GUIDELINES

for the

MORE ALLIED HEALTH SERVICES PROGRAM

(May 2008)

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Introduction

These guidelines set out how the More Allied Health Services (MAHS) Program will be funded and how it should operate. It details the aim and objectives of the MAHS Program, how funding can be used, and planning and reporting requirements.

All Divisions of General Practice that receive MAHS funding should take the time to become familiar with these guidelines. If, after reading the guidelines, Divisions have any further questions or issues they would like to raise; these should be discussed with the Department. If required, the Department will provide additional clarifications in subsequent editions of the guidelines. A contact list of Departmental officers is on page 16.

These guidelines are to be read together with the Deed for Multi-Program Funding between Divisions and the Department. In the event of any inconsistency or discrepancy between these guidelines and the Deed, the Deed takes precedence.

Program Context

The More Allied Health Services (MAHS) Program was established in 2001 to help rural communities gain better access to allied health services[1] and to address rural health workforce shortages. MAHS also supports betters links between the GP and the allied health sector, allowing the GP to focus on general practice.

In June 2007, the Department of Health and Ageing (DoHA) commissioned a review of the MAHS program to see of it was achieving its goals. The review found that:

- there was overwhelming evidence that MAHS was meeting a rural workforce need;
- the MAHS Program is increasing access to and use of allied health services in rural areas through the extension of services outside major centres; decreasing waiting periods; and is making available services to people who cannot afford private consultation; and
- increased team work, communication and shared knowledge amongst Divisions, GPs and allied health professionals have been important outcomes of the MAHS Program.

There is a strong commitment to continue to improve health outcomes for rural communities. In April 2008, following an audit of Australia's rural and regional health workforce, the Commonwealth Government announced it will:

- **Immediately** establish an Office of Rural Health in the Department of Health and Ageing, to drive reform in the rural health sector.
- **Over the next 12 months** reform the remoteness classification structure (RRMA) to ensure that incentives and rural health policies respond to current population figures and real need.
- **Over the next 12 months** examine all existing programs that support rural health professionals, to determine how to better support communities in most need of assistance.
- **Continue to invest** in rural and regional health services to ensure families get the health services they need.

This process will deliver changes that will set the health system up for the challenges of the future.

[1] As defined on page 6 of the guidelines

Aim and Objectives

The aim of MAHS is to:

> **improve the health of people living in rural areas through access to allied health care and improve local linkages between allied health care and general practice.**

The objectives of MAHS are to:

1. **Improve the health care of key groups within a rural community through the provision of efficient and effective allied health services which have been selected on the basis of the identified needs of the community.**
   The allied health services provided under MAHS address community priorities identified by a needs assessment undertaken by the Division of General Practice, in consultation with rural general practitioners, community groups and existing public and private allied health service providers (see Attachment A). The aim is to achieve optimum health outcomes in a cost efficient manner.

2. **Provide additional (in quantity or range) professional allied health services to rural communities.**
   MAHS funding will provide additional (ie a net increase in) allied health services to rural communities. Divisions' activities should result in an increase in the type of services available and the hours of service provided across the Division, if this is in response to the identified needs of the community.

3. **Facilitate an integrated approach to health care provision by allied health care professionals and general practitioners working together to meet the care needs of patients, and by the Division linking the *More Allied Health Services* Program with other State/Australian Government funded health initiatives and services.**
   Divisions are to improve access of rural communities to multi-disciplinary care, and encourage team-based approaches to care, enabling a wider range of services to the patient and helping the general practitioner to focus on general practice.

   Divisions are also to identify and monitor developments with other State/Commonwealth government health initiatives (such as Regional Health Services, Access to Allied Psychological Services, Aged Care Access Initiative or the Medicare allied health services items) and State/ Territory and Aboriginal health services, which are planned, or in place in rural areas. Divisions are to integrate program activities with these initiatives and services, so that MAHS complements these initiatives.

<u>Scope and Operation</u>

Rural populations to receive services

MAHS funding provides allied health services to rural populations living within Rural, Remote, Metropolitan Areas (RRMA) 4-7. Divisions need to ensure that MAHS funding benefits RRMA 4-7 populations rather than RRMA 1-3 populations. Divisions should contact the Department if they require assistance on the classification of a particular area.

