## Gippsland PHN

# Integrated Team Care Program

## PROGRAM GUIDELINES

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## 1. Purpose of the Operational Guidelines

The purpose of the Operational Guidelines is to provide operational advice, expectations and guidance and should be read with reference to the Service Order for the delivery of the Gippsland PHN Integrated Team Care Program and the Gippsland PHN Commissioned Services Program Guidelines.

The Guidelines are not intended to be the only source of guidance for clinicians, nor should they take precedence over state or federal policy, which is subject to change. The Guidelines should be followed subject to the clinician's judgement in each individual case.

## 2. Program summary

The Integrated Team Care Program (ITC) (and its predecessors the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs) was established to help Aboriginal and Torres Strait Islander people with complex chronic diseases unable to effectively manage their conditions through access to one-on-one assistance by Care Coordinators. Since the establishment of the ITC, the provision of care coordination, expediting access to necessary services, and developing care pathways and service linkages has resulted in an improved quality of life for clients enrolled on the program.

## 3. Aims and objectives

### 3.1 Program aims:

- contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through access to care coordination, multidisciplinary care, and support for self-management; and
- improve access to culturally appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people.

### 3.2 Program objectives:

- contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people enrolled on the program;
- improve access to appropriate health care through care coordination and provision of supplementary services for eligible Aboriginal and Torres Strait Islander people with chronic disease;
- foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sector;
- improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people; and
- increase the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Health Assessments for Aboriginal and Torres Strait Islander people and follow up items.

## 4. Program Scope

The ITC Program is provided by a team consisting of an Indigenous Health Project Officer(s) (IHPOs), Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers) and Care Coordinators.

The team works in the Gippsland PHN region, across the Indigenous and mainstream primary care sectors, to assist Aboriginal and Torres Strait Islander people to obtain primary health care as required, provide care coordination services to eligible Aboriginal and Torres Strait Islander people with chronic disease/s who require coordinated, multidisciplinary care, and improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care.

### 4.1. Systems approach:

Gippsland PHN undertakes the role of the **Indigenous Health Project Officer** providing leadership within the Gippsland region. As regional leaders there is a focus on Indigenous health and aim to improve the integration of care across the region. This work includes needs assessment and planning, developing multi-program approaches and cross-sector linkages, and supporting both Outreach Workers and Care Coordinators.

**Outreach Workers** encourage Aboriginal and Torres Strait Islander people to access health services and help to ensure that services are culturally competent. They have strong links to the community they work in. Outreach Workers carry out non-clinical tasks, e.g. helping clients to travel to their medical appointments.

**Care Coordinators** are qualified health workers (for example, nurses, Aboriginal Health Workers) who support eligible clients through one-on-one care coordination to access the services they need to treat their chronic disease according to the General Practitioner (GP) care plan. The work of a Care Coordinator can include arranging the services in clients' care plans, assisting clients to participate in regular reviews by their primary care providers, and providing clinical care. Care Coordinators work closely with Outreach Workers in many of these activities.

Care Coordinators have access to a **Supplementary Services Funding Pool** when they need to expedite a client's access to an urgent and essential allied health or specialist service, or the necessary transport to access the service, where this is not publicly available in a clinically acceptable timeframe. The Supplementary Services Funding Pool can also be used to assist clients to access GP-approved medical aids

## 5. Workforce

### 5.1 Indigenous Health Project Officer

*Roles and responsibilities*

Gippsland PHN assumes the role of the IHPO providing leadership on Indigenous health issues. Responsibilities for IHPOs include:

- working as leaders in Gippsland, i.e. overall ITC program lead, including providing regional guidance and strategic direction for the team;

- developing and implementing a coordinated team-based approach to Aboriginal and Torres Strait Islander health, especially between the IHPO, Outreach Worker and Care Coordinator positions;
- supporting Care Coordinators and Outreach Workers;
- developing and implementing strategies to improve the capacity of mainstream primary care providers to deliver culturally appropriate primary care services to Aboriginal and Torres Strait Islander people, including taking an advocacy role in:
- self-identification;
- uptake of Aboriginal and Torres Strait Islander specific MBS items including item 715 - Health Assessments for Aboriginal and Torres Strait Islander People, care planning and follow up items;
- increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people, including those provided by Commonwealth and state/territory governments, AMSs, and other organisations;
- facilitate working relationships and communication exchange between mainstream organisations, AMSs and their peak bodies;
- developing and implementing strategies to improve access to mainstream primary care for Aboriginal and Torres Strait Islander people, including through outreach programs such
- as the Medical Outreach – Indigenous Chronic Disease Program (MOICDP), the Rural Health Outreach Fund (RHOF), and the Visiting Optometrists Scheme (VOS);
- increasing awareness and understanding of the Council of Australian Governments targets to close the gap in Indigenous disadvantage; and
- collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services.

As Program leaders for ITC, Gippsland PHN will provide high level guidance and strategic direction for the ITC workforce at a regional level.

### 5.2 Aboriginal and Torres Strait Islander Outreach Worker

*Roles and responsibilities – Aboriginal and Torres Strait Islander Outreach Worker*

Outreach Workers will work with Gippsland PHN to help local Aboriginal and Torres Strait Islander people make better use of available health care services, especially mainstream health services. Outreach Workers, under supervision, will undertake the following non-clinical tasks:

- **community liaison:** establish links with local Aboriginal and Torres Strait Islander communities to promote the importance of improving health outcomes and encourage and support the increased use of health services. This includes MBS Health Assessments for Aboriginal and Torres Strait Islander people, and MBS care planning and follow-up items.

