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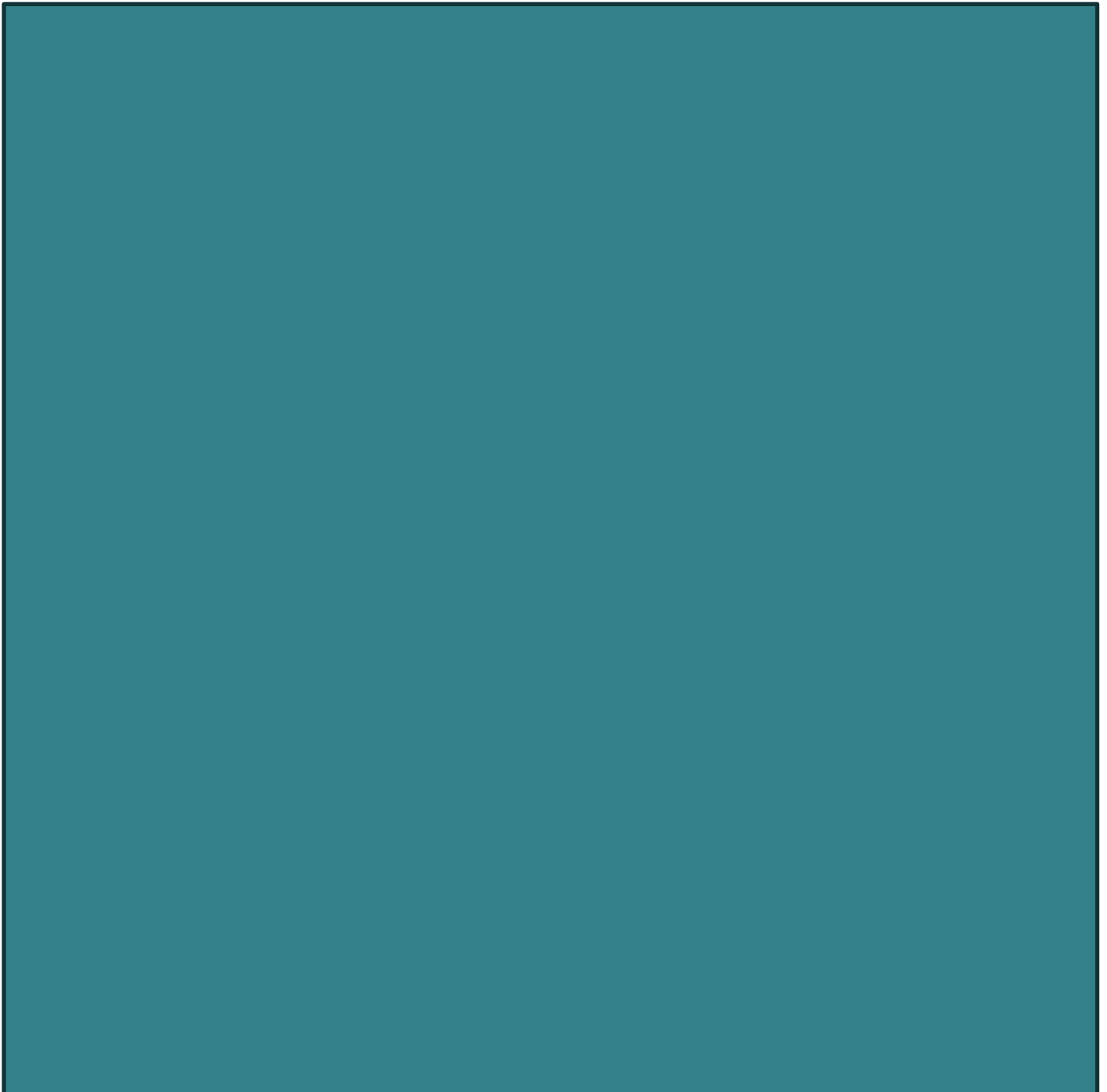
**Department of Health, Disability and Ageing**

# **Outreach Programs Service Delivery Standards**

**First Nations Health Outreach Services Program**

**Eye and Ear Surgical Support Program**

**Visiting Optometrists Scheme**





## **Versions:**

**Issued:** 20 October 2020

### **Amendment No.1:** December 2021

- Inclusion of eligibility to provides services to First Nations patients in Modified Monash (MM)1 locations under the Visiting Optometrists Scheme (VOS).
- Inclusion of an additional Travel Time Allowance under the VOS.
- Added definition of private vehicle in the glossary and clarification of use of private vehicle.
- Clarified Backfilling in the glossary.
- Clarified eligibility for Host Facility Fees.
- Expanded Workforce Support Payments.

### **Amendment No. 2:** March 2024

- 'Aboriginal and Torres Strait Islander' people replaced by 'First Nations' people.
- Minor editorial changes to improve overall readability, including updating of broken web links.

