Australian Government

Department of Health

INTEGRATED TEAM CARE

ACTIVITY IMPLEMENTATION GUIDELINES

2016-2017 to 2017-18

October 2016 Update

Contents

1 Introduction

From 2016-17, the Care Coordination and Supplementary Services (CCSS) and the Improving Indigenous Access to Mainstream Primary Care (IIAMPC) activities have been combined to form the Integrated Team Care (ITC) Activity.

This document describes the ITC Activity and provides guidance for the implementation and management of the ITC Activity.

Funds for the ITC Activity will be managed by Primary Health Networks (PHNs). PHNs must work with the Indigenous health sector when planning and delivering the ITC Activity and ensure that eligible patients of both mainstream and Aboriginal Medical Services (AMS)[1] have access to care coordination.

The ITC Activity builds on the formal evaluations of the CCSS and IIAMPC which highlighted the benefit of integrated Indigenous health teams. ITC formalises this team approach so that patients will be supported across the full pathway of care, from encouragement and assistance to accessing health care through to provision of multidisciplinary care. The combined Activity allows greater flexibility to tailor the mix of workforce positions within Indigenous health teams.

ITC provides the opportunity for PHNs to develop flexible approaches to improve Aboriginal and Torres Strait Islander people's access to high quality, culturally appropriate health care, including care coordination services. It will allow PHNs to develop innovative approaches that best meet local needs through the commissioning process.

1.1 Aims and objectives of the Integrated Team Care Activity

The aims of the ITC Activity are to:

- contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and
- contribute to closing the gap in life expectancy by improved 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.

The objectives are to:

1. achieve better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people, through better access to the required services and better care coordination and provision of supplementary services;
2. foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors;
3. improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people;
4. 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;
5. support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify; and
6. increase awareness and understanding of measures relevant to mainstream primary care.

[1] AMS refers to Indigenous Health Services and Aboriginal Community Controlled Health Services.

1.2 Activity description

ITC is provided by a team/teams of Indigenous Health Project Officers (IHPOs), Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers) and Care Coordinators. The team works in their 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. The teams work in the following ways:

- IHPOs have a policy and leadership role within a PHN region. As team leaders they ensure 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-programme approaches and cross-sector linkages, and supporting both Outreach Workers and Care Coordinators. (See Sections 3 and 6.1)[2];
- 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 patients to travel to their medical appointments. (See Sections 4 and 6.2); and
- Care Coordinators are qualified health workers (for example, nurses, Aboriginal Health Workers) who support eligible patients 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 providing clinical care, arranging the services in patients' care plans and assisting patients to participate in regular reviews by their primary care providers. Care Coordinators work closely with Outreach Workers in many of these activities. (See Sections 5 and 6.3.)

Care Coordinators have access to a Supplementary Services Funding Pool when they need to expedite a patient'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 patients to access GP-approved medical aids.

1.3 Service delivery principles

PHNs are required to consider the following service delivery principles, identified in the National Indigenous Reform Agreement, when implementing the ITC Activity:

- **Priority principle**: Programmes and services should contribute to Closing the Gap by meeting the targets agreed by the Council of Australian Governments (COAG) while being appropriate to local needs.
- **Indigenous engagement principle**: Engagement with Aboriginal and Torres Strait Islander men, women, children and communities should be central to the design and delivery of programmes and services.
- **Sustainability principle**: Programmes and services should be directed and resourced over an adequate period of time to meet the COAG targets.

[2] Historically the IHPO engaged with mainstream practices and Outreach Workers in order to improve access to mainstream services. As these activities have progressed the Commonwealth is aware that many IHPOs have also developed a strong liaison role with Care Coordinators and an Integrated Team Care approach has already been evolving.

- **Access principle**: Programmes and services should be physically and culturally accessible to Aboriginal and Torres Strait Islander people and recognise the diversity of urban, regional and remote needs.
- **Integration principle**: There should be collaboration between and within governments at all levels and their agencies to effectively coordinate programmes and services**.**
- **Accountability principle**: Programmes and services should have regular and transparent performance monitoring, review and evaluation.