They should also identify Aboriginal and Torres Strait Islander people who would benefit from improved access to these health services;

- **administration and support:** assist the IHPO to identify barriers to health services for Aboriginal and Torres Strait Islander people;
- **provide practical assistance:** provide assistance to identified Aboriginal and Torres Strait Islander people to access services and attend appointments (including GP care planning, follow-up care, specialist services and community pharmacies); and
- **provide feedback regarding access problems:** provide feedback to the PHN regarding barriers to health services for Aboriginal and Torres Strait Islander people, and, in conjunction with the IHPO, work to implement solutions.

### *Activities for Aboriginal and Torres Strait Islander Outreach Worker*

The work of Outreach Workers should be tailored to meet the needs of the communities within the nominated region. This work could include, but is not limited to:

- distributing information/resources to Aboriginal and Torres Strait Islander communities about services that are available to/for them, and encouraging them to use primary health care services in their region;
- encouraging and helping Aboriginal and Torres Strait Islander people to attend appointments with GPs, including for Aboriginal and Torres Strait Islander Health Assessments and care planning;
- assisting Aboriginal and Torres Strait Islander people to travel to and from appointments;
- encouraging and assisting Aboriginal and Torres Strait Islander people to:
    - attend appointments with referred specialist services and Care Coordinators, as necessary;
    - attend appointments for relevant diagnostic tests and /or referrals to other primary health care providers (including allied health);
    - collect prescribed medications from the pharmacist;
    - return for follow up appointments with their GP and/or practice nurse; and
    - fill out forms and understand instructions from reception staff.
- encouraging Aboriginal and Torres Strait Islander people to:
    - identify their Aboriginal and/ or Torres Strait Islander status;
    - and register for a Medicare card.
- Providing support for outreach/visiting health professionals where required;
- Distributing information to Aboriginal and Torres Strait Islander people about how to access available services (e.g. care coordination, PBS co-payment).

*Qualifications and skill competency for Aboriginal and Torres Strait Islander Outreach Worker*

Outreach Workers must have strong links with the community in which they work and possess effective communication skills.

The role of an Outreach Worker is to provide non-clinical services and does not require formal qualifications. The achievement of formal qualifications by an individual who is employed as an Outreach Worker will have no bearing on the job description. Outreach Workers are expected to work as part of a team with Care Coordinators and Gippsland PHN.

There is flexibility to tailor the role and activities of an Outreach Workers to suit local needs, considering the aims and objectives outlined in these Implementation Guidelines.

It is strongly recommended that Aboriginal and Torres Strait Islander people are recruited to work in Outreach Worker positions. Non-Indigenous candidates can be considered if no suitable Aboriginal and Torres Strait Islander candidates are available. Non-Indigenous candidates need to demonstrate significant links with the community and capacity to fulfil the role as an Outreach Worker.

### 5.3 Care Coordinator

*Roles and Responsibilities of Care Coordinator*

Care Coordinators should identify when a client's condition may require further assistance from a health professional.

Care Coordinators should develop and maintain a close relationship with their client's GP. An example of where this works well is when a Care Coordinator assists the GP by helping clients to access a range of services such as appointments with specialists and allied health professionals, arrangements for home help and making connections with support groups.

Information on the services the client has been connected to is then fed back to the GP for inclusion in the client's care plan so that it can be considered in future reviews of the plan.

Care Coordinators should work with their clients to improve their capacity to engage with the broader health system. Health care providers may be unaware of the personal, social, and environmental circumstances that impact on a client's capacity to access and follow recommended treatment and Care Coordinators help bridge this gap. One-on-one care coordination helps provide a level of care that would otherwise not be available to clients with complex chronic care needs enrolled on the program and Care Coordinators ensure that this level of support is provided when needed.

*Activities for Care Coordinator*

Care coordination activities undertaken by Care Coordinators must be in accordance with a care plan developed by a referring GP for eligible clients. Care coordination activities may include, but is not limited to:

- arranging the required services outlined in the client's care plan, in close consultation with their home practice;
- ensuring there are arrangements in place for the client to get to appointments;
- involving the client's family or carer as appropriate;
- transferring and updating the client's medical records;

- assisting the client to participate in regular reviews by their primary care providers;
- assisting clients to:
    - adhere to treatment regimens - for example, encouraging medication compliance;
    - develop chronic condition self-management skills; and
    - connect with appropriate community-based services such as those that provide support for daily living; and
- providing appropriate clinical care, consistent with the skills and qualifications of the Care Coordinator.

Through the Supplementary Services Funding Pool, the ITC Program enables Care Coordinators to assist eligible clients to access specialist, allied health and other support services in line with their care plan and specified medical aids they need to manage their condition effectively.

For care coordination to be effective, Care Coordinators need to work collaboratively with the services in their local areas, including services provided by state/territory governments, local governments and non-government organisations, to link clients with the services they need.

Where appropriate, Care Coordinators are required to establish links with other relevant activities such as outreach services delivered by multidisciplinary teams. They are also expected to work in collaboration with IHPOs and Outreach Workers.