Updated wording and new sections added to reflect recommendations from the Outreach Evaluation Report and stakeholder feedback:

- New Sections 2.2 (Reporting) and 4.9 (Program administration costs for Fundholders)
- Section 3.2: Updated wording on Outreach Advisory Forum members and observers.
- Section 3.3: Updated wording on Outreach Advisory Forum Chair
- Section 4.1: Updated wording to include Aboriginal Community Controlled Health Services as preferred providers for First Nations people.
- Section 4.8: Updated Eligible Activities
- Section 5.2: Simplified wording for Hire cars.
- Section 5.4: Removed requirement for Department approval.
- Section 5.5: Removed requirement for Department approval.
- Section 5.8: Removed requirement for Department approval for Workforce Support Payment considerations.
- Glossary: added definition of Value for Money.

### **Amendment No. 3:** June 2026

- Removed references to the Medical Outreach Indigenous Chronic Disease Program.
- Removed references to the Healthy Ears – Better Hearing Better Listening (Healthy Ears) Program.
- Included the First Nations Health Outreach Services (FNHOS) Program.
- Minor editorial changes to improve the readability.
- Section 1: Outreach Program Overview has been updated to provide greater clarity.

Updated wording to align language with the Rural Health Outreach Fund's Service Delivery Standards:

- Section 2: Updated wording on Fundholders requirements and responsibilities.
- Section 3.1: Minor wording updated wording on Outreach Advisory Forum.
- Section 3.2: Minor wording update on Outreach Advisory Forum members and observers.
- Section 4.1: Minor wording update on Culturally appropriate service delivery.
- Section 5.2: Updated wording on Travel, meals and accommodation costs for visiting Health Professionals.
- Section 5.2.2: Updated wording on Hire Care.
- Section 5.7: Minor wording update on Hospital services.
- Section 5.8.1: Updated wording on Administrative support.
- Section 5.8.7: Updated wording on Workforce support.
- Section 5.8.9: Updated wording on Upskilling.
- Section 5.8.11: Updated wording on Telemedicine and eHealth.
- New Section 5.8.13 Active response to national, health, or natural emergency.

Sections were reordered to align with the Rural Health Outreach Fund's Service Delivery Standards:

- Section 4.4 moved to 4.2.1 Who can propose a service?
- Section 4.5 moved to 4.2.2 How proposals should be assessed.
- Section 4.6 moved to 4.4 Models of care.
- Section 4.7 moved to 4.5 Eligible locations.
- Section 4.7.1 became 4.5.1 VOS patients in MM1 locations.
- Section 4.8 moved to 4.6 Eligible Activities.
- Section 4.9 moved to 4.8 Program administration costs for Fundholders.
- Section 4.10 moved to 4.7 Ineligible activities.

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# 1. Outreach Programs Overview

The Australian Government's Outreach Programs were established to improve access to medical specialists, general practitioners (GPs) and allied and other health providers to address the high need for health services in regional, rural and remote Australia. This is supported by a range of targeted rural health programs and activities. These targeted activities will link with the broader ongoing health reform agenda to develop an integrated health service where local services and outreach services work together to provide communities with the range of services required to remain vital and viable.

The Outreach Programs included in these Service Delivery Standards focus on outreach health service delivery for First Nations people.

The Indigenous Australians' Health Programme (IAHP) contributes to the [National Agreement on Closing the Gap](#) Outcome 1 - *First Nations people enjoy long and healthy lives* by providing First Nations people with access to effective high quality, comprehensive, culturally appropriate, primary health care services across Australia. The IAHP funds the following Outreach Programs:

- **First Nations Health Outreach Services Program (FNHOS)**

Increases access to a range of health services including:

- expanded primary care for First Nations people of all ages for the prevention, diagnosis and management of chronic disease, where chronic disease is defined as 'a condition that has been (or is likely to be) present for six months or longer', and
- expanded primary care for First Nations children and youth (0-21 years) for the diagnosis, treatment and management of ear and hearing health conditions

MM1 – MM7 locations are eligible for FNHOS chronic disease services. MM2 – MM7 locations are eligible for FNHOS ear health services.

- **Eye and Ear Surgical Support Program (EESS)**

Expedites access to surgical interventions to support First Nations people who require eye surgery or ear surgery for conditions resulting from Otitis Media. Patients who reside in MM3 – MM7 locations are eligible for EESS services.

The Medicare Services Special Appropriation funds the:

- **Visiting Optometrists Scheme (VOS)**

Increases access to optometry services for people living in regional, rural and remote locations. This arrangement has been in operation since 1975 and is enabled under section 129A of the *Health Insurance Act 1973*. MM2 – MM7 locations are eligible for VOS services. Services for First Nations patients may also be provided in MM1 locations (refer to clause 4.7.1).

The VOS is made up of an Indigenous and non-Indigenous component with the Indigenous component making up 40% of the total annual funding allocation in each jurisdiction.

## 2. The Fundholders

The Outreach Programs are delivered by an approved organisation in each jurisdiction, contracted by the Commonwealth Department of Health, Disability and Ageing (the department). These organisations are referred to as the Fundholders.

All fundholders are required to:

1. Deliver the activities meeting the terms and conditions outlined in their individual Standard Grant Agreements for each Outreach Program and the Outreach Program Service Delivery Standards.

2. Embed co-design, where appropriate, and shared decision-making with First Nations people into program governance and delivery of culturally safe services that respond to the needs of First Nations people.
3. Undertake a detailed needs assessment or undertake service planning in line with current and relevant needs assessments to identify service delivery gaps for specific populations to support provision of services where most needed.
4. Engage with local communities to ensure coordination of services.
5. Manage the recruitment and retention of outreach Health Professionals.
6. Maintain an internal administrative unit.
7. Maintain records and data to inform reporting deliverables.