Coverage of allied health services

For the purpose of these guidelines, an allied health service may include a service provided by:

- Aboriginal Health Workers
- Aboriginal Mental Health Workers
- Audiologists
- Chiropodists
- Chiropractors
- Counsellors
- Diabetes Educators
- Dietician/nutritionists
- Exercise Physiologists
- Occupational Therapists
- Orthoptists
- Orthotists/Prosthetists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Radiographers
- Registered Nurses, with specialist roles
- Social Workers
- Speech Pathologists

Allied health professionals employed under MAHS should have recognised educational qualifications specific to the position for which they are employed. The allied health professionals should be registered/accredited, if required for that profession, and should qualify for membership of their relevant professional association. They must not require supervision to undertake the clinical tasks for which they are employed. Divisions are required to demonstrate that they are using the clinical skills of that professional (as opposed, for example, to administrative, coordination or receptionist skills).

Registered nurses can be funded under MAHS, but only in specialist roles, such as with asthma management, diabetes education, or in mental health. Practice or generalist nurses cannot be funded under MAHS. A registered nurse with a specialist role is defined as a nurse who holds additional tertiary qualifications in that specialist area.

Divisions may fund other allied health professionals not listed above, subject to the Division obtaining written approval from the Department. Factors taken into account by the Department in considering any such request from the Division include:

- whether employing the allied health professional fits the objectives of MAHS;
- whether the allied health professional has appropriate and recognised qualifications to perform his or her proposed role; and
- whether employing the allied health professional meets the needs of the community as identified through the Divisional Needs Assessment.

This approval process would normally be done through the approval of Annual Plans and alterations to Annual Plans. A requesting Division should address the factors above in its request. The Division also needs to satisfy itself through its recruitment processes that the individual professional will safely and effectively perform his or her role.

Divisions are responsible for ensuring that funds are used for their intended purpose only. MAHS funding should *not* be used:

- as an alternative funding option for the employment of existing services/professionals in Divisions, general practices or current locations where allied health services are provided. However, use of MAHS funding to pay for an increase in the hours that these professionals are employed in providing additional services is acceptable. If a worker is to change work type and be employed using MAHS funding, their previous position should be backfilled by the employer, to ensure that additional services are in place.
- to create a situation where existing allied health services are ‘crowded out’, or made less profitable as this could lead to a loss in private sector services. Divisions should also take measures to ensure that they are not simply redistributing existing resources by recruiting professionals from an existing local service that is not then restaffed.
- to coordinate services to communities. Funding is provided to pay for additional allied health services for the community.

Increasing existing services through training and education of MAHS funded professionals is permissible under the Program. Such activity needs to be consistent with the objectives of the Program, represent value for money and result in a significant benefit for a community or communities within a short time frame. This should be negotiated with the Department.

It is recommended that the Division consider appropriate workforce retention strategies, such as mentoring or professional development.

MAHS participants and consultation

There are two primary participants in the implementation of MAHS.

1.Eligible Divisions of General Practice with rural or remote coverage will engage in ongoing consultation with stakeholders (rural general practitioners, community groups and existing public and private allied health service providers) and plan, implement, report on and continually review activities funded under MAHS.

2. The Department of Health and Ageing– (the State/Territory Offices) will assist Divisions with obtaining planning data, analyse and approve Divisions’ plans, monitor the implementation of activities, analyse reports provided by Divisions and liaise with stakeholders such as State/Territory governments. Divisions should also liaise with their jurisdictional governments where appropriate, independent of the Department of Health and Ageing.

Many other groups may have an interest in MAHS at various levels. Other groups may assist Divisions with the planning process (eg providing information for the needs assessment), in the implementation stage (eg providing advice in relation to recruitment and retention of staff, working collaboratively with allied health professionals working on MAHS activities) or in the ongoing evaluation of MAHS funded activities.

These groups may include State Based Organisations (SBOs), Rural Workforce Agencies (RWAs), the Australian General Practice Network (AGPN), Aboriginal Community Controlled Health Services, allied health professional associations or bodies representing all of these associations, University Departments of Rural Health, and Regional Health Services.

Providers of existing allied health services include: State/Territory governments and their health departments; local governments; non government organisations; private hospitals and private allied health practitioners; Aboriginal Community Controlled Health Services, as well as other services for Indigenous Australians; and specialist services for people with disabilities.

It is the responsibility of Divisions to identify stakeholders with whom they should liaise and consult. It is important that this happens from planning to implementation and evaluation. Divisions will need to demonstrate that they have done so in their reporting. This consultation will help integrate MAHS services with other programs, whilst not duplicating them.