### *Qualifications and skill competency for Care Coordinator*

Care Coordinators will be qualified health workers with a good working knowledge of the health system, such as nurses and Qualified Aboriginal Health Workers. Clinical skills allow the Care Coordinator to have a good knowledge of the health system and how best to navigate it for ITC clients, as well as understand the client's health needs and, where appropriate, assist with those needs. Consideration can be given to other appropriate qualifications or training in specific circumstances and in consultation with the Department of Health (the Department).

Care Coordinators are also expected to:

- provide culturally appropriate care;
- advocate on behalf of Aboriginal and Torres Strait Islander clients;
- have a good understanding of the local health system, including referral pathways;
- work collaboratively with a range of health professionals, including specialists, GPs, nurses and allied health professionals;
- be able to capture and share clinical information with relevant health care providers, including in electronic formats; and
- work as a team with IHPOs and Outreach Workers.

Care Coordinators must operate in accordance with the treating GP's instructions.

### *Definition of care coordination*

For the ITC Program, care coordination means working collaboratively with clients, general practices, Aboriginal Medical Services, and other service providers to assist with the care coordination of eligible clients with chronic disease.

Care Coordinators can:

- assist Aboriginal and Torres Strait Islander people to understand their chronic health condition and how to manage it; and
- assist Aboriginal and Torres Strait Islander people to follow their care plan, which may include support for chronic disease self-management and assistance with care plan compliance.

### *Definition of chronic disease*

For the ITC Program, and consistent with the Medical Benefits Scheme, an eligible condition is one that has been, or is likely to be, present for at least six months.

Dental is **not** an eligible condition for the purposes of the ITC Program. Priority should be given to clients with complex chronic care needs who require multidisciplinary coordinated care to manage their chronic disease/s.

### *How might a care coordination service work?*

If a GP in a general practice or an Aboriginal Medical Service has prepared a care plan for a client and considers that the client would benefit from assistance with managing the activities and services needed to improve their health outcomes, the client can be referred to a Care Coordinator employed under the ITC Program.

Care coordination works best when a Care Coordinator can discuss with each general practice/ Aboriginal Medical Service the type of services that can be provided by practice staff and those that need to be sourced from elsewhere or provided by a Care Coordinator.

The Care Coordinator will work in accordance with the client's care plan, in consultation with the referring GP, and should provide feedback to the GP about how the client is managing their condition, the treatment of their condition, including the services that have been arranged for the client, and any other issues regarding the client's health. The Care Coordinator may also provide feedback to the GP about the client's living environment when this information is relevant to the care plan, for example, noting home safety or access issues that have a health implication.

The Supplementary Services Funding Pool may be used by Care Coordinators to help eligible clients access services that have been identified in their care plan.

### *Examples of care coordination*

A client diagnosed with diabetes may be referred by their GP to a Care Coordinator for assistance. The GP's instructions in the client's care plan may indicate that the client urgently needs podiatry services. If the Care Coordinator is unable to urgently access podiatry services for the client through the public health system, the Care Coordinator can arrange to pay for an appointment with a private podiatrist, using the Supplementary Services Funding Pool, then arrange for ongoing care through the public system. If the client cannot access or afford transport to attend appointments relevant to their care plan, the Care Coordinator can contact the Outreach Worker and arrange for the client to

be driven to the appointments or use the Supplementary Services Funding Pool to pay for the necessary transport.

A client who is newly diagnosed with diabetes may require assistance with learning how to monitor their blood glucose levels. In accordance with the client's care plan, the referred Care Coordinator, who has the relevant qualification and skills, can teach the client how to monitor their blood glucose levels and support them as needed.

## 6. Client eligibility

To be eligible for care coordination under the ITC Program, Aboriginal and Torres Strait Islander clients must be enrolled for chronic disease management in a general practice or an Aboriginal Medical Service, have a GP Management Plan and be referred by their GP.

**Dental is not an eligible condition for the purposes of the ITC Program.**

For clients who may be eligible for ITC care coordination in remote areas but are unable to attain a GP care plan and referral due to intermittent access to a GP, referral into the ITC Program by a Remote Area Nurse or equivalent position may be permitted as an interim measure. For ITC enrolment, it is not necessary to obtain a complete copy of a client's GP care plan, such as the 715 Health Assessment. PHNs and commissioned organisations should only seek sufficient information on each client in order to assess, prioritise and plan appropriate care and support. During the interim period ITC teams would be able to provide limited support, for example coordination and provision of transport to health appointments, but not funding of services or medical aids and equipment. A GP care plan must be completed as a priority once a GP is able to attend the remote clinic.

Aboriginal and Torres Strait Islander people in Residential Aged Care Facilities (RACF) are not eligible for ITC. People in RACFs have been assessed for an Aged Care Package, which has funding attached for providing health care services in a clinically appropriate timeframe. The ITC program is not intended to supplement an Aged Care Package.

## 7. Prioritisation

Not all clients with a chronic condition will need assistance through the ITC Program. Priority should be given to clients who have complex needs and require multidisciplinary coordinated care for their chronic disease. This includes, but is not limited to, clients with: diabetes, cancer, cardiovascular disease, chronic respiratory disease, chronic kidney disease, eye health conditions associated with diabetes, and mental health conditions.