Other responsibilities will include but not be limited to:

- development and implementation of a strategic service plan that covers the duration of the grant agreement
- accurate collection, collation and appropriate analysis of data, and provision of this data to the department
- monitoring, management and fulfilment of all reporting obligations
- development and application of strategies to recruit and retain health professionals
- administration of payments to participating health professionals in accordance with services provided
- verification of service delivery following receipt of invoices
- communication with members of the medical community and the public to inform them about First Nations-specific outreach services
- development and implementation of strategies to market and educate the public and the health care sector about First Nations-specific outreach services
- working with locally based service providers including Primary Health Networks and Local Health Services to ensure details of outreach visits are known, access to services is maximised and barriers to care (e.g., procedures/surgery) are identified and addressed
- ensuring health professionals provide culturally appropriate services
- providing assistance with upskilling sessions to health care professionals as required
- planning and supporting effective coordination of service delivery at the community level
- undertaking other activities necessary for the proper operation of First Nations-specific outreach services.

## 2.1 Needs Assessment

Each Fundholder must undertake an annual Needs Assessment or health service planning to identify the priority health needs and priority locations within their jurisdiction. In undertaking the Needs Assessment, Fundholders must consult broadly and ensure the views and expertise of First Nations people, communities and organisations are an integral part of the process.

Shared decision-making structures already exist and many of these have been developed by First Nations people. Fundholders should use existing mechanisms and build new partnerships to inform needs assessment.

The following groups must be consulted as part of the Needs Assessment / health service planning:

- [First Nations Health Peak Organisations](#);
- Aboriginal Community Controlled Health Services (ACCHS);
- Aboriginal Medical Services (AMS);
- Primary Health Networks (PHN);
- hospitals and mainstream health services; and

- community-based services.

Fundholders must also:

- create a mechanism where health services and communities can propose required services;
- promote the availability of outreach services broadly within their jurisdiction; and
- make publicly available the outcomes of the Needs Assessment.

## 2.2 Reporting

Fundholders should provide host organisations, communities, [First Nations Health Peak Organisations](#), and other key stakeholders via their jurisdictional Outreach Advisory Forum (Section 3 refers) with an annual report of systems level insight into the outreach services provided in their jurisdictions. The annual report should include, but is not limited to:

- utilisation of funds;
- number of First Nations people who received outreach services for that reporting period;
- feedback received from consumers and practitioners on the outreach services; and
- any sensitivities/issues experienced during the reporting period (including risk management, if appropriate).

Annual reports will provide host organisations and communities with greater data transparency and information sharing capability to enable rigorous review and program improvement. These reports should also be made publicly available as electronic versions.

## 3. Governance

### 3.1 Outreach Advisory Forum

Each Fundholder must establish a jurisdictionally based consultative committee known as the Outreach Advisory Forum.

The principal role for each Advisory Forum is to:

- provide feedback on the Needs Assessment process and whether it has adequately consulted with key stakeholders in the jurisdiction;
- provide advice on the annual Needs Assessment and health service planning models proposed by the Fundholder;
- identify linkages with the planning mechanisms of other programs within the jurisdiction to explore possibilities for integrated program implementation, including a focus on linkages with tertiary services;
- advise whether the proposed priority locations identified by the Fundholder have the capacity and infrastructure to support the proposed service;
- advise if service proposals deliver value for money; and
- endorse the Activity Work Plan for the activity period.

While the Fundholder is the final decision maker on which services to prioritise in its Service Delivery Plan, recommendations and advice from Advisory Forum members must be considered.

Where Advisory Forum members do not agree with decisions made by the Fundholder, the differences of opinion must be documented and presented to the department with justification for the decision taken.

Advisory Forum membership and decisions of the Advisory Forum must be made public.

Information about other known Fundholders and relevant contacts should be made available upon request, particularly where more than one organisation is delivering grant-approved Outreach Programs in any state or territory.

## 3.2 Outreach Advisory Forum members and observers

The Advisory Forum must include appropriate representation of experienced people capable of giving advice, recommendations or counsel in connection with outreach health service delivery in their jurisdiction. This must include First Nations people.

Membership is facilitated by the Fundholder(s) and must include a range of stakeholders and representatives from:

- [First Nations Health Peak Organisations](#);
- State/Territory health authorities;
- Relevant health professional peak bodies or representatives;
- PHNs; and
- other health services, local hospitals, community-based services and local communities, if relevant.

Where expertise from specific Health Professionals would enhance decision making, consideration should be given to mechanisms to include input from that profession.

A representative/s of the department and/or Funding Arrangement Managers (FAMs) from the Community Grants Hub may attend meetings of the Advisory Forum as observers or invited guests of the Fundholder to provide a Commonwealth perspective.

In jurisdictions with multiple Fundholders for the Outreach Programs, Fundholders should consider establishing a single shared Advisory Forum to assist with coordinating needs assessments and service planning across the jurisdiction.

## 3.3 Outreach Advisory Forum Chair

An independent Chair and the relevant First Nations health peak body for the jurisdiction should be invited to co-chair the Outreach Advisory Forum.

