Australian Government

Department of Health, Disability and Ageing

Integrated Team Care – Program Implementation Guidelines

Contents

1 Introduction

This document describes the Integrated Team Care Program (ITC) and provides guidance for the implementation and management of ITC.

Funds for ITC will be managed by Primary Health Networks (PHNs) and other nominated organisations (commissioning bodies). Commissioning bodies should work with the Aboriginal and Torres Strait Islander health sector when planning, contracting service providers or delivering ITC to ensure that eligible clients of mainstream, Aboriginal Medical Services (AMS)[1] and Aboriginal Community Controlled Health Services (ACCHS)[2] have access to care coordination.

ITC (and its predecessors the Care Coordination and Supplementary Services and Improving Indigenous Access to Mainstream Primary Care programs) was established to empower Aboriginal and Torres Strait Islander people facing complex chronic diseases and health decisions by providing access to personalised one-on-one assistance by Care Coordinators. Since the establishment of ITC, the provision of care coordination, expediting access to necessary services, and developing care pathways and service linkages has resulted in improved continuity of care between client and provider, greater client self-efficacy and self-management.[3]

ITC provides the opportunity for commissioning bodies 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 also allows commissioning bodies to cultivate innovative approaches that best meet local needs through the commissioning process.

1.1 Objectives and outcomes of the Integrated Team Care Program

The objectives of ITC are to:

- 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 safe primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people by supporting community controlled services, while also maintaining client choice with mainstream options.

The outcomes are to:

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[1] AMS refers to health services solely funded to provide services to Aboriginal and Torres Strait Islander people (Australian Indigenous Health*InfoNet*, 2024).
[2] ACCHS refers to primary health care services initiated and operated by the local community to deliver holistic, comprehensive, and culturally safe health care which target and address the needs of the community which control it (through a locally elected Board of Management) (NACCHO, 2024).
[3] Health Policy Analysis 2018, Review of Care Coordination within the Integrated Team Care (ITC) Program – Summary report, Commonwealth Department of Health.

- contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people enrolled on ITC;
- 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/s;
- foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors;
- improve the capacity of mainstream primary care services to deliver culturally safe 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.

1.2 Program description

ITC is provided by a team and/or teams of Aboriginal and Torres Strait Islander Health Project Officers (ATSIHPOs), Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers) and Care Coordinators. The teams work within their respective PHN region/s, fostering cross-sector partnerships between the community controlled and mainstream primary care sectors whenever feasible, 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 multidisciplinary care, and improve access for Aboriginal and Torres Strait Islander people to culturally safe mainstream primary care. ITC can also assist clients to overcome barriers to their chronic disease management by providing access to medical devices, transportation, or healthcare services that may not be attainable through other funding sources, or without considerable delays.

While the mix and number of positions will vary, it is expected that the roles and responsibilities of each of the workforce positions (see Sections 5, 6, and 7) will be carried out by the ITC workforce across the PHN region/s.

An example of how the three primary roles may collaborate to implement and coordinate ITC is depicted below:

- ATSIHPOs have a policy and leadership role within a PHN region. As team leaders or program coordinators, 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-program approaches and cross-sector linkages, and supporting both Outreach Workers and Care Coordinators (see Sections 5 – Aboriginal and Torres Strait Islander Project Officers)[4];

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

- Outreach Workers encourage Aboriginal and Torres Strait Islander people to access health services and help to ensure that services are culturally safe. 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 (see Section 6 – Aboriginal and Torres Strait Islander Outreach Workers); and
- Care Coordinators are qualified health workers (for example, nurses, Aboriginal Health Workers/Practitioners) 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 (see Sections 7 – Care Coordinators).

Care Coordinators have access to a Supplementary Services Funding Pool when they need to expedite a client's access to an urgent or 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 (see Section 9).

1.3 Service delivery principles

Commissioning bodies are required to consider the Priority Reforms of the National Agreement on Closing the Gap (the National Agreement) when implementing ITC.