PHNs and commissioned organisations should take account of the *Primary Health Network and Aboriginal Community Controlled Health Organisation Guiding Principles 2016*.

2 Primary Health Networks

PHNs will have the flexibility to tailor the role and activities of the IHPOs, Outreach Workers and Care Coordinators to suit the needs of particular communities, taking into account the objectives of the ITC Activity.

PHNs and the organisations they commission are expected to ensure that Aboriginal and Torres Strait Islander employees are provided with a culturally safe working environment. This may include developing and implementing a Reconciliation Action Plan (RAP). Advice on the development of RAPs is provided on the Reconciliation Australia website.

Each PHN has a responsibility to oversee the ITC workforce across its region, including ensuring the workforce receives professional/peer support as outlined at Section 6.4.

PHNs and the organisations they commission should develop flexible approaches to ensure Aboriginal and Torres Strait Islander people are able to access high quality care, including through mainstream practices.

2.1 Service delivery and commissioning arrangements

The Commonwealth acknowledges that there are many operating models for how PHNs, AMSs and mainstream practices can interact with IHPOs, Care Coordinators and Outreach Workers.

PHNs should seek to commission service delivery arrangements that most effectively and efficiently meet the needs of patients in their regions and consider existing service arrangements including those delivered by the Aboriginal Community Controlled Health Sector. In all instances the PHN should analyse its region for its ability to meet the required service delivery arrangements.

Open approaches to the market may be considered, but may not be required in all situations.

An open application process should be applied wherever the PHN is presently the sole service provider (of IHPOs, Care Coordinators and Outreach Workers) in a region.

PHNs should base decisions about the service delivery, workforce needs, workforce placement and whether a direct, targeted or open approach to the market is undertaken, upon a framework that includes needs assessment, market analyses, and clinical and consumer input including through Clinical Councils and Community Advisory Committees. Decisions must be transparent, defensible, well documented and made available to the Commonwealth upon request.

Any funding arrangement with service providers must reflect the outcome of the above decision framework and will depend on the PHN's regional circumstances.

Appropriate workforce placement across a region, and in particular the location of IHPOs as team leaders, may involve IHPOs being placed in strategic locations across areas within a

region and/or within a PHN itself. Decisions on IHPO placement will depend on the outcome of the above decision framework. Care Coordinator and Outreach Worker services should be delivered from the most appropriate service, and wherever possible work between, AMSs and mainstream practices.

3 Indigenous Health Project Officers

3.1 Roles and responsibilities

IHPOs provide leadership on Indigenous health issues.

Responsibilities for IHPOs will include:

- working as team leaders in the PHN region, i.e. overall ITC program lead, including 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;
- 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 programmes such as the Medical Outreach – Indigenous Chronic Disease Programme (MOICDP), the Rural Health Outreach Fund (RHOF), and the Visiting Optometrists Scheme (VOS);
- 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:
    - 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 and understanding of the COAG 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.

3.2 Possible activities for Indigenous Health Project Officers

The work of IHPOs should be tailored to meet the needs of the communities within the PHN region. This work could involve:

- promoting the objectives and outcomes of the Activity to community organisations, for example through websites, conference presentations, at meetings and in reference groups for other projects;

- identifying and addressing barriers faced by Aboriginal and Torres Strait Islander people when accessing mainstream primary care services, including but not limited to primary care, pharmacy, allied health and specialists;
- promoting mainstream primary care providers to Aboriginal and Torres Strait Islander people as a valid, trustworthy and accessible first point of health care;
- assisting mainstream primary care providers to manage specific Aboriginal and Torres Strait Islander health needs and issues;
- providing support to mainstream primary care providers to encourage Aboriginal and Torres Strait Islander people to identify their Indigenous status when accessing mainstream primary care services;
- delivering or coordinating cultural awareness training and quality improvement activities;
- coordinating relevant education events;
- disseminating information about the availability of programmes (Commonwealth, state and local) that provide services for Aboriginal and Torres Strait Islander people (e.g. MOICDP, VOS, and RHOF);
- developing and disseminating resources for Aboriginal and Torres Strait Islander people about accessing services and managing chronic disease;
- developing and mapping referral pathways that incorporate available services at the local, regional and jurisdictional level; and
- assisting with programme and service coordination.