When considering prioritisation for ITC support, those most likely to benefit from the ITC Program include clients:

- who require more intensive care coordination than is currently able to be provided by general practice and/or AMS staff;
- who are unable to manage a mix of multidisciplinary services;
- who are at greatest risk of experiencing otherwise avoidable hospital admissions;

- who are at risk of inappropriate use of services, such as hospital emergency presentations;
- who are not using community-based services appropriately or at all; and
- who need help to overcome barriers to access services.

Organisations providing the ITC Program should develop policies to manage referral, intake and discharge processes, including continued non-compliance by clients. These arrangements should reflect the clients' clinical needs.

## 8. Supplementary Services

*Definition of the Supplementary Services funding pool*

The Supplementary Services Funding Pool can be used to assist clients who are enrolled in the ITC Program to access medical specialist and allied health services (as well as certain associated medical aids –Use of Supplementary Services funds' below) where these services align with the client's care plan. The funds may also be used to assist with the cost of transport to appointments.

Clients registered under the ITC Program may be referred by their GP to services that are not accessible through the public health system in a clinically acceptable timeframe, or where transport is inaccessible or unaffordable. When barriers such as these exist, the Care Coordinator may use the Supplementary Services Funding Pool to expedite the client's access to these services in the private sector.

*Priority allocation of Supplementary Services funding*

The Supplementary Services Funding Pool is not intended to fund all the follow up care required by clients who are registered under the ITC Program. Supplementary Services funds should only be used where other services are not available in a clinically acceptable timeframe and other sources of funding are not available. The allocation of priorities within the funding available is at the discretion of the fund holder / fund manager.

As the Supplementary Services Funding Pool is a limited resource, urgent priority should be given to purchase services that:

- address risk factors, such as a waiting period for a service that is longer than is clinically appropriate;
- reduce the likelihood of a hospital admission;
- are likely to reduce a client's length of stay in a hospital;
- are not available through other funding sources; and/or
- ensure access to a clinical service that would not be accessible because of the cost of a transport service.

As access to the Supplementary Services Funding Pool may be required in urgent circumstances, local arrangements need to accommodate rapid approval of expenditure and access to Supplementary Services funds.

## 9. Allowable use of funds for the ITC Program

ITC funding can be applied to:

- salaries, salary on-costs, and travel associated with the employment of Outreach Workers, and Care Coordinators. It can include travel and accommodation costs for Care Coordinators and Outreach Workers to attend meetings and orientation and training activities.
- care coordination service support costs such as professional indemnity insurance directly attributable to the care coordination service;
- funding may be used to cover travel costs of Outreach Workers who assist Aboriginal and Torres Strait Islander people to attend appointments (e.g. leasing a vehicle or reimbursing staff for use of private vehicles). This program is considered separate to any travel assistance provided by Care Coordinators using funds from the Supplementary Services Funding Pool;
- peer support and professional development activities for Care Coordinators and Outreach Workers;
- Funding must not be used to provide clinical services, other than those provided by Care Coordinators where appropriate.

## 10. Use of Supplementary Services Funds

Organisations providing the ITC Program will have an allocation of Supplementary Services Funding to a commissioned organisation. These organisations will be required to report how the Supplementary Funding Pool is expended to the Gippsland PHN.

Supplementary Services Funds can only be accessed by Care Coordinators. Funds may not be accessed by Outreach Workers.

Dental is **not** considered an eligible condition for the purposes of the ITC Program, and Supplementary Services funds cannot be used to pay for dental aids, procedures or services.

### 10.1 Fees for service

Care Coordinators can draw on Supplementary Services Funds to assist clients to access medical specialist and allied health services, where these services are not otherwise available in a clinically acceptable timeframe.

Supplementary Services Funds may be used to directly pay fees for services by allied health providers or to pay in full or meet the difference between MBS rebates and fees charged by private specialists or allied health providers. A panel of preferred providers and organisations that provide services in a culturally appropriate way, or providers who agree to bulk bill clients being referred under the ITC Program, may be established at the local level.

Organisations providing the ITC Program should refer to the information outlined in the ITC Frequently Asked Questions at Appendix 1 for more detail. For further information relating to claiming Medicare items, please contact Medicare Australia at www.humanservices.gov.au, or telephone 132 011. For provider enquiries, telephone 132 150.

### 10.2 Medical aids

Medical aids may only be acquired using Supplementary Services funding where:

- the medical aid is not available through any other funding source in a clinically acceptable time;
- the need for the medical aid is related to the client's chronic disease and is documented in the client's care plan;
- provision of the medical aid is part of a primary health care service provided by a GP, specialist or allied health provider (e.g. a pharmacist or podiatrist); and
- the client is educated on the use and maintenance of the medical aid.

Care Coordinators will be expected to work with the client's GP and other health practitioners to determine whether access to a medical aid is appropriate, taking into consideration the client's ability to use and maintain the medical aid and associated accessories/consumables. Supplementary Services funds may be used for maintenance costs for the specified list of medical aids.

The medical aids allowable under Supplementary Services are:

- Assisted breathing equipment (including asthma spacers; nebulisers; masks for asthma spacers and nebulisers; continuous positive airways pressure (CPAP) machines; accessories for CPAP machines);
- Blood sugar/glucose monitoring equipment;
- Dose administration aids;
- Medical footwear that is prescribed and fitted by a podiatrist; and
- Mobility aids (e.g., crutches, walking frames, or non-electric wheel chairs) or shower chairs.
- Spectacles (see Section 14.3 for conditions)

Where possible, spacers should be used rather than nebulisers.

