AJRH The Australian Journal of Rural Health

Aust. J. Rural Health (2011) **19**, 52–53

Short Report

Model for rural and remote speech pathology student placements: Using non-traditional sites and partnerships

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The Broken Hill University Department of Rural Health (BH UDRH) operates a successful multidisciplinary rural clinical placement program in far western New South Wales.[1] However, until recently, the development of allied health programs had been constrained by the region's limited access to allied health services and their capacity to support students. There are few placement opportunities nationally across the UDRH network for allied health disciplines such as speech pathology (22 students in 2008/2009; J. Ramsay, pers. comm., 2010).

In Broken Hill, local primary school teachers and parents had raised concerns about the lack of paediatric speech pathology services and the impact this was having on educational attainment. We proposed a novel solution using a clinical education model[2] structured around student-run clinics[3] in the primary schools. The development relied on non-traditional partnerships with school education, a commitment by speech pathologists from the Area Health Service to allocate time for clinical supervision and work by BH UDRH staff to engage academic partners from a feeder university, recruit students and manage the placements.

Participants, methods and results

The program was piloted in 2009 and three groups of final year students (17 students) completed a fieldwork placement during 2010. The six-week placements were scheduled for school terms 1, 2 and 3, and each included orientation and three days of structured teaching on cross cultural education, primary health care principles, preparation for fieldwork and professional resilience.

Students worked in pairs running clinics at local primary schools supervised by local speech pathologists. Clinical activity varied with each placement. The first group of the year focused on screening kindergarten children while subsequent rotations screened other children referred by parents or teachers. The students delivered speech pathology interventions for children with straightforward problems, assisted speech pathologists in complex cases and referred to associated services if required. They also provided teacher and parent education. Each consultation was documented on a standard form, reviewed by the speech pathologist and filed in school records. The supervising speech pathologist referred children for ongoing treatment or further assessment to the speech pathology service as required.

Individual student needs were closely monitored and tailored levels of clinical and non-clinical supervision/support developed to enhance participant experiences. Students also participated in the local inter-professional learning program.

The curriculum requirements for the placement were determined and monitored by academic staff from the Faculty of Health Sciences, University of Sydney and delivered collaboratively on-site.

A total of 231 primary school aged children, including 167 from kindergarten (93% of enrolments) were assessed in 2010. Fifty-eight per cent of kindergarten children had a speech pathology intervention. Furthermore, the number of new referrals on the speech pathology service waiting list has decreased from 250 clients in September 2009 to eight in September 2010 (D. Grant-Thomson, pers. comm., 2010).

Both formal and informal feedback from speech pathology students, teachers, parents and health staff about the program has been positive and three students have already returned for an 'adult' placement in Broken Hill. A formal evaluation of the program is planned.

Comment

A greater investment in rural and remote fieldwork placements for allied health students is required to

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doi: 10.1111/j.1440-1584.2010.01177.x

respond to the rural health workforce shortages and difficulties in accessing sufficient placements in these regions. The development of a community-led placement model has dramatically increased the number of speech pathology placements in the Broken Hill region. The program had an immediate impact through the provision of clinical services that would otherwise not be available to primary school children, and has played a role in attracting a clinician (D.G.-T.) to the region with an interest in direct clinical service provision and teaching.

Acknowledgements

We wish to thank the primary schools and their staff for organising the clinics and hosting the students. This program is supported by a grant from the Department of Health and Ageing, *Increased Clinical Training Capacity (ICTC) Program*. The Broken Hill University Department of Rural Health is funded by the Australian Government Department of Health and Ageing.