The objective of the National Agreement is to enable Aboriginal and Torres Strait Islander people, governments and all associated organisations to work in genuine partnership together to overcome the inequality experienced by Aboriginal and Torres Islander people and achieve life outcomes equal to all Australians. Commissioning bodies should be aware of and consider the PHN guidance document on working collaboratively with ACCHS. Implementation of ITC should also align with the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (the Health Plan), which focuses on systematic service improvement to address geographic disparities through more effective and innovative regional arrangements. As per the Health Plan, commissioning bodies should thoroughly explore ways in which ITC can drive:

- **Genuine shared decision making and partnerships**: shared decision making, partnerships, and collaborative cross-sector approaches which operate across all levels of health planning and services delivery, prioritising ACCHS and including mainstream services.
- **Aboriginal and Torres Strait Islander community controlled comprehensive primary health care**: a strong, sustainable and well-equipped ACCHS sector which can deliver comprehensive health, social and emotional wellbeing services.
- **Sustained Aboriginal and Torres Strait Islander workforce growth**: grow Aboriginal and Torres Strait Islander representation and leadership across the health, disability and aged care workforces of ACCHS and mainstream services, with a focus on personal and professional development.

- **Identification and elimination of racism**: implement mechanisms (e.g., reporting systems, data collation, feedback processes) to address individual and institutional racism in service delivery and improve cultural safety training across mainstream health services and settings.
- **Access to person-centred and family centred care**: strengthen access to health care that is responsive to local context and different population groups by addressing barriers to access and harnessing emerging technologies.
- **Shared access to data and information at a regional level**: establish partnerships between Aboriginal and Torres Strait Islander people and government agencies to improve collection, access, management and use of data, including identifying improvements to existing data collection and management at regional levels. Acknowledge that communities have ownership and control over their data in line with Aboriginal and Torres Strait Islander data sovereignty.

2 Care Coordination

2.1 Definition of care coordination

In the case of ITC, care coordination means working collaboratively with clients, GPs, ACCHS, AMS, and other service providers to assist with the care coordination of eligible clients.

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.

2.2 Definition of chronic disease

In the case of ITC, 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 ITC. Priority should be given to clients with complex chronic care needs who require multidisciplinary coordinated care in order to manage their chronic disease/s.

2.3 How might a care coordination service work?

If a GP in a general practice or ACCHS 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 ITC.

Care coordination works best when a Care Coordinator is able to discuss with general practices and ACCHS 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 or preferences. 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 (refer Section 9) may be used by Care Coordinators to help eligible clients access services that have been identified in their care plan.

2.4 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. The Care Coordinator may also link the client with a credentialled Diabetes Educator, who could provide expert advice on diabetes self-management and fast-track administrative access to support services like the National Diabetes Services Scheme (NDSS).

2.4.1 Occasion(s) of care

An occasion of care for the purposes of ITC is defined as each unique care coordination service provided to an ITC client. For example, organising an appointment for a client, attending the appointment with them, and providing follow-up assistance afterwards would be three unique occasions of care.

2.5 Client eligibility

To be eligible for care coordination under ITC, Aboriginal and Torres Strait Islander clients must receive a referral from their GP and have in place, a suitable care plan (see Appendix 1 Frequently Asked Questions - 8(i)). The healthcare professional and/or team should proactively work together with the client to manage their chronic condition/s to meet personalised health milestones which are reviewed regularly at general practices or ACCHS. Dental is **not** an eligible condition for the purposes of ITC (See Section 2.2 'Definition of chronic disease'). 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.

For clients eligible for ITC care coordination who have mental health conditions, PHNs should consider the 'Primary Health Networks (PHN) primary mental health care guidance – Aboriginal and Torres Strait Islander mental health services' in the PHN Primary Mental Health Care Flexible Funding Pool Programme.

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 ITC by a Remote Area Nurse or equivalent position may be permitted as an interim measure. 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 the purpose of providing health care services in a clinically appropriate timeframe. ITC is not intended to supplement an Aged Care Package.

2.5.1 Prioritisation

Not all clients with a chronic condition will need assistance through ITC. Priority should be given to clients who have complex needs, multimorbidity 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 ITC include clients:

- who require more intensive care coordination than is currently able to be provided by general practice and/or ACCHS/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.

Commissioning bodies and contracted service providers should develop policies to manage referral, intake and discharge processes, including where clients experience continued challenges engaging with treatment and services to workshop solutions and identify barriers to care coordination. These arrangements should reflect the clients' clinical needs and adopt a strengths-based approach.

3 Commissioning bodies

Commissioning bodies have the flexibility to tailor the role and activities of the ATSIHPOs, Outreach Workers and Care Coordinators to suit the needs of particular communities, taking

into account the objectives of ITC and remaining consistent with the Program Implementation Guidelines.