**Dose administration aids, blood sugar/glucose monitoring equipment and most assistive breathing equipment is currently available under the Quality Use of Medicine Maximised for Aboriginal and Torres Strait Islander People (QUMAX) program for clients of participating Aboriginal Medical Services.**

**Continuous glucose monitoring devices are not eligible for funding under Supplementary Services.**

**For more information, please visit https://www.ndss.com.au/CGM.**

Care Coordinators will be required to include in the quarterly progress reports to Gippsland PHN the details of Supplementary Services funding used to acquire approved medical aids (e.g. type of aid, cost, full cost or contribution, purchase/hire).

### 10.3 Conditions for purchasing spectacles with Supplementary Services funding

Spectacles may only be purchased under the following conditions:

- Supplementary Services funds can be used only where the state/territory funded scheme is fully subscribed, or there is likely to be a reasonable delay in supply;
- New spectacles are available once every two years unless there is a significant change in prescription within the two years;
- The maximum Supplementary Services spend for entire product is $250. This includes multi-vision, bifocal, anti–glare, polarising, frames etc.;
- The Outreach Worker or Care Coordinator must attend the appointment with the client to ensure the cost is kept to within the maximum spend allowable;
- It is up to each organisation providing care coordination services to discuss/negotiate fee arrangements with each Optometrist;
- Where Supplementary Services funded spectacles have been lost, broken or stolen, replacement using further Supplementary Services funds is not allowable; and
- All these conditions must be clearly communicated to the client.

### 10.4 Exceptional Circumstances

Where a request for a medical aid to be paid through Supplementary Services Funding is made, but the item falls outside the list of allowable Medical Aids, consideration may be made for exceptional circumstances to Gippsland PHN. The item must be on the client's GP Management Plan, be considered clinically necessary, consider client needs, and funding must be available.

Supplementary Services funds cannot be used for maintenance costs of medical aids purchased under exceptional circumstances. Organisations providing the ITC Program must consider the financial impact on their annual budgets as well as the ITC client's ability to use and maintain the aid before considering purchasing a medical aid under exceptional circumstances.

### 10.5 Transport

Supplementary Services funding can be used to support clients' transport to the closest regionally available health care professional, where this is necessary to access the required health care in a clinically appropriate timeframe.

In such cases, the manager of the Supplementary Services Funding Pool must ensure that all other funding options (e.g. patient assisted travel schemes) have been exhausted and that the most cost-effective means of transport (and any essential accommodation) is used. For example, Supplementary Services funds may be used to fund the difference between the full cost of travel and any funds provided through alternative funding mechanisms.

Travel beyond the closest available regional service can be supported in cases of extreme urgency.

Organisations proving the ITC Program should liaise with the relevant fund holder regarding opportunities to access outreach services.

## 11. Financial guidelines

Strong financial management is essential under the Program, with specific financial management responsibilities set out in the Service Order. Funding under the Program is for Integrated Team Care services and as follows. Financial reports must provide a breakdown by the following categories: fees for medical specialist and for allied health services, medical aids and transport.

### 11.1 Program budget

Health Services are required to properly apportion costs between salaries of staff delivering the service and other business and operational costs. For example, if a clinical/health coordinator works both in an administrative role and provides primary health care under the program, then Health Services must establish processes to ensure that costs are properly identified and correctly attributed to the relevant line item.

Health Services must ensure that salary(s) of the staff delivering the services and business and operational costs are cost-effective as the emphasis of funding provided under the Program is for service provision to communities.

There can be no transfer of funds from Section A - *Salary of Staff Delivering the Services* to Section B - *Business and Operational Costs* in the Work Plan without written approval from Gippsland PHN.

Gippsland PHN requires Health Services to keep within the allocated budget split of eighty per cent for costs associated with salaries of staff delivering the service and twenty per cent for business and operational costs.

A program budget is required with each new or revised Work Plan. It must be submitted in the format approved by Gippsland PHN.

*Salaries of staff delivery costs*

Service delivery costs are costs related to the direct provision of primary health care and may include:

- **Contract costs**

  Contract costs of non-employed allied health and other primary health professionals and workers directly engaged by the funded organisation under the program, including clinical/health coordination. These costs are per contractor arrangements e.g. hourly rate paid on invoice.

- **Salary costs**

  Salary costs of employed allied health and other primary health professionals and workers directly engaged by the funded organisation under the program, including clinical/health coordination costs.
  Contract costs/salary costs should comprise the majority of expenditure across the program to ensure that primary health services are delivered to rural and remote communities.

- **Salary on-costs**

Salary on-costs of employed allied health and other primary health professionals and workers directly engaged in the program. On-costs are the additional costs (above the annual salary) incurred. These costs include provisions for superannuation, long service leave, workers' compensation and payroll tax.

*Business and Operational costs:*

Business and Operational costs are indirect costs associated with administering the program e.g. staff time for writing plans and reports, or for evaluation and monitoring. These costs may include:

- **Salary/Contract costs**

Contract costs of non-employed management or administrative staff. These costs are per contractor arrangements e.g. hourly rate paid on invoice. Salary costs of employed management or administrative staff engaged by the funded organisation to provide administrative support under the program.