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1 Lyle D, Morris J, Garne D *et al*. Value adding through regional coordination of rural placements for all health disciplines: the Broken Hill experience. *Australian Journal of Rural Health* 2006; **14**: 244–248.
2 McAllister L. Issues and innovations in clinical education. *International Journal of Speech-Language Pathology* 2005; **7** (3): 138–148.
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Position Statement

RURAL AND REMOTE ACCESS TO MEDICARE AND RELATED ALLIED HEALTH SERVICES

January 2012

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Background

Services for Australian Rural and Remote Allied Health (SARRAH) is nationally recognised as a peak body representing rural and remote Allied Health Professionals (AHPs) working in both the public and private sector.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These AHPs provide a range of clinical and health education services to individuals who live in rural and remote Australian communities. AHPs are critical in the management of their clients' health needs, particularly with chronic disease and complex care needs.

AHPs work across the health care continuum and they have significant roles in the health care and health education sectors.

The AHP, particularly in rural and remote areas, is required to adapt to workforce shortages and is well versed in the interdisciplinary and team approach to health care, especially for management of chronic disease and to improve health behaviour.

It is noteworthy that in many smaller and more remote communities, people in need of primary health care are reliant on nursing and allied health services because of workforce issues. If these health professionals are well supported then the need to access specialist and hospital services will be reduced. According to the Australian Institute of Health and Welfare:

> *"Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (e.g. emphysema). These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment.*
>
> *Clear differences exist in health service usage between areas. There are, for example, lower rates of some hospital surgical procedures, lower rates of GP consultation and generally higher rates of hospital admission in regional and remote areas than in major cities. There are also inter-regional differences in risk factors; for example, people from regional and remote areas tend to be more likely than their major cities counterparts to smoke and drink alcohol in harmful or hazardous quantities. It is also likely that environmental issues such as more physically dangerous occupations and factors associated with driving (for example. long distances, greater speed, isolation, animals on roads and so on) play a part in elevating accident rates and related injury death in country areas.*
>
> *However, it is not currently possible to apportion the generally poorer health outcomes outside major cities to access, environment or risk factor issues. It is likely that each of these three play a part[1]."*

[1] AIHW 2011, Impact of Rurality on Health Status, Accessed from: http://www.aihw.gov.au/rural-health-impact-of-rurality/ November 2011.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that AHP services are basic and core to Australians' primary health care[2] and wellbeing and to the improvement in health outcomes for remote and rural residents. It is the Government's responsibility to ensure the provision of this care.

Access

There is currently a mix of responsibility for the delivery of allied health services in rural and remote communities including State and Territory government funded services (hospital and community based); Australian Government funded services such as Rural Primary Health Services (RPHS), Medicare, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and AHPs working in the private sector.

Medicare, Australia's universal health insurance scheme, provides access to health care services. However, the level of expenditure from this scheme and other programs per capita in rural and remote Australia is less than in metropolitan areas, indicating unequal access.

> *There is a total rural health deficit in rural and remote areas of at least $2.1 billion a year. This equates to a shortage of 25 million services, and it includes the rural Medicare deficit which has now reached $1 billion a year.*[3]

This deficit is partially offset by the 'Rural Primary Health Services' program which provides some funding for allied health services. Limited Medical Benefits Schedule (MBS) funding is currently spent on allied health professional services, further exacerbating the lack of access to services required by consumers. This is particularly true in rural and remote areas.

SARRAH contends that access to allied health services should be equitable across Australia, and that inequitable access to Medicare funded allied health services and other

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[2] Declaration of the Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, Accessed 22 June 2009 from: http://www.who.int/publications/almaata_declaration_en.pdf

PHC, known as *comprehensive PHC*, is defined by the World Health Organisation as:

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

For further information about this issue please refer to the SARRAH Position Paper on Primary Health Care available for download at www.sarrah.org.au

[3] National Rural Health Alliance Inc, 2011, Fact Sheet 27: The extent of the rural deficit, March 2011, Accessed from: http://nrha.ruralhealth.org.au/cms/uploads/factsheets/Fact-Sheet-27-rural-deficit.pdf, 28 November 2011.

Australian Government programs such as the 'Helping Children with Autism' and 'Better Start' is contributing to poorer health outcomes for non-metropolitan Australians.