Delivery Models

Divisions are expected to deliver allied health services in a way that best meets the needs of their rural communities. The Department supports Divisions using models of delivering the allied health services which are practical and acknowledge the individual characteristics (eg geographic, demographic) of a Division. The Department requires that delivery models address the outcomes of the Division's ongoing consultation with stakeholders, and take into account the aim and objectives of MAHS.

Delivery models include:

- full time or part time employment of an allied health professional by a Division;
- "topping up" existing part time positions/expanding existing services in an agency external to the Division (eg community health centres, local hospitals);
- Divisions subcontracting services through practices or groups of practices;
- "sharing" an allied health position with another Division or other organisation;
- contracting visiting allied health professionals; and
- contracting private allied health service professionals to provide a free service to patients, or providing support to encourage them to increase availability of private services (to be accessed through private health insurance schemes) in a rural location.

This is not an exhaustive list and Divisions may combine different models for different activities. In developing a model, the Division should plan a cost-effective approach that results in the maximum services on the ground.

In addition, allied health services may be located in a variety of settings. These may include groups of general practices, private/bush nursing hospitals in small towns (thus assisting their viability), multi-purpose centres, local community health centres or other appropriate service centres.

Operational Matters

MAHS funded allied health services should be accessed by consumers in rural communities through their general practitioner (ie initial referral via a general practitioner). This approach

increases the opportunities for collaborative work between general practitioners and the allied health professionals employed under MAHS, provides opportunities for increased use of care planning and case conferencing, and promotes continuity of care.

Allied health services funded under MAHS should be provided *free of charge to rural consumers*. Special circumstances may require that fees are charged for services (eg if a MAHS funded allied health service is provided in a setting where a nominal fee is currently charged for the use of disposable items). Divisions wishing to seek a nominal fee from patients accessing the service must request approval from the Department of Health and Ageing. In this request, the Division should address how the following principles will be maintained:

- an expectation that an inability to pay fees will not result in an inability to access the allied health service (for example, special conditions may be provided for pensioners and Health Care Card holders);
- people with high access needs are not charged more than a specified maximum amount in a given time frame;
- revenue from fees will be used to enhance/expand the level of allied health service provision and will not result in individual/agency receiving financial gain; and
- fees should be kept to a minimum as the service is largely funded through MAHS.

Allied health professionals will provide clinical services to referred patients either on an individual or a group treatment basis. For individual treatment, these services may include case conferencing and care planning. For group treatment, services might include secondary preventative/ educational intervention for clients with existing conditions. Occasional community level primary prevention/health promotion work is permissible for projects approved by the Division although it is expected that direct clinical service provision to individual or groups of clients to address existing conditions will be the main workload.

MAHS is funded for people living in RRMA 4-7 communities, including circumstances in which practices outside RRMA 4-7 areas provide care to these people. However, the Department encourages service provision to the maximum extent possible in RRMA 4-7 areas.

MAHS, the MBS and Private Health Insurance

If an individual Allied Health Professional is receiving payment from the Division as part of the Division's Government-funded role or function, or providing services funded under an Australian Government program, such as MAHS, they would not be able to also provide and claim for Medicare items while working under the same arrangements. To claim for Medicare items an allied health provider would need to be working in private practice. If an allied health professional employed under a Government-funded program also accessed Government funding through Medicare as part of that employment they would clearly be double-dipping.

Additionally MAHS funding cannot be used to cover the gap between what is covered through the Medicare rebate and out of pocket expenses for the patient. Out of pocket costs will however count towards the Medicare Safety Net for that patient. Equally MAHS funding cannot be used to cover the co-payment for patients with private health insurance.

Funding

Eligibility of Divisions for funding

Divisions with a minimum of 5% of their total population (figures based on the 1996 census) living in rural areas are eligible for funding under MAHS. "Rural" for the purposes of MAHS is defined as those populations living in areas categorised as Rural, Remote and Metropolitan Areas (RRMAs) 4-7. The RRMA categories are classed as follows:

1 – capital city of state/territory
2 – other metropolitan centres (100 000 plus)
3 – large rural centre (25 000-99 999)
4 – small rural centres (urban centres 10 000-24 999)
5 – other rural areas (remaining sites in rural locations with populations less than 10 000)
6 – remote centres (centres of 5000 plus in remote locations)
7 – other remote areas (remaining sites in remote locations)
(Source: Rural, Remote and Metropolitan Areas Classification, November 1994).