4 Aboriginal and Torres Strait Islander Outreach Workers

4.1 Roles and responsibilities

Outreach Workers will work with the IHPOs 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 practical 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.

4.2 Possible activities for Aboriginal and Torres Strait Islander Outreach Workers:

The work of Outreach Workers should be tailored to meet the needs of the communities within the PHN region. This work could include:

- 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 coordination, 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).

5 Care Coordinators

5.1 The role of Care Coordinators

Care Coordinators can provide support to identify when a patient's condition may require further assistance from a health professional.

Care coordination is most successful when there is a close relationship between the patient's GP and the Care Coordinator. For example, a Care Coordinator can assist the GP by assisting patients 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 patient has been connected with will then be fed back to the GP for inclusion in the patient's care plan so that it can be considered in future reviews of the plan.

5.2 Possible activities for Care Coordinators

Care coordination activities undertaken by Care Coordinators must be in accordance with a care plan developed by a referring GP for eligible patients. Care coordination activities may include:

- providing appropriate clinical care, consistent with the skills and qualifications of the Care Coordinator;
- arranging the required services outlined in the patient's care plan, in close consultation with their home practice;
- ensuring there are arrangements in place for the patient to get to appointments;
- involving the patient's family or carer as appropriate;
- transferring and updating the patient's medical records;
- assisting the patient to participate in regular reviews by their primary care providers; and
- assisting patients 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.

Through the Supplementary Services Funding Pool (refer Section 8), the ITC Activity also enables Care Coordinators to assist eligible patients 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, in order to link patients with the services they need.

Where appropriate, Care Coordinators are required to establish links with other relevant activities (for example, MOICDP, which provides for outreach services delivered by multidisciplinary teams). They are also expected to work in collaboration with IHPOs and Outreach Workers.

6 Qualifications and skill requirements

6.1 Indigenous Health Project Officer

Qualifications, skills and experience are not specified for the IHPO role. It is expected that IHPOs will have the qualifications and/or skills and experience in working with Aboriginal and Torres Strait Islander people required for the performance of the roles and responsibilities outlined in Section 3.

Aboriginal and Torres Strait Islander people should be engaged to work as IHPOs where possible. IHPOs are expected to work as team leaders and support Care Coordinators and Outreach Workers.

6.2 Aboriginal and Torres Strait Islander Outreach Workers

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 IHPOs.

There is flexibility to tailor the role and activities of the Outreach Workers to suit local needs, taking into account 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.

6.3 Care Coordinators

Care Coordinators will be qualified health workers, such as nurses and Aboriginal Health Workers. Clinical skills will allow the Care Coordinator to understand the patient'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 patients;
- 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.

6.4 Professional/peer support

PHNs and the organisations they commission are expected to ensure that appropriate ongoing peer support, professional guidance and mentoring are provided for Care Coordinators, IHPOs and Outreach Workers. Where team members work at a distance from others undertaking the same role, provision of peer support and professional networking opportunities, e.g. discussions on case studies or models of care, may enhance on-the-job learning, quality of service and retention rates. This could involve liaison with other PHNs to enhance skills, share information and facilitate peer support.

Professional and peer support should be provided by PHNs or the organisations they commission as appropriate.

7 Care Coordination

7.1 Definition of Care Coordination

For the purpose of the ITC Activity, care coordination means working collaboratively with patients, general practices, AMSs, and other service providers to assist with the care coordination of eligible patients 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.

7.2 Definition of chronic disease

For the purpose of the ITC Activity, and consistent with the MBS, 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 Activity. Priority should be given to patients with complex chronic care needs who require multidisciplinary coordinated care in order to manage their chronic disease/s.

7.3 How might a care coordination service work?

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

Care coordination works best when a Care Coordinator is able to discuss with each general practice/AMS 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 patient's care plan, in consultation with the referring GP, and should provide feedback to the GP about how the patient is managing their condition, the treatment of their condition, including the services that have been arranged for the patient, and any other issues regarding the patient's health. The Care Coordinator may also provide feedback to the GP about the patient'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 (refer Section 8 below) may be used by Care Coordinators to help eligible patients access services that have been identified in their care plan.