The Medicare Allied Health Initiative

From 2004, the Australian Government introduced direct fee for service payments for AHPs treating a person with a chronic and complex condition through the MBS allied health access programs, following a referral from a General Practitioner (GP) as part of a Team Care Arrangement.

The main Medicare allied health initiatives are:

- Chronic Disease Individual Allied Health Services under Medicare items 10950-10970.
- Follow up Allied Health Services for People of Aboriginal and Torres Strait Islander Descent under Medicare items 81300-81360.
- Psychological therapy services under Medicare items 80000 to 800020.
- Focused Psychological strategies under Medicare items 80100 to 80170.
- Pregnancy support counselling under Medicare Items 81000 to 81010.
- Allied Health Group Services For Patients with Type 2 Diabetes under Medicare items 81100-81125.
- Children with Autism, Pervasive Developmental Disorder or Disability under Medicare Items 8200 to 82035.
- Chronic Disease Allied Health Services in Residential Aged Care Facilities under Medicare Items 10950 to 10980.
- Oral health care for people with chronic medical condition and complex care needs under Medicare Items 85011-85986 (Dentists); 86012-86986 (Dental Specialists); and Items 87011-87777 (Dental Prosthetics).
- Optometrical Services provided under Medicare Items 10905 to 10943.

More details about each of these initiatives can be found in Attachments A, B and C.

SARRAH recognises that these initiatives are an important step in recognising the effectiveness of multidisciplinary team care and in supporting this practice through enabling rebates for consumers having both medical and allied health services.

Issues of Concern

Australia's Medicare Legislation is based around the notion that all Australians have the right to basic health services according to need. However, there are considerable human, social and economic consequences to people residing in rural and remote Australia with chronic illness or disability, through not being able to access even basic AHP services.

Cant and Foster[4] critically examined the utilization of the 13 allied health services provided through the Medicare Chronic Disease Management program and related general practitioner care planning initiatives. Their study included billing data from July 2005 to June 2009. Their study clearly indicated *"Inequality of accessibility for patients was*

[4] Cant, RP & Foster MM, 2011, *Investing in big ideas: utilisation and cost of Medicare Allied Health Services in Australia under the Chronic Disease Management initiative in primary care*, Australian Health Review 35(4) 468-474.

apparent." As part of their conclusions they state: "*Five years into the program, a review of Medicare Allied Health SDM policy is warranted".* To date such a review has not been undertaken.

SARRAH raises the following questions about Medicare:

- What is the review process for Medicare when adding new items and removing existing items that do not meet evidenced based best practice?
- Will the uptake, impact and effectiveness of allied health services claimable under Medicare be evaluated? If so, when?
- What is the differential in the uptake of MBS item numbers and services provided under the allied health initiative between remote, rural, regional and metropolitan Australia?

SARRAH *recommends* that the Australian Government undertake a review of the impact and effectiveness of allied health initiatives, with particular attention to equity in uptake between remote, rural and metropolitan areas.

While various initiatives have in some cases increased access to allied health services in many areas, there are a range of issues of concern to SARRAH in ensuring that these initiatives adequately meet the needs of people residing in rural and remote Australia. These concerns include:

1. Chronic Disease Management – number of sessions

The unrelenting nature of chronic disease necessitates many more than five sessions of treatment over a year. The length of the treatment session varies according to the type of AHP service and consumer need. However, the rebate is a set amount with longer sessions incurring an additional gap payment for the consumer or reduced compensation for the AHP. Treatment beyond that of the initial 5 sessions available under this initiative are either at a cost to the consumer or will be requested from public sector services which in many areas of rural and remote Australia are overstretched or do not exist, with the result that the consumer will not receive the services needed.

For example, if a consumer with a chronic disease diagnosis receives an assessment from an Occupational Therapist, Physiotherapist and Psychologist only two sessions remain over a whole year for follow up treatment from these AHPs or further allied health assessment and/or treatment.

