of stay in hospital, increased anxiety for both the client and their family, and 'bed block' reducing availability of beds for new admissions.

We seek consideration by LTCSA of the problems encountered as a result of their current approval process for the approval to commence the search for the transition accommodation and assessment of its appropriateness for the individual client.

SSCIS thank you for the opportunity to raise the issues listed above to the fourth review of the LTCSA. No further issues have been identified by SSCIS for consideration for the 4th Review.

ACI NSW Agency for Clinical Innovation

ATTACHMENT 2

Submission by the ACI Brain Injury Rehabilitation Directorate (BIRD)

Prepared by: Barbara Strettles, Network Manager, BIRD on behalf of the Brain Injury Rehabilitation Directorate and the NSW Brain Injury Rehabilitation Program. Please note that an additional submission is being provided by the Brain Injury Rehabilitation Team, Children's Hospital Westmead.

The ACI Brain Injury Rehabilitation Directorate (BIRD) welcomes the opportunity to utilize clinician and consumer feedback to contribute to the ACI response for the 4th review. This information will review progress regarding issues and concerns that were acknowledged in the 3rd review and will provide information about new issues and concerns.

1. Impact of the Lifetime Care Support Scheme (LTCS)

This is a continuing issue for all of the 14 specialist brain injury rehabilitation services who work with the most severely brain injured clients involved with the LTCS as either interim or accepted participants. The high administrative burden of the LTCS continues to be the primary reason for redirecting BIRP clinician time away from therapy with clients and their families during the critical stages of recovery and rehabilitation. The need for NSW Health to develop processes for financial reinvestment to retain service levels is being explored. The support on the costing of services initiated by LTCSA and involving NSW Health Finances Branch is helpful.

In some situations the rapid growth in the number of LTCS Coordinators and the expansion to three office locations has increased the burden for clinicians and highlighted inconsistent decision making. However, the communication pathways have improved for those NSW BIR Programs able to negotiate with the relevant Local Health District (LHD) dedicated LTCSA liaison positions on the basis of increased revenue opportunities. The outcome is to reduce the clinician's time required to complete requested paperwork, respond to approval rejections and adjust requests for reasonable and necessary plan approvals. The ACI BIRD supports the continuing need for implementation of Recommendation 7 for LTCSA to provide a lump sum payment to cover the cost of system upgrades and for additional staff resources.

Clinicians continue to value being involved in the review of the many forms essential for operationalising the information required by LTCSA for plan approvals. This process worked well for the review of the community discharge plan and could be utilised for address other forms and request formats. This collaborative approach could address the service provider notifications, form duplication for equipment hire (Recommendation 8) and feedback formats for rejections of plan requests (Recommendation 10). Potentially, the LTCSA could improve efficiency by convening a forms committee with clinicians membership and organise workshops to discuss and recommend changes to forms and processes of concern.

2. Administration of LTCS revenue within the public health system

LTCSA, NSW Health and ACI have continued to work on this issue with limited progress. The change from Area Health Services to Local Health Districts has in some ways stalled

progress in seeking a solution for developing a reinvestment strategy. Other activity includes:

LTCSA engaged Ernst and Young to prepare a report on the actual cost of specialist rehabilitation services for participants in the Scheme. ACI convened a series of meetings to identify what are the clinical elements of the specialist rehabilitation services provided in the designated NSW Health Facilities and services ACI BIRD is awaiting final approval by LTCSA of the changes to the Schedule of Fees to ensure that the services provided are included for services in all settings of care.

Implementation of Recommendation 6 remains critical to resolving the issues for administration of LTCSA revenue. Clarifying and agreeing to service obligations for specialist brain injury rehabilitation is an important development for Local Health Districts to meet LTCS funding expectations and best practice models of care.

3. The interface between LTCSA and the BIRP.

There continues to be tension arising from the different service approaches between BIRP clinicians, LTCS Coordinators and the LTCS approver. LTCSA recruit staff from a variety of backgrounds and skills who seek to determine what is reasonable and necessary to decide funding for treatment rehabilitation and care. The LTCS has a lifelong relationship with participants accepted into the Scheme. The BIRP is a provider of specialist rehabilitation services to people with traumatic brain injury (TBI) and their families utilizing a majority of skilled and expert staff to improve outcomes for the person as an individual and as part of their family and community. The NSW BIRP is an episodic service where the client will be discharged, usually when rehabilitation goals have been achieved.

Recommendation 11 talks about modifying the language used on the website and in official publications when referring to families and providing clear information on support services available to carers. Consideration is requested of the 4th review to extend this recommendation to include the family as an acknowledged and valued member of the rehabilitation team. This extends to acknowledging and valuing the important part families have in the life of the Scheme participant (interim or accepted) when providing support and care to their loved one.