7.4 Examples of care coordination

A patient diagnosed with diabetes may be referred by their GP to a Care Coordinator for assistance. The GP's instructions in the patient's care plan may indicate that the patient urgently needs podiatry services. If the Care Coordinator is unable to urgently access podiatry services for the patient 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 patient 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 patient to be driven to the appointments, or use the Supplementary Services Funding Pool to pay for the necessary transport.

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

7.5 Patient eligibility

To be eligible for care coordination under the ITC Activity, Aboriginal and Torres Strait Islander patients 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. Dental is **not** an eligible condition for the purposes of the ITC Activity. (See Section 7.2 'Definition of chronic disease').

For patients eligible for ITC care coordination who have mental health conditions, PHNs should consider the PHN Mental Health and Suicide Prevention Implementation Guidance and the Primary Health Networks: Indigenous Mental Health Flexible Activity in the PHN Program: Primary Mental Health Care Schedule.

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

As a guide, patients most likely to benefit from the ITC Activity include patients:

- 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.

PHNs and the organisations they commission should develop policies to manage referral, intake and discharge processes, including continued non-compliance by patients. These arrangements should reflect the patients' clinical needs.

8 Supplementary Services

8.1 Definition of the Supplementary Services Funding Pool

The Supplementary Services Funding Pool can be used to assist patients who are registered under the ITC Activity to access medical specialist and allied health services (as well as certain associated medical aids – refer Section 9.2 'Use of Supplementary Services funds' below) where these services align with the patient's care plan. The funds may also be used to assist with the cost of transport to appointments.

Patients registered under the ITC Activity 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 patient's access to these services in the private sector.

8.2 Priority allocation of Supplementary Services funding

The Supplementary Services Funding Pool is not intended to fund all of the follow up care required by patients who are registered under the ITC Activity. Supplementary Services funds should only be used where other services are not available in a clinically acceptable timeframe.

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 patients 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 Activity

9.1 Integrated Team Care

ITC funding can be applied to:

- salaries, salary on-costs, and travel associated with the employment of IHPOs, Outreach Workers, and Care Coordinators. It can include travel and accommodation costs for Care Coordinators, IHPOs and Outreach Workers to attend meetings and orientation and training activities. PHNs have the flexibility to allocate funds to employ an appropriate mix of Care Coordinators, IHPOs and Outreach Workers as determined by regional needs;
- 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 activity is considered separate to any travel assistance provided by Care Coordinators using funds from the Supplementary Services Funding Pool;
- reasonable recruitment costs;
- peer support and professional development activities for IHPOs, Care Coordinators and Outreach Workers;
- Activity administration of up to 7% of total funding for PHNs – recognising that there are different circumstances and challenges in different PHN regions, an administrative fee of up to 7% of total Activity funding is considered to be a reasonable benchmark. Activity administration includes commissioning, ongoing contract management, and reporting requirements;
- where a direct arrangement is to be commissioned, Activity administration fees are to be kept to a minimum, in recognition of the limited commissioning activity required. In such cases, the Department also expects efficiencies on the part of the organisation/s commissioned by the PHN; and
- needs assessments and market analyses might result in more than one PHN commissioning the same service provider. If this situation occurs the PHNs, and the service provider, would be expected to work together to ensure that the most efficient administrative approach is implemented.

Funding must not be used to provide clinical services, other than those provided through care coordination, or to purchase assets.

PHNs have the flexibility to work with neighbouring PHNs, AMSs or mainstream services following agreement by all parties. This may include pooling of resources.

Such arrangements would need to be reflected in the Activity Workplans of the PHNs involved. The relevant Health State Network Office must be advised of any such arrangement and PHNs will need to receive prior approval from the Department through the Activity Workplan development process.

9.2 Use of Supplementary Services Funds

PHNs will generally manage the Supplementary Services Funding Pool centrally and will have responsibility for reporting to the Department on the number and type of services purchased and how the Supplementary Services Funding Pool is expended. In certain circumstances, the PHN may choose to provide an allocation of Supplementary Services Funding to a commissioned organisation. In such cases, the commissioned organisation would report the above information to the PHN, which will include this information in its reporting to the Department.