State or territory Fundholders may choose not to nominate a specified chairperson where arrangements for a shared advisory forum exist to coordinate fair and reciprocal decision making. The objectives of the Outreach Advisory Forum should be consistent with the points of reference described in Section 3.1.

## 3.4 Administration of the Outreach Advisory Forum

The Advisory Forum/s must meet at least annually, with additional meetings held as needed. Alternative meeting arrangements, such as by video/teleconference, are acceptable.

The Fundholder will provide secretariat support. Responsibilities include:

- establishment of the committee, ensuring an appropriate mix of key stakeholders;
- providing support for the nominated co-chairs;
- organising and documenting meetings;
- managing any follow up activities.

# 4. Service Eligibility

## 4.1 Culturally appropriate service delivery

Cultural Awareness and Safety Training: All Health Professionals providing services to First Nations patients through Outreach Programs must verify that they have undertaken appropriate Cultural Awareness and Safety Training prior to commencing service delivery. The Fundholder will be responsible

for verifying and/or arranging this training and ensure it is acceptable to organisations receiving outreach services.

Fundholders will consult with the relevant [First Nations Health Peak Organisation](#) to identify appropriate cultural awareness training for locations within the jurisdiction and consider the development of Reconciliation Action Plans and formal partnerships, agreements, or memorandums of understanding with First Nations organisations.

Fundholders must embed culturally appropriate practices in their delivery of outreach services to First Nations people. This includes culturally appropriate information given to patients about the health service being provided, including choices/options of care and financial implications of any agreement (e.g. costs attributed to the Low-Cost Spectacle Scheme).

Under the National Agreement on Closing the Gap, Australian Governments have acknowledged that ACCHS are often preferred providers of primary health care for Aboriginal and Torres Strait Islander communities. As such, where capacity allows, ACCHS should be seen as preferred providers of Outreach Programs.

## 4.2 Services to be provided under Outreach Programs

Effective health service planning is required to ensure the objectives of the programs are met. The Outreach Programs will build on existing services and establish new services in locations of greatest need, consistent with the aims of individual programs. Service types of greatest need will be prioritised.

Outreach Programs should complement services provided by State and Territory governments or other providers/ funders. Fundholders must work with host organisations when scheduling outreach visits to ensure convenient timing of visits, seek synergies with existing services to maximise the benefit of the outreach visit, and limit overlap/duplication of services being provided in communities.

### 4.2.1 Who can propose a service?

Service proposals will be considered by the Fundholder in line with the outcomes of the Needs Assessment and advice from the Advisory Forum. Any interested Health Professional can submit a proposal for the delivery of outreach health services in areas of need identified by the Fundholder.

In areas where workforce availability is limited, Fundholders should seek workforce from outside their jurisdiction.

Fundholders are responsible for promoting Outreach Programs, seeking proposals, and informing applicants of the outcome of their proposal.

### 4.2.2 How proposals should be assessed

The Service Matrix scorecard at Attachment A can be used as a guide to identify service proposals that address areas of greatest need. Key considerations include that the service proposal:

- is in line with the aim and objectives of the relevant Outreach Program;
- addresses high community need for the service;
- demonstrates cultural appropriateness;
- complements existing service levels or addresses a shortfall or gap within the community;
- takes account of local workforce and infrastructure that will support the service;
- links with other State, Territory or Australian Government health programs;
- offers bulk billing;
- demonstrates value for money when compared with other potential similar services.

## 4.3 Health Professionals supported by the Outreach Programs

Funding for Outreach Programs can be used to support a range of appropriately qualified Health Professionals. Health Professionals include those working in primary, secondary and tertiary health (refer to glossary).

All Health Professionals providing services through the Outreach Programs must maintain the following:

- appropriate qualifications, registration and/or license and insurance to practise in their profession both individually and in their area of speciality, if appropriate;
- unique Medicare provider numbers that will enable them to claim under the Medicare Benefits Schedule (MBS);
- cultural awareness and safety training that is locally relevant, as specified at section 4.1;
- Working with Children check [where applicable];
- Working With Vulnerable People registration for the jurisdiction in which services are delivered; and
- compliance with child safety requirements consistent with the Commonwealth Child Safe Framework.

The activity delivered must be directly related to outreach health services and not be for research or other purposes.

On request, evidence of the above must be made available to the host facility before outreach health services are provided.

Services should be delivered in accordance with relevant clinical guidelines. For example, the 2020 [Otitis Media Guidelines for Aboriginal and Torres Strait Islander Children](#).

## 4.4 Models of care

A range of flexible outreach service delivery models may be used, such as:

Individual Outreach: service provision provided to eligible communities by Health Professionals travelling to these locations from a larger town/city.

Cluster: service provision to multiple communities from a variety of Health Professionals located in different communities within the cluster. Coordination is paramount in this model to ensure a united approach to care.

Hub and spoke: service provision provided both in a central town and the Health Professionals travelling to remote communities.

Telehealth: service provision provided through telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers.

Where feasible, a multidisciplinary team approach is the recommended service model to increase efficiencies. All services should be coordinated to ensure effective care pathways for patients.

Outreach Health Professionals must work with the local health service to embed their service delivery in existing structures including, but not limited to, the patient information and recall system used by the health service.