A review into the MBS allied health program should occur with a view to expanding the number of available sessions attracting a patient rebate per year to be more reflective of the nature of chronic disease management by multidisciplinary team care. This will potentially increase the current cost to the Government, but the cost benefit in terms of the overall management of chronic disease, reduction in disability and hospitalisation will outweigh the increase in Medicare costs[5].

[5] Bird S, Noronha M, Sinnott H: *An integrated care facilitation model improves quality of life and reduces use of hospital resources by patients with chronic obstructive pulmonary disease and chronic heart failure.* Aust J Prim Health 2010, 16(4):326-333.

SARRAH recommends that the number of AHP sessions claimable under MBS for consumers needs to be increased in line with visits available under other initiatives. For example: allow for 10 visits per year in line with access to psychological services under the MBS.

2. Appropriate remuneration

A standardised allied health assessment session can take from 30 minutes to several hours and a comprehensive assessment can take two or even three sessions. The time for assessment depends on the particular profession undertaking the assessment and the needs of the consumer. A report on the tests/assessment process and findings is then required to be provided to the referring GP. The rate of remuneration under the Chronic Disease Management item numbers does not match the level of skill and time taken for a comprehensive assessment.

A review of Medicare rebates is required to analyse and determine the time factor and actual cost of service provision by the different professions with a view to the development and implementation of standard (in clinic and outside clinic) and extended session item numbers (in clinic and outside clinic).

SARRAH *recommends* the implementation and funding of standard and extended session item numbers to enable remuneration for allied health services provided under the MBS to reflect the time factor and actual cost of service provision by the different professions.

3. Access to health care provided by Allied Health Professionals in rural & remote communities

Consumers must have a GP referral to an AHP working in private practice in order to activate funding under these Medicare item numbers. In many rural and remote communities this structured process blocks access to services as commonly there is no GP to initiate the referral process and access to services for the consumer OR there are no private AHPs, thus impacting adversely on the consumer's options for appropriate care.

In rural and remote communities there may be allied health providers, for example state funded and/or employed under other Australian Government programs such as the Rural Primary Health Services Program. However, often these AHPs are either not available, have long waiting times for access, or funded to provide services for a small range of identified clinical priorities that may not be included in chronic disease management

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Lorig KR, Sobel DS, et al: *Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial.* Med Care 1999, 37(1):5-14.

Clinical Epidemiology & Health Service Evaluation Unit: *Potentially preventable hospitalisations: a review of the literature and Australian policies.* Melbourne: CEHSEU; 2009.

targets. As a result the consumer either does not get access to necessary care or is required to travel and incur the extra costs of travel, accommodation and sustenance to access allied health services. Currently travel assistance schemes do not meet consumer costs associated with accessing allied health services.

SARRAH recommends the Australian Government fund and implement an adequate level of innovative and flexible solutions to enable access to allied health services by people living in rural and remote communities where there are limited GPs and private allied health practitioners.

4. Helping Children with Autism Program, and Better Start Program for children with Disability

Several issues of concern arise with this program funding which include:

- The lack of availability of private Paediatricians and Psychiatrists in some rural and remote areas is a significant blocking point for access to this program for children accessing the Medicare items through Helping Children with Autism program. For rural and remote residents access to specialist referral and to AHPs with the appropriate skills can mean considerable travel and accommodation expenses and associated disruptions and economic burden on families of children with Autism. The referral for children under Better Start requires a GP referral and it is recommended that this be considered for the referral pathway for Medicare access for Helping Children with Autism.
- The lifetime cap of 24 allied health sessions (spread over the likely 7 allied health professions involved in care of children with autism) is insufficient to provide intervention to what is a lifetime condition.

SARRAH recommends the Australian Government fund and implement innovative and flexible solutions to enable access to team based allied health services for children living with autism, pervasive developmental disorder of disability, appropriate for a lifetime condition and in areas where there is limited access to required services.