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

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

9.2.1 Fees for service

Care Coordinators can draw on Supplementary Services Funds to assist patients 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 patients being referred under the ITC Activity, may be established at the local level.

PHNs and the organisations they commission should refer to the information outlined in the ITC Frequently Asked Questions document 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.

9.2.2 Medical aids

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

- the medical aid is not available through any other activity in a clinically acceptable time;
- the need for the medical aid is related to the patient's chronic disease and is documented in the patient'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 patient is educated on the use and maintenance of the medical aid.

Care Coordinators will be expected to work with the patient's GP and other health practitioners to determine whether access to a medical aid is appropriate, taking into consideration the patient's ability to use and maintain the medical aid and associated accessories/consumables.

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 9.2.3 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) programme for patients of participating AMSs. For eligible patients of AMSs, QUMAX must be used to acquire these items rather than making an application to use Supplementary Services funding.

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

9.2.3 Conditions for purchasing spectacles with Supplementary Services

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 patient 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 of these conditions must be clearly communicated to the patient.

9.2.4 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 by the PHN. The item must be on the patient's GP Management Plan, be considered clinically necessary, take into account patient needs, and funding must be available. If required, the PHN may send the request to the relevant Grant Officer in the Department's Health State Network for a decision.

Please refer to the ITC Decision Tool for further information about this process.

9.2.5 Transport

Supplementary Services funding can be used to support patients' transport to the closest regionally available health care professional, where this is necessary in order 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.

PHNs and the organisation they commission should liaise with the relevant fund holder for the MOICDP/RHOF/VOS regarding opportunities to access outreach services.

Financial reports must provide a breakdown by the following categories: fees for medical specialist and for allied health services, medical aids and transport (see Section 12).

10 Management of funds

PHNs are the fund holders for the ITC Activity, and will be responsible for reporting all ITC Activity to the Department (see Section 12). For management of the Supplementary Services Funding Pool, see Section 9.2.

11 Needs assessment

The process for undertaking a needs assessment is provided in the *PHN Needs Assessment Guide, December 2015*

PHNs should consider the following issues when undertaking or updating their needs assessments:

- local Aboriginal and Torres Strait Islander population characteristics;
- existing mainstream and Indigenous health services;
- stakeholder views and expectations;
- analysis of health care and access needs; and
- changing patterns of uptake and demand.

12 Reporting

As part of the deliverables under the ITC Activity in the Indigenous Australians' Health Programme Funding Schedule, PHNs are required to submit Activity Workplans and annual budgets and six monthly performance reports (including financial reports). PHNs must meet these requirements, and to an appropriate standard, in order to receive ITC Activity funding.

Financial statements must be provided in a form determined by the Department and must include details of expenditure against:

- Care Coordinator, IHPO and Outreach Worker expenses;
- Supplementary Services; and
- Activity administration.

Commissioning arrangements must also include a requirement to report against these components.

PHNs must collect and report data for monitoring the performance of the ITC Activity. PHNs should use the reporting template provided with the ITC Activity in the Indigenous Australians' Health Programme Funding Schedule for reporting purposes.

Reports from PHNs should provide a summary of the of the Activity data across their region.

PHNs must make themselves familiar with all of the reporting requirements and ensure that they have systems in place to collect and collate the necessary information/data from all commissioned organisations. This should include systems for the protection of private information and adherence to principles of confidentiality in accordance with Commonwealth and state/territory legislation where relevant.

13 Assessment and approval

Payments to PHNs will be dependent on approval of deliverables by the Department. In assessing annual plans, annual budgets and six monthly performance reports for the Activity, the Department will consider:

- how well the objectives of the ITC Activity are being met;
- how well the identified needs are being met;
- reporting against performance indicators (where required);
- whether the requirements of the Funding Schedule and these guidelines are being met; and
- whether activities are cost-effective and align with ITC Activity outcomes.

14 Maintenance of information and data

PHNs are required to collect and maintain the information and data needed to meet the planning and reporting requirements.

15 Further information

For further information, please contact your relevant Health State Network Office.