Funding allocations to eligible Divisions

Annual allocations for eligible Divisions will vary according to the total MAHS allocations available each year. MAHS funding may be used only for MAHS activities, consistent with these guidelines and the Deed for Multi-Program Funding. Funding available for MAHS is subject to parliamentary appropriation.

The emphasis of MAHS is that funding is for <u>service provision</u> for rural communities. Funding for costs outside salary and recruitment must be negotiated with the Department.

Allowable use of funding

Funding under MAHS is for allied health service provision. "Service provision" includes amounts for:

Allied Health Professional Salaries

This should be the bulk of MAHS expenditure, to ensure clinical care gets delivered to rural communities. Divisions need to consider risk management strategies to avoid the possibility of double payment for professionals between different programs.

Reasonable Recruitment Costs

Recruitment costs must be kept to a reasonable limit. If a Division is unsure of their own circumstances, they should discuss this with the Department.

Reasonable Retention Costs

Retention activities must be comparable with conditions available to allied health professionals working for other services in the area, require a small proportion of annual funding, be cost-effective and not used as salary in kind.

Service Support Costs

Service Support Costs are any costs related to the direct provision of allied health services and may include:

- equipment/resources for the allied health professional where reasonable*;
- reasonable travel costs for allied health professionals to locations of service provision (and overnight accommodation costs where necessary);
- costs related to renting a location for allied health service provision (eg a room in a multipurpose centre or bush nursing hospital);
- employment of interpreters; and
- professional indemnity insurance costs directly attributable to MAHS services (this would depend on whether the allied health professional was employed by the Division or subject to a contractual arrangement).

Other service support costs will be considered, subject to application and approval by the Department. The Division needs to ensure that its service support costs are cost-effective.

** in respect of motor vehicles, or any other substantial assets, leasing arrangements are preferred. Purchasing of motor vehicles will only be considered in exceptional circumstances and only after a business case has been submitted and approved by the Department.*

Division Support Costs

Division Support Costs are those costs incurred by the Division in the administration of the Program (eg staff time for writing plans and reports, or, for evaluation and monitoring, or costs incurred in conducting the needs assessment).

Generally Divisions are expected to spend no more 10% of their annual MAHS allocations (excluding rephased or rolled over amounts) for Division support costs. In some circumstances up to 20% of the allocation will be considered, subject to application and approval by the Department.

The determination of appropriate percentages/ amounts to be allowed for Division support will be determined by the Department.

Financial Management Practice

Strong financial management is essential for administering MAHS funding, for both Divisions and the Department. Financial management responsibilities are set out in the Deed for Multi-Program Funding, and include:

- ensuring funds are used for their intended purpose and in a way which meets the conditions of the funding agreement;
- keeping proper accounts;
- appropriate invoicing of the Department;
- managing assets;
- repaying funds under certain circumstances; and
- risk management, including insurance.

Divisions need to put in place systems to meet these responsibilities. The Department is also required to manage public moneys properly and effectively. Payments of funding can not be made in advance of need. The first payment should be made on execution of the Deed for Multi-Program Funding. Later payments are always subject to satisfactory progress and compliance with conditions of funding. The aim is to make sure that public funding is used appropriately.

Insurance

The Deed for Multi-Program Funding sets out the insurances that must be held by the Division. In addition, if the delivery of allied health services is undertaken by sub-contractors who are not covered by the Division's insurance, the Division should ensure that the sub-contractor effects and maintains appropriate types and levels of insurance.

Planning, Reporting, and Evaluation

Eligible Divisions are required to provide planning and reporting documentation and have these approved, in order to receive MAHS funding. Divisions are to submit all plans and reports to the Department for approval.

Planning

Needs Assessment Plans

Divisions should undertake a MAHS needs assessments as part of their planning cycle. A current Needs Assessment for all MAHS Divisions should be completed by 1 October 2008 and submitted to the Department. Divisions will need to keep documents relating to the planning process (see Attachment A) undertaken in the development of the MAHS Needs Assessment.

The documented Needs Assessment will include a summary of identified priorities for MAHS, based on the planning process undertaken by the Division. It will reflect the objectives of MAHS and discussion should address:

- the range of stakeholders' support for the proposed activities;
- prioritisation of one identified need over another, which may be based on practical considerations (eg the ease of recruitment of one service over another, or ease of access by patients to one allied health service over another);
- management of practical considerations and risk management (see Attachment A); and
- new initiatives and programs in the region, including the impact upon need and any identified efficiencies.