Experienced AHPs working with children with autism, pervasive developmental disorder or disability identify the following solutions to reduce the barriers and enhance this initiative.

SARRAH recommends

- Changing the Helping Children with Autism and Better Start Programs service provision allowance from a capped 24 sessions in a lifetime to a set provision allowance per year for children up to 16 years of age. Alternatively bring the allowance in line with the recommendations for Chronic Disease Management which is 12 sessions per year for children after 7 years of age.
- Enabling appropriately trained GPs in identified rural or remote areas to refer consumers in the Helping Children with Autism program reducing the access blocks caused by the need for referrals by specialists and lack of transport options.
- Ensuring that an evaluation of the Helping Children with Autism and Better Start programs takes into account equity of access for rural and remote residents who are eligible for these services.
- Establishing options for allied health care delivered to children under these programs via teleconference and videoconference.
- Creating greater flexibility within the current funding arrangements, where resources can be applied to cover the travel costs of approved panel providers, to enable a fly-in-fly-out service to be provided where no suitable local private or public service is available.

5. Chronic Disease Allied Health Services in Residential Aged Care Facilities

Aged care residents are eligible for 5 allied health services on GP referral, however access to these services in remote and rural areas can be difficult to source.

Residents in aged care are generally unable to access services outside the facility due to transportation difficulties. Remuneration under this MBS item to allied health services is only available to private providers and is not sufficient to cover the time taken for a facility based visit, making service provision financially unattractive. There is also confusion when working in these facilities about the eligibility of the residents under low/high care classifications particularly when these change for the resident. Depending on the care needs of the residents within the aged care facility and the allied health service required, Occupational Health and Safety (OH&S) issues can have an impact on the type of management/skill/service delivered by the practitioner. For example, a resident's room and or bed may not be ideally suited to the type of service required.

SARRAH recommends the Australian Government fund and implement improved access to allied health services in aged care facilities by reviewing the remuneration for these items recognising the time demands for the provision of such services by visiting AHP's and OH&S difficulties in providing such visiting services.

6. Oral health care for people with chronic medical condition & complex care needs

Access to dental services for people living in rural and remote communities is reduced due to the lack of qualified dentists and dental specialists providing services in these locations.

A large range of dental services provided under the Medicare Chronic Disease Dental Scheme and the Medicare Teen Dental Plan can be competently carried out by a nationally registered dental therapist, dental hygienist or oral health therapist, working within their scope of practice in a collaborative and referral model of team care.

Currently dental therapists, dental hygienists and oral health therapists are unable to register with Medicare Australia to provide dental care services under the Medicare Dental Initiatives. The dental care services they deliver must be provided under a dentist's Medicare provider number. In rural and remote communities where the services of a dentist are often limited or non-existent, this indirect billing feature adds an additional layer which often blocks access to Medicare funded dental services.

SARRAH recommends that dental therapists, dental hygienists and oral health therapists are allocated Medicare provider numbers to enable direct access to Medicare services within their scope of practice.

The Medicare Chronic Disease Dental Scheme will end on 31 December 2011. The closure of this scheme will leave many chronically ill consumers without subsidised access to dental care in rural and remote Australia.

SARRAH recommends a review of the Medicare Chronic Disease Dental Scheme, including an investigation of uptake of the scheme in rural and remote Australia. Funding alternatives should be put in place so chronically ill consumers are not further disadvantaged with regard to accessing dental services which will impact on their overall health outcomes.

7. Clinical Pharmacy services for people with chronic disease.

People in rural and remote communities have high levels of chronic disease and thus have complex medication regimens. Multiple medications can often result in poor levels of medication compliance, and thus poor management of chronic disease, and/or can result in medication mismanagement and adverse outcomes, resulting in increased hospitalisations.