The LTCSA website and official publications do not provide or have readily apparent the Scheme principles that are generally available as part of organizational standards. The Principals provide the governance framework in relationship to the Scheme and was previously encapsulated in the Preamble of the MAA Legislation. Providing ready access to the LTCS Principles would provide a context for stakeholders to understand funding decisions and the role of the Scheme in their lives. It would provide a context for LTCS staff, BIRP and non BIRP staff to determine reasonable and necessary when considering requests for funding and promote consistency for obtaining approvals. This clarity of purpose would potentially reduce situations of conflict between clinicians and LTCS Coordinators where views of reasonable and necessary differ.

Instead, or at least more apparent and available are guidelines to what will or will not be funded with no explicit context for decisions. This approach risks changing from a client-centred approach that promotes recovery to maximize social inclusion following severe and permanent impairment after TBI to funding what is only the list for treatment rehabilitation and care.

The ACI BIRD recommends the review of the website and official publications from Recommendation 11 be extended to ensure that the Principles for the LTCSA are explicit, in plain English and available for both Scheme participants and service providers.

4. LTCS Coordinators & the Approvers

The collaborative approach to deciding treatment rehabilitation and care is a key component of the LTCS and an intra-disciplinary approach is critical to working with people managing the changes in physical abilities, cognition, behaviour and communication that are evident in the pathway from injury to community reintegration. The ACI BIRD seeks to continue working with LTCSA in the Liaison Meeting and other venues to resolve process issues that improve the effectiveness of LTCS and BIRP staff.

In many situations in the recovery pathway for people following a TBI they rely on the staff of the NSW BIRP (as well as non BIRP staff) to advocate on their behalf about when services are needed, the type of services needed and reasonable and necessary treatment rehabilitation and care.

- There continues to be a need to implement a process for achieving a quicker turnaround or emergency response than the 10 days guaranteed by the LTCS and to manage those situations where the 10 days to approval has not been possible. LTCS considered that their increased staffing would mostly resolve these issues. The ACI BIRD and LTCS have commenced discussion of these issues in the Liaison Meetings and will monitor the impact of staffing and, if required will identify a process for emergency approvals and clarify circumstances where a shorter (say 5 day) turn around would be useful for managing plan approvals.

- The 3rd review includes issues, suggestions and LTCSA comments about the review and dispute resolution processes. The general approach of cooperativeness to resolving issues is acknowledged however, in some situations where decisions cannot be agreed then access to an external process needs to be available. This would allow intervention prior to a formal dispute resolution process being initiated. The availability of external approved assessors to review plan proposals would be useful in these situations and provide a reasonable and timely solution to prevent escalation into dispute resolution processes.

5. Leisure and recreation

The ACI BIRD welcomes Recommendation 12 for LTCSA to consider a provision for funding public transport and community transport options as part of leisure and recreation services, particularly for people with severe activity limitation and poor social inclusion following TBI.

- This group has little opportunity to improve their income status from disability benefits to a wage. Leisure and recreation options are often a full time alternative to employment for a significant proportion of LTCS participants with severe TBI following motor vehicle accidents.

- Involvement in community activities is a core component of integrating rehabilitation into everyday situations for people with severe TBI. This means that affordability for transport is often a barrier to participate and achieving meaning in their lives. Rehabilitation outcomes can be compromised if the person becomes socially isolated as a result of transport barriers. Improving access to public and community transport options provides opportunities for social inclusion that can improve challenging behaviour, reduce depression and lower the risk of suicide.

- LTCS participants would benefit from a new approach that incorporates provisions for long term support and maintenance of access to leisure and recreation options when work is not an option or active goal by funding public and community transport options.

The ACI BIRD recommends that consideration be given to expanding the provision for funding transport to include access to leisure and recreation aspects of the care and needs plan when return to work is not an active goal. The introduction of a number of pre-approved public transport and community transport hours/costs for each care and needs plan would be useful.

6. Aspects of access and eligibility are continuing areas of concern.

Recommendation 2 in the 4th Review suggests a review of the medical assessment tools. The ACI BIRD seeks to expand on this recommendation to ensure that people for whom the Scheme is intended are able to access the scheme at the point of injury and entry for lifelong support at the 2 year review.

In the Introduction of the 4th Review Report it states *' The LTCS.... provides lifelong treatment rehabilitation and care for people severely injured in MVA in NSW, regardless of who was at fault in the accident...'.* The LTCS website further explains that....*'The Scheme covers catastrophic injuries including spinal cord injury, moderate to severe brain injury, multiple amputations, severe burns or permanent blindness..'.*

LTCS is currently reviewing and clarifying issues of access for people with amputations and blindness from motor vehicle related crashes. A similar approach to TBI is required as anomalies and inequities have become obvious as more experience is gained over time with more people entering the Scheme, as interim or lifelong participants.

The current reliance on the assessment of functional independence as a primary measure of eligibility for people with moderate to severe TBI and the absence of a functional assessment for people with spinal cord injury is of growing concern for LTCS access and eligibility.