Issues relating to the coordination and continuity of care of patients, sequencing of visits, managing the impact on the community and costs related to travel must be considered when planning services.

## 4.5 Eligible locations

The department uses the Modified Monash (MM) Model classification system for service locations across Australia. A map detailing the different MM classifications can be found on the [Doctor Connect website](#). Whilst MM3 - MM7 locations are to be prioritised for some Outreach Programs, others allow for services in MM1 and MM2 locations. Please refer to Section 1 of this document for individual program specifications.

Fundholders from different jurisdictions may work together to fund and provide services across State and Territory boundaries, where appropriate.

#### 4.5.1 VOS patients in MM1 locations

In recognition of the need for culturally safe and responsive health care services for First Nations people, VOS funded outreach services may be provided in major cities (MM1), provided that the service is delivered in an Aboriginal Medical Service, Aboriginal Community Controlled Health Organisation or other culturally safe/appropriate host organisation.

Fundholders should also consider other options for providing culturally safe and responsive health care services for First Nations patients in MM1 locations.

### 4.6 Eligible Activities

In addition to provision of clinical services for patients, funding can be used for:

- coordination and administration of these services;
- travel costs, accommodation and meals/incidentals for visiting Health Professionals;
- equipment lease;
- host facility fees;
- upskilling / training associated with the outreach visit;
- cultural awareness training for non-salaried private providers;
- orientation to communities;
- professional support associated with outreach services;
- program administration costs for Fundholders (see Section 4.8);
- marketing, health promotion and activities to raise public awareness of outreach services;
- hospital services limited to surgical support services provided under the EESS program only (Fundholders should refer to their Standard Grant Agreement for additional information on eligible EESS expenditure);
- insurance for Health Professionals to provide the outreach services;
- development and implementation of patient experience markers, engagement (e.g. infrastructure, yarning circles, outreach forums) and outcome measures (e.g. surveys, focus groups, interviews).

Section 5 provides details on the types of expenses supported in these categories.

### 4.7 Ineligible activities

Funding may not be used to support:

- hospital services outside of those listed at Section 5.7;
- salaries for Health Professionals (other than the support payment arrangements outlined at Section 5.8);
- elective cosmetic surgery;
- dental treatment/s;
- stand-alone training;
- research activities;
- alternative/complementary health services – for example Chinese Medicine, reflexology;
- capital expenditure;
- the covering of retrospective costs;
- purchase of land;
- overseas travel;

- purchase of medical equipment outside of the VOS exemption at Section 5.5; and
- purchase or leasing of a motor vehicle.

## 4.8 Program administration costs for Fundholders

The maximum allowable administration cost is 15% of the annual funding allocation. This can include, but is not limited to:

- salaries/wages and on-costs for administrative staff;
- accounting/auditing fees;
- communications and IT;
- utilities;
- online planning/administration tools;
- logistics, practice management and scheduling software for the purpose of outreach services;
- venue/room hire for education and upskilling events related to outreach services.

This list is not exhaustive but aims to provide guidance around eligible administration costs. Any queries should be directed to the department.

## 5. Expenses Supported by Outreach Programs

The Fundholder will determine which expenses will be paid, using these Service Delivery Standards as a guide.

### 5.1 Orientation to the outreach location

Orientation to the outreach location is an essential element of Outreach Programs. Orientation visits to each new location for each new health provider (excluding students) will be supported under Outreach Programs. Orientation visits should include a briefing on cultural protocols specific to the community. Travel and Travel Time Allowance payments will be available for orientation visits.

### 5.2 Travel, meals and accommodation costs for visiting Health Professionals

Outreach Programs will cover the cost of travel by the most efficient and cost-effective means to and from the outreach service location. This may include commercial air, bus or train fares, charter flights, and/or expenses personally incurred by a Health Professional associated with the use of a private vehicle as per the national rates accepted by the Australian Taxation Office (ATO) for the current financial year. Other incidental costs such as fuel for hire cars, parking and taxi fares may also be covered in line with accepted and current ATO rates. The current ATO rates can be found on ATO website at <http://www.ato.gov.au/>.

#### 5.2.1 Air

Flights will be paid at the economy class level. Use of private aircraft will be considered. However, if a commercial flight services the location, reimbursement will be capped at the economy flight cost, whichever is the lesser.

#### 5.2.2 Hire car

If road travel is the most cost-effective option, the visiting Health Professional may elect to travel to and from the outreach location by a self-drive hire car.

Fuel costs for a hire car, parking and taxi fares should be paid on a cost recovery basis where appropriate. Fuel allowances payable for a hire car are outlined on the ATO website via [www.ato.gov.au](http://www.ato.gov.au). Parking and taxi fares are paid on a cost recovery basis only.

### 5.2.3 Accommodation

Accommodation will be paid in accordance with the rates considered reasonable and published annually by the ATO in a Taxation Determination. As accommodation in some locations may be more expensive due to seasonal variations, or if suitable accommodation is scarce, consideration should be given to paying higher rates on a case-by-case basis. Accommodation rates can be accessed via the ATO website at: <https://www.ato.gov.au/>

### 5.2.4 Meals and Incidentals

Meals and incidentals for visiting Health Professionals and approved accompanying staff may be paid in accordance with the rates considered reasonable and published annually by the ATO in a Taxation Determination. Rates can be accessed via the ATO website at: <https://www.ato.gov.au/>

Please note the incidental allowance payments are only payable for the second and any subsequent days of a visit at the outreach location. Breakfast on the first day and dinner on the last day of outreach visits are not payable. The meals and incidental allowances payable can be accessed via the ATO website at: <https://www.ato.gov.au/>.