Commissioning bodies and commissioned service providers are expected to ensure and continue to build on providing Aboriginal and Torres Strait Islander employees with a culturally safe working environment. Organisations should consider developing and implementing a Reconciliation Action Plan (RAP). Advice on the development of RAPs can be accessed through Reconciliation Australia. Cultural safety practice is an ongoing learning journey and requires an iterative framework of review and reflection, where organisations should routinely seek the opinions of Aboriginal and Torres Strait Islander colleagues and health care users to drive systems improvement.

Commissioning bodies have a responsibility to oversee the ITC workforce across their regions, including ensuring the workforce receives appropriate support and development as outlined at Section 8.

Commissioning bodies and contracted service providers should develop flexible approaches to ensure Aboriginal and Torres Strait Islander people are able to access high quality care, including through community controlled and mainstream practices in response to identified local needs or preferences. ACCHS are well placed to provide targeted primary health care and drive solutions, develop models of service and meaningful outcome indicators for the Aboriginal and Torres Strait Islander communities they serve. As such, where capacity allows, support should be provided to building a strong and sustainable Aboriginal and Torres Strait Islander community controlled sector as is outlined in Priority Reform 2 of the National Agreement. Commissioning bodies (see Section 3.1) should follow a needs-based approach to enable communities to have rights of choice in accessing ITC from service providers that best fit their health values. This represents an important commitment towards driving Aboriginal and Torres Strait Islander self-determination and building the community-controlled sector, consistent with the Health Plan and Priority Reform 2 of the National Agreement.

In regions lacking nearby or local ACCHS, or where the community prefers a culturally safe mainstream provider, ITC delivery and service provider commissioning should prioritise offering clients a choice based on local needs-based assessments and community input.

3.1 Service delivery and commissioning arrangements

Commissioning bodies should seek to commission service delivery arrangements that best meet place-based client needs or preferences, taking into account regional capacity to ensure effective ITC coverage. This includes leveraging existing service arrangements such as those delivered by the Aboriginal Community Controlled Health Sector.

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

Commissioning bodies 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. This process must be transparent, defensible, well documented and made available to the Commonwealth upon request. Funding arrangements with service providers

stemming from this process should align with the aforementioned analyses and may, additionally integrate specific regional factors, client preferences or community feedback.

Appropriate workforce placement across a region, and in particular the location of ATSIHPOs as team leaders or program coordinators, may involve ATSIHPOs being placed in strategic locations across areas within a region, including within commissioning bodies if appropriate. Decisions on ATSIHPO 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 AMS, ACCHS and mainstream practices.

4 Improving the Cultural Safety of Mainstream Primary Care

According to data from the most recent National Aboriginal and Torres Strait Islander Health Survey 2018-2019[5], approximately 54% of survey participants reported visiting a mainstream GP when they sought medical care. Use of mainstream practice as the usual source of health care was greater in major cities (75%), compared to remote (27%) or very remote regions (6%). This highlights the importance of reinforcing a health system that is responsive and culturally safe for Aboriginal and Torres Strait Islander health needs.

ITC plays a key role improving the cultural competency of mainstream primary care services so Aboriginal and Torres Strait Islander people can access safe and responsive care.

Activities to improve the cultural safety of mainstream primary care include, but are not limited to:

- Developing a Reconciliation Action Plan (RAP);
- Delivering or organising cultural competency training for staff;
- Encouraging uptake of Aboriginal and Torres Strait Islander MBS items such as 715 health checks and ensuring follow-up services are utilised; and
- Helping practices create a more welcoming environment by considering the space and co-designing display materials, inclusive signage, language resources or dedicated private spaces with community Elders and local artists.

Note: this list is not intended to be exhaustive and should represent the minimum activities conducted as part of improving the cultural safety of mainstream primary care.

Commissioning bodies should appoint an individual from the ITC workforce (ATSIHPO, Care Coordinator, Outreach Worker) take the lead in improving the cultural safety of mainstream primary care services, however each of the ITC workforce positions may assist with working towards this objective as appropriate for local circumstances. While commissioning bodies have primary responsibility for ensuring this objective is met, each organisation commissioned to deliver ITC should ensure that this activity is being undertaken. It is expected that commissioning bodies include a requirement that these activities will be

[5] Australian Institute of Health and Welfare (AIHW). Access to primary care. *Aboriginal and Torres Strait Islander Health Performance Framework - Summary report.*

undertaken in their funding agreements with organisations commissioned to deliver ITC services (see Program Outcomes 3 and 4 in Section 1).