Many consumers in rural and remote communities have little or no access to a Pharmacist. Current models of delivery of pharmacy services through small business are not viable in small communities. Clinical Pharmacy services such as patient medication and device education, health professional medication education, Dose Administration Aid (DAA) packing, disease management, case conferencing and wound care need to be remunerated under MBS items. Currently, only Home Medicines Reviews (HMRs) and Residential Medication Management Reviews (RMMRs) pharmacy services are remunerated through MBS item numbers. The current remuneration for the HMR and RMMR and associated travel allowance are insufficient to cover costs in rural and remote areas.

SARRAH recommends

- The Australian Government add MBS items for an extended range of clinical pharmacy services.
- An increase in remuneration for HMR & RMMR items to make them viable for rural and remote patients.

Innovative solutions

Throughout this document SARRAH has identified issues in relation to Commonwealth Government funded Medicare initiatives to increase access to allied health services and team based care for Australian health consumers. Of major concern is the reduced access to health services provided by these initiatives as a result of lack of private AHPs, Dentists, GPs and other health practitioners eligible under the programs.

SARRAH strongly recommends an evaluation of the Medicare initiatives to identify inequities in uptake between metropolitan, regional, rural and remote areas of Australia and the impact and effectiveness of the initiatives where they are being fully implemented.

The Commonwealth Government must ensure that in rural and remote areas, where there are no or very limited private practitioners available to provide services, flexible options for families in such areas are identified and implemented to obviate the need to travel long distances to access services.

Innovative solutions include:

SARRAH recommends

- Increase the number of AHP sessions claimable under MBS for consumers in line with visits available under other initiatives to better reflect actual need. For example: allow for 10 visits per annual year in line with access to psychological services under the MBS.
- Implement and fund standard and extended session item numbers to enable remuneration for allied health services provided under the MBS to reflect the time factor and actual cost of service provision by the different professions.
- Include allied health services in telehealth initiatives as with the expansion of Medicare rebates to fund the provision of such services via telehealth, particularly in regions where access to the required allied health service is not otherwise available or limited.
- As with services delivered by Aboriginal Health Workers, provide MBS item numbers for services delivered by Allied Health Assistants supervised by AHPs remotely to increase access to allied health services for consumers with chronic and complex conditions in rural and remote communities.
- Improve financial support under the various Patient Assistance Transport Schemes to include costs associated with accessing allied health services to enable rural and remote consumers to travel greater distances when services are not available locally.
- Provide consumers with the opportunity to purchase services from available public providers (e.g. State health), where there are no suitable private practitioner options available, under the same conditions and controls applicable to private providers. It is not suggested that funding be allocated directly to State/Territory government services or that this model be introduced where needs are already being met, but that under special circumstances an exemption should be provided with appropriate controls in place. For example the model provided by Commonwealth Government Department of Veteran's Affairs providing access to allied health services for Veterans in areas where there are no private practitioners.
- Expand the Medical Specialist Outreach Assistance Program Indigenous Chronic Disease (MSOAP-ICD) model to all chronic disease management for health consumers in areas where access to the required service is not otherwise available.

Whilst the funding and implementation of such innovative solutions may initially increase health costs under the Medicare initiatives, the benefits for health consumers would include:

- Facilitating health promotion and illness prevention;
- Promoting team based care of those with chronic and complex conditions;
- Reducing complications as a result of chronic conditions; and
- Reducing admissions to and length of stays in hospital.

Conclusion

In order to improve access to allied health services for consumers with chronic and complex conditions in rural and remote Australia, a review of the current MBS allied health provisions and other related Australian Government programs (e.g. FaHCSIA funded) is required. Programs need to reflect the true nature of the service delivery by the different professions under the allied health category; the number of services needed, and be flexible enough to enable access to the required services to be met for consumers in rural and remote communities.

SARRAH as the peak body representing AHPs delivering health services to people residing in rural and remote communities across Australia is well positioned to work with the Australian Government and other stakeholders to enhance the MBS and other related programs in particular those items relating to allied health services.