- **Salary on-costs**

Salary on-costs of employed management or administrative staff directly engaged in the program. On-costs are the additional costs (above the annual salary) incurred. These costs include provisions for superannuation, long service leave, workers' compensation and payroll tax.

- **Room rental costs**

Costs incurred by the program for renting rooms specifically for allied health and other primary health professionals and workers to provide allied health services under the Program.

- **Professional indemnity costs**

Annual premiums paid by the Service Provider to cover professional indemnity costs for allied health and other primary health professionals and workers employed under the Program.

- **Travel and accommodation costs**

Travel and accommodation costs incurred by allied health and other primary health professionals and workers in provision of allied health services e.g. outreach services, fly-in fly-out services.

- **Vehicle and running costs**

Vehicles that are used by allied health and other primary health professionals and workers in the direct provision of allied health services under the program. 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 Gippsland PHN.

- **Professional development costs**

Course fees, conferences directly related to their profession (employees only) and service provision under the program.

- **Medical supplies**

Any purchases directly associated with consumables used by allied health and other primary health professionals and workers in provision of allied health services e.g. podiatry supplies used in foot therapies.

- **Other administration costs**

Other costs may include audit fees, bank fees, catering costs for program meetings, IT network, office equipment hire and lease costs, depreciation on office equipment, general insurance, office cleaning costs, security, maintenance and licensing costs, and staff training and accreditation costs. A breakdown of these costs may be required by Gippsland PHN if requested.

# Appendix 1 – Frequently Asked Questions (FAQs)

The FAQs are not meant to be an exhaustive list on what is excluded/out of scope of ITC funding. On first principles, the Implementation Guidelines provides information on what is in-scope. If you have any questions on activities and items eligible for ITC funding, please consult with your relevant PHN contact.

Medicare Australia, located in the Department of Human Services, should be contacted for all questions regarding claiming Medicare rebates for services.

Website - www.humanservices.gov.au General Enquiries – **132 011** (local call rate) Provider Enquiries – **132 150** (local call rate)

## Client Eligibility

### Who can refer a client for care coordination?

The client must be referred by a GP from the practice that is responsible for providing most of care for the client and developing the client's care plan. This can be in a mainstream general practice or Aboriginal Medical Service.

### Can clients with a high risk of chronic disease be included in the ITC Program even though they have not yet developed a chronic disease?

No. High risk clients are not eligible. The care coordination component of the ITC Program is not aimed at tackling risk factors for chronic disease. The aim of the Program is to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people already diagnosed with chronic conditions through better access to coordinated and multi-disciplinary care.

### What is considered a chronic disease for the purposes of the ITC Program?

The ITC Program uses the Medicare Benefits Schedule (MBS) definition of a chronic disease, which is: a disease that has been, or is likely to be, present for at least six months.

Dental is not an eligible condition for the purposes of the ITC Program.

Priority should be given to clients with complex chronic care needs who require multidisciplinary coordinated care to manage their chronic disease/s. This includes, but is not limited to, clients with diabetes, eye health conditions associated with diabetes, mental health conditions, cancer, cardiovascular disease, chronic respiratory disease and chronic renal disease.

### Can children access the ITC Program?

Yes. Children must be referred by their usual practice GP and have a care plan for their chronic disease.

## Care Coordinator Eligibility

### Can a non-clinical person work in the Care Coordinator role?

Wherever possible, Care Coordinator positions should be filled by an individual with relevant clinical skills. In specific circumstances and in consultation with the Department of Health, consideration may be given to people who have other appropriate qualifications, training, skills and personal attributes.

## Travel

### Can Supplementary Services funding be used for a health care provider to travel to a client (e.g. a home visit) rather than the client travelling to visit them?

Supplementary Services funds can be used to allow a health care provider to visit the client's home. For example, if a client is unable to leave their home, or if it is clinically necessary to deliver the service in the client's normal home setting (e.g. for Activities of Daily Living, mobility, and falls prevention assessments).

### Can Supplementary Services funding be provided for a client to travel out of town to visit a health care provider, rather than arranging for the provider to travel to the client's location?

When it is necessary for a client to access required health care in a clinically appropriate timeframe, Supplementary Services funding can be used to support a client's travel to the closest regionally available health care provider (i.e. GP, specialist or allied health practitioner).

In such cases, the manager of the Supplementary Services fund must ensure that all other funding options (e.g. Patient Assisted Travel Schemes) have been exhausted and that the most cost-effective means of transport (and any essential accommodation) is used. For example, Supplementary Services funds may be used to fund the difference between the full cost of travel and any funds provided through alternative funding mechanisms.

Note: Managers of the Supplementary Services fund are encouraged to liaise with the relevant fund holder for the Medical Outreach - Indigenous Chronic Disease Program (MOICDP) and/or the Rural Health Outreach Fund (RHOF) and/or the Visiting Optometrists Scheme (VOS) regarding opportunities to access outreach specialist services.

### Can Supplementary Services funds be used to support travel and accommodation costs of the client's parent, carer or other support provider?