With reference to Priority Reform 4 of the National Agreement, PHNs are strategically positioned to collaborate with other commissioning bodies and service providers and should endeavour to facilitate mutual access to data and information. This collaboration extends to areas such as identifying GP practices with may benefit from capacity uplift in cultural awareness training.

5 Aboriginal and Torres Strait Islander Project Officers

5.1 Roles and responsibilities

ATSIHPOs provide leadership and strategic direction on Aboriginal and Torres Strait Islander health issues.

Responsibilities for ATSIHPOs include:

- working as team leaders, liaison officers or program coordinators in the PHN regions, i.e. overall ITC lead, including providing regional guidance and strategic direction for the team;
- providing input into developing and implementing a coordinated team-based approach to Aboriginal and Torres Strait Islander health, particularly in defining the scope of roles among the ATSIHPO, 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 safe primary care services to Aboriginal and Torres Strait Islander people, including taking an advocacy role in:
  - self-identification of Aboriginal and/or Torres Strait Islander status;
  - 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, AMS, ACCHS and other organisations;
- facilitate working relationships and communication exchange between mainstream organisations, AMS, ACCHS 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 Priority Reforms and targets/outcomes of the National Agreement and the Health Plan; and

- collaborating with local Aboriginal and Torres Strait Islander health services and mainstream health services in a partnership approach for the delivery of primary care services.

ATSIHPOs may provide high level guidance and strategic direction for the ITC workforce at a regional level, but this will depend on specific program and team structures and position descriptions. Depending on local circumstances and preferences of the clinical workforce, it may be appropriate for a senior Care Coordinator to provide clinical leadership for a smaller team of ITC workers within PHN regions.

5.2 Activities

The work of ATSIHPOs should be tailored to meet the needs of the communities within the PHN region. This work could involve, but is not limited to:

- promoting the objectives and outcomes of ITC to the broader community, for example through community days, 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;
- empowering Aboriginal and Torres Strait Islander clients with the autonomy to select their preferred healthcare provider by facilitating connections to mainstream primary care where appropriate;
- 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 self-identify their Aboriginal and Torres Strait Islander status when accessing mainstream primary care services;
- delivering or coordinating cultural competency training and quality improvement activities;
- coordinating relevant education or health promotion events;
- disseminating information about the availability of programs (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 program and service coordination.

5.3 Qualifications and skill requirements

Qualifications, skills and experience are not specified for those undertaking the ATSIHPO role. It is expected that ATSIHPOs 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 5.1.

Aboriginal and Torres Strait Islander people should be engaged to work as ATSIHPOs where possible.

6 Aboriginal and Torres Strait Islander Outreach Workers

6.1 Roles and responsibilities

Outreach Workers will work with ATSIHPOs and Care Coordinators to help local Aboriginal and Torres Strait Islander people make better use of available health care services. With the support of clinical teams, Outreach Workers play a pivotal role in the following non-clinical responsibilities:

- **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**: communicates barriers faced by ITC clients to the ATSIHPO or Care Coordinator to identify areas for program improvement;
- **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 ATSIHPO, work to implement solutions.

6.2 Activities

The work of Outreach Workers should be tailored to meet the needs of the communities within the PHN 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;
- empowering and assisting Aboriginal and Torres Strait Islander people to:
  - navigate the complex healthcare system;

  - 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);
  - understand complex therapeutic management plans, diagnostic results, personalised action plans or instructions from health professionals to build on health literacy;
  - collect prescribed medications from the pharmacist and/or organise for dose administration aids where required;
  - return for follow up appointments with their GP and/or practice nurse; and
  - fill out forms and understand administrative instructions from reception staff.
- encouraging and supporting Aboriginal and Torres Strait Islander people to:
  - identify their Aboriginal and/ or Torres Strait Islander status;
  - register for MyMedicare; and
  - register for a Medicare card and/or concession and health care cards (if applicable).
- 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).

6.3 Qualifications and skill requirements

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.

There is flexibility to tailor the role and activities of the Outreach Workers to suit local needs, taking into account the objectives and outcomes outlined in these Program 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 local community, cultural competency, and capacity to fulfil the role as an Outreach Worker.

7 Care Coordinators

7.1 Roles and responsibilities

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 can 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. Care Coordinators are clinical staff (see Section 7.3) well placed to ensure that a level of personalised support which meets the individual clients' needs is provided.