Divisions need to demonstrate that they have consulted in the development of the needs assessment. This includes consultation with the groups outlined in the section 'MAHS participants'. For example, have other services in the region, such as Regional Health Services or community health centres, already identified and met a need related to allied health?

Updated MAHS funded goals, strategies and outcomes must be reflected in:

Annual Plans

New and continuing MAHS funded outcomes and activities will be incorporated into Divisions' Annual Plans. Divisions will need to provide information on their model of service delivery within the Annual Plan. The model should demonstrate how the Division plans to employ the allied health professionals, how the services will be delivered, where the services will be delivered, whether the service operates in partnership with other Divisions of General Practice or agencies and any other relevant operational matters such as the use of fees.

Budget

A MAHS budget is required with each new Annual Plan. It must be provided in the format approved by the Department (using the financial planning and reporting template). The

budget may only include amounts sought for “allowable uses of funding” (see the funding section of this document for details). The budget will need to be approved by the Department of Health and Ageing.

Departmental assessment and approval

The MAHS Annual Plan and Budget will require the approval of the Department. The Department will need to be convinced that the requirements of these Guidelines have been met satisfactorily prior to granting approval.

In assessing the Annual Plan and Budget, the Department will consider:

- how well the Annual Plan meets the objectives of MAHS;
- how well the Annual Plan addresses needs identified in the most recent Needs Assessment;
- whether the Annual Plan meet the requirements of the contract and these Guidelines; and
- whether the Annual Budget is cost-effective.

Reporting and Evaluation

Reporting requirements for Divisions of General Practice receiving MAHS funding are specified under the Deed for Multi-Program Funding.

Six-Monthly/ Twelve-Monthly Progress Reports

Divisions are required to report against MAHS activities as part of the Six and Twelve Monthly Progress Reports. These reports will need to be approved by the Department in order for continued funding to be provided.

Financial reports

MAHS financial reports are to be provided with the Six and Twelve Monthly Reports using the financial planning and reporting template.

The financial report provided as part of the Twelve Month Progress Report is required to be prepared in strict accordance with the Australian Accounting Standards and Australian Auditing Standards by a Qualified Auditor independent of the Participant.

Data

In order for the Department to collate performance information relating to MAHS across Divisions, MAHS performance indicators have been devised. Divisions are required to report against these performance indicators when providing their Twelve Month Reports. See Attachment B.

Partnerships

Divisions which are undertaking MAHS funded activities in partnership with other Divisions of General Practice or other agencies (for options, see “the delivery of allied health services” section on page 9) must identify such partnerships in the performance indicator section of their Annual Plans. Also, the jointly funded activity should be identified in the MAHS budget

and financial report.

The proportion of a full time equivalent (FTE) position which the Division is funding itself via MAHS will need to be identified, in association with a statement about the proportion funded by the partner. Performance information provided in twelve-monthly reports and six-monthly progress reports must relate to the proportion of the activity funded by the individual Division's MAHS funding allocation. Divisions are encouraged to develop memoranda of understanding with partners about the funding and management responsibilities for the allied health professionals.

Evaluation

The Department will evaluate the Program overall regularly, which will involve consultation with the Divisions network and other stakeholders, as well as using data from Divisions. The Department may also review a specific MAHS service by a Division, or Divisions, from time to time.

Further Information and Resources

For further information about MAHS, Divisions are encouraged to contact their relevant State/Territory Office of the Department:

NEW SOUTH WALES: Caroline Curtin PH: (02) 9263 3814	**NORTHERN TERRITORY**: Robin Clark PH: (08) 8919 3494
QUEENSLAND: Michele Flint PH: (07) 3360 2614	**SOUTH AUSTRALIA:** Simon McMahon PH: (08) 8237 8289
VICTORIA: Michelle Callander PH: (03) 9665 8906	**WEST AUSTRALIA:** Paul Purdy PH: (08) 9346 5430
TASMANIA: Bob Stubbs PH: (03) 6221 1426	

Attachment A: Planning Process for Divisions

Please note: the Department may request documented evidence of community consultation for assessment of Annual Plans.

Consultation with community groups and interested parties

Consultation by Divisions with key stakeholders is considered a crucial element of the planning process. Divisions are expected to undertake discussions with a broad range of groups, including:

- General Practitioners in RRMA 4-7 locations, irrespective of whether they are a member of the Division;
- existing allied health service providers in the Division (this should incorporate providers located in RRMA 1-3 locations if these have the potential to provide services to RRMA 4-7 areas) including;
  - local, State/Territory, Commonwealth Government services;
  - non government organisations;
  - private medical services (eg private hospitals including bush nursing hospitals); and
  - private allied health practitioners;
- co-ordinators of existing/planned Commonwealth, State/Territory, local government health initiatives such as those which are part of the Regional Health Strategy – this includes Regional Health Services;
- Aboriginal and Torres Strait Islander health services and advisory mechanisms;
- consumer representatives from the RRMA 4-7 areas;
- Royal Flying Doctor Service; and
- Local allied health networks and associations.