If this is required to enable a care coordination client access to a health care appointment and all other options have been explored and excluded, Supplementary Services funds can be used for this purpose. Only the number of client transports should be recorded. Do not record the parent or carer's transport in the number of transport services used.

### Can Supplementary Services be used to cover parking for a care coordination client attending a health care appointment?

Yes.

### Should Primary Health Networks contact the Department's Health State Network Office to discuss options when travel beyond the closest available regional service has been requested due to an urgent need to access treatment?

No, this is not necessary. Travel beyond the closest available regional service is acceptable when there is no regional solution. Decisions regarding an individual client's care needs should be made at the Primary Health Network level.

### Can a client seek treatment across PHN Regions?

Where patients enrolled on ITC seek treatment across PHN regions, the relevant PHNs and commissioned organisations should work together to develop processes that best meet local circumstances.

## Medical Aids

### Can Supplementary Services funding be used to provide medical aids?

Yes. See the ITC Program Implementation Guidelines Section 10.2.2 for information on medical aids.

## Other Services

### Can Supplementary Services funding be used to provide care coordination clients with services such as 'Meals on Wheels'?

Supplementary Services funding may be used for services other than those detailed in the Implementation Guidelines, e.g. meals on wheels, if that service will assist with the management of the client's chronic disease and is detailed in the client's care plan. All other funding options need to be explored prior to using Supplementary Services funds.

The allocation of priorities within limited funding is at the discretion of the fund holder / fund manager.

Can Supplementary Services funding be used to pay for health services that clients accessed prior to being enrolled in the ITC Program?
No. Supplementary Services funds cannot be used to pay for costs incurred by clients prior to being referred to and accepted into the ITC Program.

### Can Supplementary Services funds be used to access dietary resources such as nutrition information and healthy recipes needed to aid healthy eating and the management of chronic disease?

Yes, provided a relevant health professional has advised that the client should use these resources and they have been included on the client's care plan under consultation with the client's primary care provider.

### Can Supplementary Services funding be used to pay for food-related dietary supplements e.g. Sustagen?

Yes, provided a relevant health professional has recommended that the client should use dietary supplements and they have been included on the client's care plan under consultation with the client's primary care provider. This is not intended to cover vitamins or other similar products.

## Client Consent and Confidentiality

### Does client consent need to be obtained for participation in the ITC Program?

Yes. To ensure privacy requirements are met, Care Coordinators must obtain and record written informed consent from each client, or the client's legal guardian. This will include consent for both the provision of ITC services and for the collection of information for the minimum data set.

Care Coordinators should confirm that the client wishes that the practice recorded on the client consent form to be their usual care provider and be responsible for their chronic disease management.

## Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) – Gap Costs

### Can Supplementary Services funding be used for a client to undergo surgery?

No. Supplementary Services funds cannot be used for surgery in acute or sub-acute settings. Use of Supplementary Services funding is restricted to funding primary care follow-up services.

### Can Supplementary Services funding be used for services performed by a specialist or allied health practitioner in their private rooms?

Yes. Supplementary Services funds can be used for specialist or allied health services, including those in private rooms, if the services are detailed in the client's care plan. Rooms that are located within hospital grounds but are privately leased by the specialist or allied health professional are private rooms.

### Can Supplementary Services funding be used for treatments provided at a hospital outpatient clinic?

No. Any treatments or procedures that occur in a hospital (public or private) cannot be funded under the ITC Program.

However, Supplementary Services funds can be used for treatments or procedures that occur in rooms that are located within a hospital but are privately leased by a specialist or allied health professional.

### Can Supplementary Services funding be used to pay the gap between the MBS rebate and the fee charged for diagnostic tests e.g. MRI, blood tests and x-ray?

Yes. See question 7(ix) for more information.

### Can Supplementary Services funding be used to fund private diagnostic tests e.g. MRI, blood tests and x-ray?

Private services can be purchased with Supplementary Services funding if publicly funded services are not available in clinically appropriate timeframes, as determined by the referring GP, and provided that all other funding options have been explored. The allocation of priorities within limited funding is at the discretion of the fund holder / fund manager.

### Can Supplementary Services funding be used to cover the gap which may remain after the subsidy is provided through the PBS Co-payment?

No. Supplementary Services funding cannot be used to pay the PBS Co-payment gap.

### Can Supplementary Services funding be used to pay for non-PBS listed medications?

No. Supplementary Services funding cannot be used for the purchase of non-PBS medications.

### Can Supplementary Services funding be used to pay the full amount of the health care provider fee upfront?

Yes. However, if the organisation providing care coordination services decides to pay the full cost of the service up front, the Medicare rebate for the service cannot be claimed.

### Can Supplementary Services be used to pay the gap between the Medicare rebate and a health practitioner's fee?

Yes. To pay the gap between the Medicare benefit and the fee charged by the health practitioner, the organisation providing the ITC Program must follow the claiming advice provided below. Organisations providing the ITC Program can call 132 150 (Medicare Provider enquiry line) if they have any further questions.

Note: The organisation accounts cannot be submitted electronically.