Care Coordinators should develop and maintain a close relationship with their client and their respective 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 with 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 identify when a client's condition may require further assistance from other health professionals.

7.2 Activities

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 are 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:
  - actively engage in actions arising from their care plan goals, for example, encouraging regular medication uptake;
  - manage upkeep of medical devices (e.g., asthma puffers, blood pressure monitors, blood glucose monitors etc);
  - develop chronic condition self-management skills;
  - 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 (refer to Section 9), ITC also 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, ACCHS/AMS, local governments and non-government organisations, in order to link clients with the services they need.

Where appropriate, Care Coordinators should forge program connections to optimise client access to services and capitalise on funding opportunities afforded by other schemes (for example, MOICDP, which provides for outreach services delivered by multidisciplinary teams). They are also expected to work in collaboration with ATSIHPOs and Outreach Workers.

7.3 Qualifications and skill requirements

Care Coordinators are qualified health workers with a good working knowledge of the health system, such as nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers (current registration with the Australian Health Practitioner Regulation Agency where applicable, is preferred but not mandatory). Clinical skills allow Care Coordinators to have sound knowledge of the health system and how best to navigate it for ITC clients. This, in addition to a good understanding of the client's health needs, will allow for timely delivery of health care services and, where appropriate, targeted intervention. Consideration can be given to other appropriate qualifications or training in specific circumstances and in consultation with the Department of Health, Disability and Ageing (the department).

Care Coordinators are also expected to:

- provide culturally safe 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 ATSIHPOs and Outreach Workers.

Care Coordinators must operate in accordance with the treating GP's instructions as part of a formal management plan. It is recommended that Aboriginal and Torres Strait Islander people are recruited to work as Care Coordinators where possible.

8 Workforce Support and Development

Commissioning bodies and service providers are expected to ensure that appropriate ongoing support and development activities are provided to the ITC workforce. This includes formal training, peer support, professional guidance and mentoring. Provision of peer support, professional networking opportunities, training courses or other professional development, discussions on case studies or models of care, will 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 commissioning bodies or the organisations they commission as appropriate. Up to 3% of program funds should be allocated to support and development of the ITC workforce. Capacity building initiatives extended to the ITC workforce must prioritise cultural safety and responsiveness, ideally

delivered by or in partnership with Aboriginal and Torres Strait Islander community-controlled organisations wherever possible.

9 Supplementary Services

9.1 Definition of the Supplementary Services Funding Pool

The Supplementary Services Funding Pool can be used to assist clients who are enrolled in ITC to access medical specialist and allied health services (as well as certain associated medical aids – refer to Section 10.2 '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 ITC 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.

9.2 Priority allocation of Supplementary Services Funding

The Supplementary Services Funding Pool is not intended to fund the totality of follow up care required by clients who are registered under ITC. 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 commissioning body holds discretion regarding the overall allocation of Supplementary Services Funds and determines the eligibility of items or services for expenditure. The Care Coordinator's responsibility is to evaluate patient requirements and allocate the fund appropriately to meet the client's needs within the limits defined by the commissioning body.

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 costs of transport service(s).

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.

10 Allowable use of funds for ITC

The ITC budget should allocate at least 60% of funds to workforce as part of the Integrated Team Care component (see Section 10.1), with the remainder attributed to the Supplementary Services Fund component (see Section 10.2) of ITC.

Approval should be sought from the department if the forecasted or actual workforce allocation is expected to fall below 60%, accompanied by appropriate justification. A minimum allocation of 20% should be reserved for the Supplementary Services Funds to ensure both the care coordination and Supplementary Services objectives of ITC can be adequately met. The department may consider lesser allocations on a case-by-case basis.