## 5.3 Travel, meals and accommodation costs associated with the EESS program

EESS program funding can be used to support the transport of the patient and one carer from MM3 to MM7 locations into regional/ metropolitan centres for eye or ear surgical treatment. The cost of meals and accommodation for the patient and their carer will also be supported.

Where possible, transport should be provided for multiple patients and carers collectively.

## 5.4 Equipment lease

Fundholders may consider equipment lease arrangements for the delivery of outreach services. All lease arrangements must include a budget for replacement parts and maintenance to ensure equipment meets required standards. The period of the lease may not exceed the end date of the contract the Fundholder has with the Health Professional. Fundholders should consider the following when assessing requests to lease equipment:

- type of equipment;
- availability of equipment in the area to receive the services;
- how often services are to be provided;
- impact on the relevant Outreach Program budget.

## 5.5 Equipment purchase

Fundholders may consider the purchase and maintenance of equipment **under the VOS only**.

Fundholders should consider the following when assessing requests for purchasing (and maintaining) equipment:

- type of equipment;
- availability of equipment in the area to receive services;
- ability to lease equipment;
- how often services are to be provided;
- ability for the equipment to be maintained;
- impact on the overall VOS budget.

The cost of transportation of equipment (on commercial transport) for use by the Health Professionals delivering services through other Outreach Programs may be considered.

## 5.6 Host facility fees

Fees incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. The suggested maximum facility fee payable for any venue is \$200 per day (GST exclusive). However, as suitable facilities in some locations may be more expensive due to seasonal variations, or availability, consideration can be given by the Fundholder to paying a higher rate on a case-by-case basis.

To be eligible for Host Facility Fees, the venue or facility used to support outreach service provision must be separate to an organisation engaged to deliver outreach services.

## 5.7 Hospital services

Hospital services are limited to surgical support services provided **under the EESS program only** and refer to clinical services that take place in a hospital. Additional information on eligible EESS expenditure can be found at Section 5.3 and in the Standard Grant Agreement. Funding cannot be used to cover the cost of surgery. Health Professionals must bill Medicare.

The provision of all other hospital services to public patients is the responsibility of State/Territory governments under the National Health Reform Agreement and will not be met through the Outreach Programs.

Any proposed arrangement outside of these parameters must be approved by the department in line with Special Arrangements, as outlined below.

## 5.8 Support payments for visiting Health Professionals

### 5.8.1 Administrative support

Participating Health Professionals may receive funding for administrative costs associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients at the outreach location.

Outreach Programs may cover the cost of administrative support for up to the same working hours (consultations/treatment time) as those hours undertaken by the visiting Health Professional. The rate payable for administrative support should be equivalent to the hourly rate paid for administrative support using the State or Territory of the service at a grade 2 or 3 level, depending on the complexity of the work.

Administrative support staff will not be funded during the time the visiting Health Professional provides upskilling to local Health Professionals.

Any person providing assistance to visiting Health Professionals is engaged under an arrangement with the Fundholder, host service, or visiting service provider, and has no claim as an employee of the Australian Government. The Australian Government will not cover any costs associated with employment and/ or termination of administrative support staff.

### 5.8.2 Registrars, technical staff and accompanying Health Professionals' assistants

Backfilling, travel costs, accommodation, meals and incidentals, for accompanying staff with specific technical skills/qualifications required to assist with procedures will be considered only where such personnel are not available locally.

It is preferred that, where possible, staff are recruited locally and upskilled if needed.

### 5.8.3 Allied health and optometry students

To support sustainable rural and remote allied health and optometry services, travel costs, accommodation, meals and incidentals can be provided for students wishing to gain exposure to outreach service provision by accompanying outreach funded Health Professionals during visits.

Learning objectives must be clearly defined. The Fundholder will negotiate arrangements with the principal outreach provider prior to undertaking services, taking account of efficient use of overall program funds.

#### 5.8.4 Cultural training and orientation

In recognition of the diverse cultural environments in which visiting Health Professionals may be required to work, the Outreach Programs may provide funding for cultural training and orientation for Health Professionals who provide outreach services. The method of delivery is flexible and may take the form of a formal cultural awareness course provided by facilitators/presenters and/or self-learning cultural awareness education program.

Non-salaried private Health Professionals providing outreach services may claim Travel Time Allowance for the time they attend cultural training and orientation.

#### 5.8.5 Travel Time Allowance

An allowance is payable to non-salaried private Health Professionals and accompanying registrars to compensate for loss of business opportunity due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling.

The hourly rate payable is consistent with the fee-for-service hourly rates paid by the relevant State/Territory government, area health service or local hospital (depending on the organisational level at which these payments are established in the State/Territory).

#### 5.8.6 Travel Time Allowance under the VOS

To compensate for time spent travelling to and from an outreach location to deliver VOS supported services, an allowance is payable for salaried optometrists employed by private/non-government organisations delivering VOS services.