People with moderate to severe traumatic brain injury (TBI) are required to have neurological evidence of a brain injury as measured by the period of post traumatic amnesia being more than one week (with variations for children) **and** a functional impairment. People with a traumatic lesion of the neural elements of the spinal canal that results in permanent sensory, motor or bladder/bowel dysfunction **do not** also require a functional impairment.

A comparison example would be a person with a spinal cord injury reviewed at 2 years who remains in the Scheme with permanent but mild sensory changes (measured on the ASIA scale) on the left abdominal area and changes in tone in one hand (occasional involuntary movement) has returned to pre injury work full time, is independent in all aspects of community and personal life. A man with a TBI and 15 days post traumatic amnesia (PTA) exits the Scheme although he has not returned to work at all and is no longer living independently but is living with support from family because he does not have a functional impairment on the FIM. However, he has neurological impairment from the severe brain injury evidenced by both PTA and a neuropsychological assessment.
An example of a woman being denied entry to the Scheme shows a PTA of 15 days indicating a severe brain injury but her functional assessment was delayed until 4 months post injury when no functional impairment was assessed on FIM. This woman demonstrated impairment of brain function on neuropsychological testing to support the severity of the brain injury. She was not admitted to a specialist rehabilitation program as a continuum of acute care and had significant difficulties accessing treatment, rehabilitation and care in the early recovery phase while living in the community.

The three examples provided identify two people with TBI who are disadvantaged as a result of the reliance on the FIM for interim access or lifelong entry to the LTCS without due consideration for the duration of PTA as evidence of brain impairment. In addition,

there appears little justification for the person that made a significant recovery from a spinal cord injury during the interim period with minimal to mild permanent sensory changes and no functional impairment at two years receiving lifelong LTCS participation. If his function was assessed using the FIM he would most likely have the top score of 7 in most if not all areas and no scores less than 6, the same scores or better than the man with TBI.

In summary, neurological assessments of impairment are required for both traumatic spinal cord injury and brain injury to determine interim participation and, when combined with appropriate functional assessment for the two year review.

The Functional Independence Measure (FIM) measures the support a person requires to complete tasks and includes items for cognition and communication ability but does not include items for assessing the behavioural and psychological changes that are frequently evident after moderate to severe TBI. These impairments cannot always be included in the FIM assessment, although they are the result of severe TBI, interfere with function and require support, often lifelong treatment rehabilitation and care. The FIM is therefore not considered a reliable tool for determining the range of lifelong support that may be required to manage the effects of brain impairment for Scheme entry and exit when the person has made a good physical recovery but continues to have impairment of brain function that is disabling. An additional or alternative measure needs to be considered for all age groups.

If PTA duration over one week is accepted as valid for neurological impairment independent of the FIM for people scoring 6/7 then this would resolve access for interim participation of people with moderate/severe TBI. PTA duration is also a valid tool for predicting outcome and needs to be considered an indicator of neurological impairment of brain function for entry at the two year review particularly when other evidence (e.g. neuropsychological assessment, medical imaging) supports the severity of injury and need for lifelong treatment rehabilitation and care.

ACI BIRD supports the 3rd Review Recommendation 2.
Additionally, the ACI BIRD recommends that the LTCSA consider an expansion of Recommendation 2 to include a review of the medical assessment tools for Scheme access at injury and for the 2 year review, in particular the use of PTA duration and the FIM/WeeFIM.

We further suggest that LTCS :

- collaborate with clinical and research experts to determine what assessments can complement the ASIA for determining exit or entry for the LTCS at the two year review for people with spinal cord injury and mild impairment with no/minimal effect of functional outcomes
- utilise the duration of PTA as a predictor of outcome for Scheme entry as an interim participant and as a valid medical assessment tool of neurological impairment requiring lifelong treatment rehabilitation and care at the two year review
- collaborate with clinical and research experts to identify and implement the use of a more appropriate functional assessment tool people who make a good physical recovery and the FIM/WeeFIM is not sufficiently sensitive. The PCANS and CANS may be appropriate additional or alternative medical assessment tools to initially consider.

7. **Supported accommodation and attendant care** remain issues of concern for BIRP clinicians and these have been included in previous reviews.

There remain limited options for transitioning to interim and permanent accommodation as a continuum of care and a range of workforce issues for the availability and skill mix of attendant care staff as well as agency support.

The development of supported accommodation options has been a slow process and usually resolves the problem for one to two clients but is not the solution for all clients. The ACI BIRD would like to see the admission criteria and processes for supported accommodation vacancies clarified so that vacancies are filled when it is the most appropriate option for the person and their family and not to reduce the overall cost. This approach will enable new options to continue to develop around identified gaps in supported accommodation models and across different locations. The outcome will be a range of appropriate solutions in different locations in NSW that become available and utilised to meet individual needs rather than restricting options to one type and setting of care and support for short term financial imperatives.

The ACI BIRD thank you for the opportunity to raise the issues listed above to the fourth review of the LTCSA. No further issues have been identified for consideration for the 4th review.