10.1 Integrated Team Care

ITC funding can be applied to:

- salaries, salary on-costs, and travel associated with the employment of ATSIHPOs, Outreach Workers, and Care Coordinators. It can include travel and accommodation costs for Care Coordinators, ATSIHPOs and Outreach Workers to attend meetings and orientation and training activities. PHNs have the flexibility to allocate funds to employ an appropriate mix of ATSIHPOs, Outreach Workers and Care Coordinators as determined by regional needs;
- care coordination service support costs such as professional indemnity insurance directly attributable to the care coordination service;
- 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 ATSIHPOs, Care Coordinators and Outreach Workers;
- program administration of up to, but no more than, 8% of total funding for commissioning bodies. There are different circumstances and challenges in different PHN regions, and an administrative fee of up to 8% of total Program funding is considered a reasonable benchmark for organisations commissioned to deliver ITC services. Commissioning bodies can consider the individual circumstances of commissioned organisations when finalising contracting arrangements with commissioned organisations, noting that value for money should be a key consideration. Program administration includes commissioning, ongoing contract management and reporting requirements.
    - This allocation may be used, if appropriate and necessary, to fund staff involved in program administration, e.g., managing program expenditure including Supplementary Services and reporting. Where this is the case, ITC funding must only be used to fund the proportion of staff wages that is the same as the proportion of their time spent on ITC work. ITC funds must not be used to pay 100% of the wages to support staff unless 100% of the work is on ITC.

- **costs such as rent and other utilities must come from the core funding of commissioning bodies and not ITC funding**; and
- needs assessments and market analyses might result in more than one commissioning body contracting the same service provider. If this situation occurs, the respective commissioning bodies 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 by Care Coordinators where appropriate.

Funding must also not be used to purchase assets.

Commissioning bodies have the flexibility to work with neighbouring commissioning bodies, PHNs, ACCHS/AMS or mainstream services following agreement by all parties. This may include pooling of resources.

Such arrangements would need to be reflected in the Activity Work Plans of the commissioning bodies involved. The relevant Grant Officer or Funding Arrangement Manager (FAM) must be advised of any such arrangement and will need to receive prior approval from the department through the Activity Work Plan development process.

> If you are unsure whether ITC funds can be used for a particular item or activity, please contact your relevant Grant Officer or FAM.

10.2 Use of Supplementary Services Funds

Commissioning bodies may manage the Supplementary Services Funding Pool centrally, and 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 commissioning body may choose to provide an allocation of Supplementary Services Funding to a commissioned organisation. In such cases, the commissioned organisation will report the above information to the commissioning body, 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 ATSIHPOs or Outreach Workers.

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

10.2.1 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 safe way, or providers who agree to bulk bill clients being referred under ITC, may be established at the local level.

Commissioning bodies and their contracted organisations 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 Services Australia at www.servicesaustralia.gov.au or telephone 132 011. For provider enquiries, telephone 132 150.

10.2.2 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;
  - continuous glucose monitoring (CGM) devices are **not** eligible for funding under Supplementary Services. Eligibility for access to subsidised CGM products under the National Diabetes Services Scheme is available from the NDSS website.
- dose administration aids;
- medical footwear that is prescribed and fitted by a podiatrist;
- mobility aids (e.g., crutches, walking frames, or non-electric wheelchairs) or shower chairs; and
- spectacles (see Section 10.2.3 for conditions)

Where possible, spacers should be used rather than nebulisers.

Requests for medical aids which are not listed in Section 10.2.2 can be submitted to the department for consideration on a case-by-case basis, accompanied by the appropriate justification.

Many of the quality use of medicines (QUM) devices listed above are available through the *Indigenous Health Services Pharmacy Support (IHSPS)* and *Indigenous Dose Administration*

Aids Program administered by the pharmacy sector. These programs replace the Quality Use of Medicine Maximised for Aboriginal and Torres Strait Islander People (QUMAX). Where possible and when available, PHNs and organisations commissioned to deliver ITC must preferentially use these programs to support ITC clients before utilising the Supplementary Services Funds. More information on each of the programs is available from the following links:

- **Indigenous Health Services Pharmacy Support (IHSPS)**: Indigenous Health Services Pharmacy Support Program – Pharmacy Programs Administrator (ppaonline.com.au)
- **Indigenous Dose Administration Aids**: Indigenous Dose Administration Aids - Pharmacy Programs Administrator (ppaonline.com.au)

Care Coordinators will be required to include in the 12–monthly progress reports to the department the details of Supplementary Services Funding used to acquire approved medical aids (e.g. number and type of aid(s), relevant costs to purchase/hire).

10.2.3 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-year window;
- 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; and
- where Supplementary Services funded spectacles have been lost, broken or stolen, replacement using further Supplementary Services Funds is not allowable.

All of these conditions must be clearly communicated to the client.

10.2.4 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 commissioning body. The item must be on the client's GP care plan, be considered clinically necessary, take into account client needs, and funding must be available. Supplementary Services Funds cannot be used for maintenance costs of medical aids purchased under exceptional circumstances. Commissioning bodies and commissioned organisations 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.