The suggested hourly rate payable is three times the current rate paid for Medical Benefits Schedule Item 10910 (Initial consultation), but Fundholders have discretion to determine the rate they pay. Value for money must be considered.

#### 5.8.7 Workforce support

Under exceptional circumstances, financial support (at sessional rates) may be available to private Health Professionals (including allied Health Professionals). Workforce support payments should be prioritised in MMM3 to MMM7 locations and must only be used as a last resort where services would otherwise not be provided.

A workforce support payment may be paid in circumstances where access to MBS payments are not assured or patient attendance at appointments is uncertain.

Medical professionals who receive a workforce support payment are also eligible to receive payments such as the Travel Time Allowance.

Visiting Health Professionals who accept a workforce support payment will generally be precluded from claiming MBS payment for the delivery of services for the same clinical session. Any proposed arrangement outside of these parameters must be approved by the department.

Fundholders must consider the impact on the relevant Outreach Program budget when assessing the use of workforce support payments in lieu of usual MBS payments for Health Professionals. Prior to making any decision in relation to a workforce support payment, Fundholders should consider the comments and recommendations from the relevant jurisdictional Advisory Forum.

#### 5.8.8 Backfilling and locum support for salaried Health Professionals

The cost of backfilling salaried Health Professionals who provide outreach services may be covered however, any claims made against the MBS by salaried Health Professionals for outreach services would render void any claim to cover backfilling costs.

An optometrist providing outreach services may be eligible to receive locum support for the principal practice to a maximum of 600 hours annually. Locum support will be based on evidence of costs incurred.

### 5.8.9 Upskilling

Upskilling supports building a sustainable health workforce in regional, rural and remote locations and improves health outcomes in those communities.

Where possible and appropriate, outreach Health Professionals should provide educational and upskilling activities, of either a theoretical or clinical nature, to local medical and Health Professionals and, where appropriate, other members of the public (such as carers). Arrangements for formal upskilling activities must be developed in consultation with local Health Professionals and aim to complement existing training arrangements within the area.

Funding may be provided for supported procedural and non-procedural upskilling. The cost of the venue/facility/room hire can also be covered.

Outreach Programs will not cover the cost of allocation of points for Continuing Professional Development.

In addition, non-salaried private Health Professionals may claim an hourly rate which is consistent with the applicable fee-for-service rates for the time required to present the agreed upskilling activity.

Upskilling cannot be supported as a “stand alone” activity.

### 5.8.10 Professional Support

Professional support means the informal support provided by the visiting Health Professionals to local medical and Health Professionals through, for example, lunchtime meetings and/or telephone/email support once the Health Professional has returned to their principal practice.

Non-salaried private Health Professionals may claim an hourly rate for providing professional support which is consistent with the fee-for-service rates paid by the relevant State/Territory government, area health service or local hospital (depending on the organisational level at which these payments are established in the State/Territory).

### 5.8.11 Telemedicine and eHealth

The use of telemedicine services as a supplement to usual face-to-face consultations between patients and Health Professionals is supported through Outreach Programs. This includes the cost of venue and equipment hire associated with consultations using this medium.

The department encourages the use of eHealth initiatives (e.g. My Health Record) and access to and use of video conferencing for patient consultations when clinically and culturally appropriate to support continuity of care.

Other telehealth service costs will be considered by the department on a case-by-case basis in line with Special Arrangements, as outlined below.

### 5.8.12 Special arrangements

Fundholders may negotiate with the department for funding to be provided under special arrangements to guarantee service delivery in priority locations. These special arrangements may include costs that fall outside allowances included in these Outreach Programs Service Delivery Standards, but that are required to ensure service delivery to First Nations people.

All requests to use special arrangements payments must be submitted to the department for approval. They will be considered on a case-by-case basis.

### 5.8.13 Active response to national, health, or natural emergency

Fundholders may adapt models of care or flexibly apply other elements of their program delivery to ensure patient accessibility to essential health services is maintained during periods active response to national, health, or natural emergency.

Prior to making any decision in relation to changes to models of care or program delivery, Fundholders should consider the comments and recommendations from the relevant jurisdictional Advisory Forum with a focus on tailoring adaptations to suit the needs of the communities impacted by the emergency.

Any proposed arrangement significantly outside of the parameters outlined in the Service Delivery Standards must be approved by the department.

# Attachment A

## The Service Matrix

Service Proposed.....

Service Location.....

Outreach Program.....

Date of Consideration.....

Score .....