Needs Assessment

Local population needs should be researched (and the sources of this information documented) to identify:

- National, regional and local health priorities (including priorities for key groups such as Aboriginal and Torres Strait Islander populations);
- Demographic information, including key population groups;
- Epidemiological information;
- Towns/clusters of towns in RRMA 4-7 which are priorities for allied health service provision;
- A brief overview of current allied health service delivery (by program/agency) in the region;
- Strengths in allied health service provision in the Division (including recent health initiatives conducted by other agencies);
- Gaps in allied health service provision in the Division (and some possible reasons for this); and
- Adverse environmental factors (eg geographical) which will impede the provision of allied health services.

Some of this information may be obtained from stakeholders during the consultation process.

Practical considerations for implementing activities

Recruitment/retention considerations for allied health services

Consideration should be given to staff recruitment and retention issues when planning which allied health services should be provided. Such issues may include:

- Lines of staff reporting/mentoring for the allied health professional - perhaps through existing services within the Division or an adjacent Division as required;
- Consideration of an appropriate location/centre for the provision of the specific allied health service proposed (such as small rural hospitals or multipurpose centres);
- Consideration of cultural and community principles such as Aboriginal community control over supervision and mentoring for allied health professionals where necessary;
- Methods of monitoring ethical and professional conduct of allied health professionals;
- Acknowledgment of the potential difficulties with recruiting certain professionals; and
- Possible approaches for attracting allied health professionals to rural areas.

Risk Management

Risk Management is an important component of project management. Divisions must develop a risk management strategy that addresses the particular circumstances and/or characteristics of their Division.

For example, Divisions should consider possible risks associated with:

- partnerships undertaken with external agencies (eg the development of service agreements or the provision of funds to other agencies); and
- the direct employment of allied health professionals, especially where this has not previously been undertaken by the Division.

As noted previously, Divisions need to implement risk management strategies to avoid the possibility of double payment for professionals between different programs.

In addition, Divisions must implement strategies to ensure compliance with relevant legislation.

Attachment B: MAHS Data for Performance Indicators

Divisions receiving MAHS funding are required to detail planned activities against three key performance indicators in the Annual Plan, and report against these same indictors in the Twelve Month Progress Report.

The performance indicators for MAHS are as follows:

MAHS 1
The number of allied health services provided and the number of allied health service providers by provider type.

When reporting against this indicator please provide:
- the number of MAHS services provided
- the number of allied health services provider by both provider type and FTE

When describing the provider, use a term from the following list:

Aboriginal Health Workers	Orthotists/Prosthetists
Aboriginal Mental Health Workers	Osteopaths
Audiologists	Physiotherapists
Chiropodists	Podiatrists
Chiropractors	Psychologists
Counsellors	Radiographers
Diabetes Educators	Registered Nurse, Asthma Educator
Dieticians/Nutritionists	Registered Nurse, Mental Health
Exercise Physiologists	* Registered Nurse, Other specialist role
Occupational Therapists	Social Workers
Orthoptists	Speech Pathologists

If another type of professional has been employed or contracted with the approval of the Department, then this should be listed as ‘Other’, with the specific type of profession noted in brackets.

* If a Registered Nurse, ‘Other’ is employed, then the specific role of this Registered Nurse should be specified.

MAHS 2
Evidence of shared planning and priority setting with other local organisations.

When reporting against this indicator please provide:

- A description of the level of involvement and results from the following groups, in the planning and delivery of the MAHS program
  -Other Commonwealth government programs
  -Other State or Territory Health Programs
  -General practice
  -Allied health professionals
  -Aboriginal health services
  -Consumers

MAHS 3
The number of GPs within the Division referring their patients to MAHS services.

When reporting against this indicator please provide:

- The number of GPs within the Division referring their patients to MAHS services.
- What proportion of GPs within the Division are referring their patients to MAHS services.

Assessment:
In assessing results against the performance indicators, possible areas of improvement include increases in service and referral rates and evidence that any changes or increases reflect the Needs Assessment.