Attachment A

The Commonwealth Government Department of Health and Ageing: Medicare Benefits Schedule Allied Health Services, 1 November 2011 which is available via this link: http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/2CF0C0E825700B77CA257903007A598C/$File/201111-Allied.pdf

The document contains information on:

- information for Allied health providers
- individual Allied health services for patients who have a chronic condition and complex care need;
- group Allied health services for patients with type II diabetes;
- follow-up Allied health services for aboriginal and Torres Strait Islander peoples who have had a health assessment;
- psychological therapy services;
- focused psychological strategies;
- pregnancy support counselling; and
- children with autism, pervasive developmental disorder or disability.

The guidelines provide information about eligible patients and the services available under the Medicare guidelines. This includes the number of services per year; the service length and type; eligible allied health professions; referral requirements; referral validity; subsequent referrals and reporting requirements.

Eligibility of Patients

Eligible patients	Number of allied health services per patient	Allied health professional eligible to provide the service
Patients who have a chronic (or terminal) medical condition and complex care needs requiring a multidisciplinary approach	Up to five individual services (in total) per calendar year (no exceptions)	Aboriginal health worker Audiologist Chiropractor Diabetes educator Dietitian Exercise physiologist Mental health worker Occupational therapist Osteopath Physiotherapist Podiatrist Psychologist Speech pathologist

Eligible patients	Number of allied health services per patient	Allied health professional eligible to provide the service
Aboriginal and Torres Strait Islander peoples who have had a health check	Up to five individual services (in total) per calendar year (Note: these services are in addition to the five individual services for patients with a chronic or terminal medical condition and complex care needs)	Aboriginal health worker Audiologist Chiropractor Diabetes educator Dietitian Exercise physiologist Mental health worker Occupational therapist Osteopath Physiotherapist Podiatrist Psychologist Speech pathologist
Patients who have type 2 diabetes	One individual assessment and up to eight group sessions per calendar year (Note: these services are in addition to the five individual services for patients with a chronic or terminal medical condition and complex care needs)	Diabetes educator Dietitian Exercise physiologist
Patients with an assessed mental disorder	Up to ten individual services and up to ten group therapy services per calendar year.Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to 80170 and/or GP focussed psychological strategies services (items 2721 to 2727).	Clinical psychologistPsychologistOccupational therapistSocial worker(Note: services can also be provided by a qualified medical practitioner)
Women who are concerned about either a current pregnancy, or one that occurred in the previous 12 months	Up to three services per pregnancy	Psychologist Social worker Mental health nurse (Note: services can also be provided by a qualified medical practitioner)
Children with autism, pervasive developmental disorder (PDD) or disability – aged under 13 years for diagnosis services and under 15 years for treatment services	Up to four services for assessment (in total per child) and up to 20 early intervention treatment services (in total per child).	Audiologist Occupational therapist Participating Optometrist Orthoptist Physiotherapist Psychologist Speech pathologist

Attachment B

The Commonwealth Government Department of Health and Ageing Medicare Benefit Schedule: Dental Services which is available via this link:

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2CF0C0E825700B77CA257903007A598C/$File/201111-Dental.pdf

The document provides information about the Dental program including:

- Which dental practitioners are eligible to use the dental items;
- Which patients are eligible for dental services;
- What dental services are covered by the Medicare items;
- How does the patient limit of $4,250 in benefits work;
- Informing the patient about the cost of services;
- Charging and billing for dental services;
- Private health insurance;
- Referrals and reporting;
- Dentures; and
- Claiming under Medicare.

Attachment C

Commonwealth Government Department of Health and Ageing Medicare Benefits Schedule Book: Optometrical Services Schedule which is available via this link:

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2CF0C0E825700B77CA257903007A598C/$File/201111-Optom.pdf

The document provides information about the Optometrical Services program including:

- Benefits for services by participating Optometrists;
- Participation by Optometrists;
- Provider numbers;
- Patient eligibility;
- Scheduled fees and Medicare Benefits;
- Billing Procedures;
- Limitations on Benefits;
- Referrals; and
- Provision for review of Schedule.