Recommendation: **Service Supported / Not supported**

	Criterion	Score	5 Excellent	4 Very Good	3 Acceptable	2 Marginal	0 Not acceptable
1	Is identified as high medical need in the community		High need	High to medium need	Medium to low need	Low need	Not required
2	Local workforce and facilities can support any treatment performed / provided		Highly able to be supported	Mostly able to be supported	Some capacity to be supported	Low capacity to be supported	Not able to be supported
3	Increases access to Health Professionals for local and regional residents		Maximum increase in access	High increase in access	Medium increase in access	Some increase in access	No increase in access
4	Has linkages with other state/ territory and Australian Government health service programs in the region		Multiple linkages	Many linkages	Some linkages	Few linkages	No linkages
5	Service provider identified		Provider identified and agreed to commence	Provider approached	Provider targeted	Search commenced	No search commenced
6	Support from all medical professionals in the region		Fully supported	Mostly supported	Under negotiation	Not really supported	No support apparent
7	Provider has capacity to meet the requirements of the Outreach Program		Full capacity	Full capacity but may need assistance	Some capacity	Partial capacity	No capacity
8	Provides value for money		Outstanding in all respects	Well met and has additional factors that set it apart	Well met	Partially met	Not met
9	Demonstrates cultural safety and appropriateness e.g. embedded effective health literacy practices into service delivery		Highly engaged	Local linkages and sound strategies	Some linkages and specified strategies	A few culturally appropriate materials and linkages	Not met
	<b>Total</b>						

## Glossary

This table provides a definition of terms applicable to any document associated with the administration of the relevant Outreach Program.

Administration costs	Payments to cover the costs of administration directly related to the provision of patient services including reception duties, organising appointments, processing of correspondence, typing of referral letters and making hospital bookings etc.
Advisory Forum	State/Territory based committee that provides advice to the Fundholder on how best to deploy resources, determine priorities in project plans, and the suitability of services being proposed for funding under the Outreach Programs.
Backfilling	Short-term relief of a position vacated by a Health Professional who is providing approved outreach services.
Chronic disease	Chronic disease is defined as 'a condition that has been (or is likely to be) present for six months or longer'.
General practitioner	A duly licensed medically qualified person. This term is used interchangeably with Medical Practitioner.
Health Professional	A general term for a person with tertiary qualifications working in primary, secondary or tertiary care. e.g. doctor, dietician, nurse, pharmacist, physiotherapist, psychologist, surgeon etc.
Hospital services	Applies to clinical services provided in a hospital. See MBS online: <a href="http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home">http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home</a>
Modified Monash Model	The Modified Monash Model (MMM) defines an area according to geographical remoteness and town size. The model measures on a scale of Modified Monash (MM) category MM1 to MM7. MM1 is a major city and MM7 is very remote.
Multidisciplinary teams	A team of Health Professionals from a range of disciplines in primary, secondary and tertiary care working together to deliver comprehensive health care. Commonly includes medical, nursing and allied health professionals. The composition of multidisciplinary teams will vary depending on the health and treatment needs of communities and individual patients.
Need	Need includes consideration of issues such as the burden of disease, level of disadvantage, services currently available locally, linkages and integration with other services and effect on local planning and initiatives.
Outreach service	Where a Health Professional provides services in a location that is not the location of their principal practice.
Primary care	The primary care Health Professional is usually the first point of medical consultation. This includes general practitioners, family physicians, nurse practitioners, Aboriginal Health Workers and physician assistants.
Private car	Any private vehicle used by a Health Professional to deliver outreach services. A private vehicle may include a company car provided by a Health Professional's workplace.
Professional support	Informal support provided by the visiting Health Professional once the Health Professional has returned to their main practice. For example: <ul style="list-style-type: none"> <li>informal discussions/telephone conversations/meetings with general practitioners for specific patient management; or</li> <li>support for the general practitioner and specialist e.g. seeing the patient together.</li> </ul>

Registrar	Medical registrars are either “basic trainees” or “advanced trainees”. Basic trainees have generally completed at least two post-graduate years in hospital practice (usually more), but have not completed any specialty exams. Advanced trainees have completed at least four post-graduate years (usually more), and are undertaking advanced training in general medicine (internal) or in a particular sub-specialty. On the successful completion of their training, they will have met the requirements for fellowship of the relevant specialist college. All registrars require support/supervision from an appropriately qualified supervisor.
Secondary care	Care provided by medical specialists, for example, cardiologist, rheumatologist, urologist or other specialty physician. Also includes care provided by physical therapists, respiratory therapists, speech therapists, occupational therapists and other allied Health Professionals.
Service/location	A single town or community where a Health Professional (i.e. any individual medical specialist, GP, nurse and/or allied Health Professional) provides a consultation at an approved location.
Session	A period of time, usually 3.5 – 4.0 hours.
Specialist	A medical practitioner who: <ul style="list-style-type: none"> <li>• is registered as a specialist under national law; or</li> <li>• holds a fellowship of a recognised specialist college; or</li> <li>• is considered eligible for recognition as a specialist or consultant physician by a specialist recognition advisory committee.</li> </ul>
Tertiary care	Treatment requiring a higher level of specialised care, usually in a hospital. For example, care provided by surgeons.
Travel Time Allowance	A payment made to non-salaried private Health Professionals for the time spent travelling to and from a location where they are providing approved outreach services and/or upskilling.
Upskilling	Training in a clinical or practical context. Upskilling is provided by the visiting Health Professional and may be structured or unstructured. Examples include: <ul style="list-style-type: none"> <li>• state-wide programs for both procedural and non-procedural training in a clinical or practical context;</li> <li>• after hours meeting where the Health Professional’s knowledge is shared with general practitioners, other Health Professionals and carers/community members where appropriate.</li> </ul>
Value for money	A measure that evaluates an investment (of monetary value, time or resources) to be of good value to the program. Fundholders should weigh an assessment of costs against an assessment of outcomes for each investment.

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