1. Specialist/Allied Health Practitioners issue an unpaid account to the Primary Health Network/commissioned organisation.
2. The organisation providing the ITC Program submits the unpaid account together with the Medicare claim form (available at http://www.humanservices.gov.au/customer/forms/pc1). When lodging the account and completed claim form, it can be either sent directly to the Department of Human Services, GPO Box 9822 in your capital city or placed in a 'drop box' at one of Medicare's Service Centres. The claim cannot be submitted electronically.
3. Once the account and claim form are received, Medicare will process the account and send a Medicare benefit cheque (made payable to the servicing provider) to the Primary Health Network/commissioned organisation.
4. The organisation providing the ITC Program must forward the Medicare cheque along with a Primary Health Network/commissioned organisation cheque for the gap amount to the servicing provider.

### Can Supplementary Services funding be used for private dental services, including the purchase of dentures?

No. The Commonwealth is currently implementing several dental programs designed to reduce waiting times and expand services for adults in the public dental system. More information regarding the new dental programs and commencement timeframes can be found at www.health.gov.au/dental

On this basis Supplementary Services funds cannot be used to fund private dental services.

## Care Plans

### What type of care plan do GPs need to provide for a client to be eligible for ITC assistance?

The ITC Implementation Guidelines specify that Aboriginal and Torres Strait Islander clients must be enrolled for chronic disease management in a general practice or an AMS, have a GP Management Plan and be referred by their GP. The GP is encouraged to provide an eligible client with a Medicare care plan such as, but not limited to, an Aboriginal and Torres Strait Islander health check (MBS item 715), GP Management Plans (GPMP – MBS item 721) and/or Team Care Arrangements (TCA – MBS item 723).

The benefits of the GP Management Plan (MBS item 721) for ITC clients are that it provides for more formal care planning, such as agreeing to management goals, identifying actions to be taken by the client, documenting these, and including a review date. The GPMP review process (Review of a GPMP – item 732) helps ensure an ITC client is receiving the appropriate care for their current health needs.

### Can Supplementary Services be used to support people to get a care plan?

No. The Guidelines state that the client must have a care plan, be enrolled for chronic disease management in a general practice or Aboriginal Medical Service and be referred by their GP for care coordination services. An Aboriginal and Torres Strait Islander Outreach Worker may be able to assist with transport to attend GP appointments.

# Appendix 2 – Decision Support Tool for the ITC activity

## For ITC workers and their teams managing the care coordination and supplementary services components

### Purpose of decision support tool

This tool is primarily designed to assist with decisions about allocating care coordination services and supplementary services funding under the ITC activity, particularly for determining whether to use, or to not use, supplementary services funding for exceptional circumstances.

It aims to support the internal decision processes and build the organisational capacity of organisation providing the ITC Program to make more timely decisions about how they prioritise and allocate services and supplementary services funding.

### Before using this tool

Before using this tool, first read the Gippsland PHN Program Guidelines and ITC Frequently Asked Questions (FAQs).

Always consider the ITC aims and objectives; however, the following considerations will be helpful in your decision making. Will the proposed service or aid:

- Contribute to improved health outcomes for the Aboriginal and Torres Strait Islander person with chronic disease(s) through better access to coordinated and multidisciplinary care?
- Contribute to better self-management of the person's chronic disease(s)?
- Keep the person well and out of hospital?
- Reduce unplanned and avoidable attendances and/or presentations to an emergency department?
- Reduce the likelihood of inappropriate use of emergency departments?
- Reduce the person's length of stay in a hospital?
- Provide for a better quality of life for the person with a chronic disease(s)?

### Process for elevating an ITC query

Where there is a request for a medical aid to be paid through Supplementary Services Funding, but the item falls outside the list of allowable Medical Aids, it may be considered for exceptional circumstances funding by the organisation providing the ITC Program. The item must be on the patient's GP Management Plan, be considered clinically necessary, consider patient needs, and funding must be available. If required, the organisation providing the ITC Program may send the request to the relevant Program Officer in Gippsland PHN for a decision.

Once you have read the ITC Program Guidelines and the ITC FAQs, use this tool to assist you in answering questions/queries you may initially be unsure about. If you have completed these questions, discussed with your relevant management team and remain unsure, send your query, together with this completed form to Gippsland PHN for further advice.

## Template Decision Support Tool

| Question | Response |
|---|---|
| What is your interpretation of the ITC Implementation Guidelines in relation to this request? | |
| **Question** | **Response** |
| Do you think the patient is likely to improve and benefit from this ITC service/aid? | |
| Do you think the patient's access to this ITC service/aid is justified – from both a clinical and ethical perspective? | |
| Have you explored other publicly funded/affordable programs relevant to this request? | |
| Do you think the patient will adhere to treatment and attend services? | |
| Will the patient be at risk of an unplanned/avoidable hospital admission/presentation if this request is not carried through? | |
| Will the patient's self-management of their chronic disease be significantly compromised if this request is not carried through? | |
| Is there an immediate clinical risk to the patient if the service/aid is not provided (i.e. patient is in a high-risk category for infection or spread of disease to the community) | |
| Do you have GP/Allied Health Provider/Medical Specialist sign off on the patient's GP Care Plan, and are they willing to support the patient's access to this service/aid? | |
| Do you have management and team support for this request? | |
| Have you considered how this request could be applied equitably across the community for other patients with a similar case? | |

| Question | Response |
|---|---|
| Have you considered what the community expectations will be if you supported this request? | |
| How will this affect your budget for this financial year? | |
| How will you report this service/aid to the Department of Health? | |
| Have you consulted with your local clinical advisory team? Do they support this request? | |