If required, commissioning bodies may send the request to the relevant Grant Officer or Funding Arrangement Manager (FAM). Please refer to the ITC Decision Tool at Appendix 2 for further information about this process.

10.2.5 Transport

Supplementary Services Funding can be used to support clients' 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. client 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.

Commissioning bodies and service providers 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 13).

11 Management of funds

Commissioning bodies are the fund holders for ITC and will be responsible for all ITC reporting to the department (More information is provided at Section 13 'Reporting'). For management of the Supplementary Services Funding Pool, see Section 10.2.

12 Needs assessment

The Primary Health Networks (PHNs) needs assessment policy guide provides a model for undertaking a needs assessment and can be used a general guide for commissioning bodies in this process. This is accessible via the following link: Primary Health Networks (PHNs) needs assessment policy guide.

Commissioning bodies are expected to conduct a needs assessment that span the duration of ITC delivery but have the flexibility to customise the needs assessment to align with their organisation's requirements and operational structure. This ensures that the health needs of Aboriginal and Torres Strait Islander people can be met through targeted activity at the local level. Commissioning bodies may also explore or collaborate with PHNs within the regions of their service areas to access existing, up-to-date needs assessments.

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

- characteristics of the local Aboriginal and Torres Strait Islander population;
- existing mainstream and Aboriginal and/or Torres Strait Islander health services;
- stakeholder views and expectations;

- analysis of health care and access needs; and
- changing patterns of uptake and demand.

13 Reporting

As part of the deliverables under ITC in the Indigenous Australians' Health Programme Funding Schedule or Standard Grant Agreements, commissioning bodies are required to submit Needs Assessments, Activity Work Plans, annual budgets and twelve-monthly performance reports (including financial reports). Commissioning bodies must complete all of the report and budget templates, this includes budget information about all of the commissioned workforce positions. Commissioning bodies must meet these requirements, and to an appropriate standard, in order to receive ITC funding.

Financial statements must be provided in the budget template determined by the department and must include details of expenditure against:

- ITC workforce expenses;
- Supplementary Services; and
- Program administration.

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

Commissioning bodies must collect and report data for monitoring the performance of ITC. PHNs must use the reporting templates and submit deliverables through the Primary Health Networks Program Electronic Reporting System (PPERS). Other commissioning bodies will submit the reports to their respective FAM.

Reports from commissioning bodies should provide a summary of the of the Program data across their region.

Commissioning bodies 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, especially the financial data. 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.

14 Assessment and approval

Payments to commissioning bodies will be dependent on approval of deliverables by the department. In assessing Needs Assessments, Activity Work Plans, annual budgets and 12-monthly performance reports for the Program, the department will consider:

- how well the objectives of ITC 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 outcomes.

15 Maintenance of information and data

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

16 Further information

For further information regarding ITC implementation, please contact your relevant Grant Officer in the department or FAM.

Appendix 1 – Frequently Asked Questions (FAQs)

The FAQs are not meant to be an exhaustive list of what is excluded/out of scope for ITC funding. If you have any further questions on activities and items eligible for ITC funding, please consult the relevant commissioning body, FAM or Grant Officer.

Services Australia should be contacted for all questions regarding claiming Medicare rebates for services.

Website - www.servicesaustralia.gov.au

General Enquiries – **132 011** (local call rate)

Provider Enquiries – **132 150** (local call rate)

1. Client Eligibility

i. Who can refer a client for care coordination?

The client should receive a referral from a GP associated with the primary practice responsible for delivering the majority of care to the client and for developing the client's care plan. Referral from a GP who regularly interacts with the client to review and maintain a care plan established by another provider is also acceptable. This can be in a mainstream general practice or Aboriginal Community Controlled Health Service / Aboriginal Medical Service.

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 ITC by a Remote Area Nurse or equivalent position may be permitted as an interim measure. 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.

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

No. High risk clients are not eligible. The care coordination component of ITC 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.

iii. What is considered a chronic disease for the purposes of ITC?

ITC uses the Medicare Benefits Schedule (MBS) definition of a chronic disease, which is: a disease or condition that has been or is likely to be present for at least six months6, including (but not limited to) asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis or a musculoskeletal condition.

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[6] MBS Online. Medicare Benefits Schedule – Note AN.0.47 *Chronic Disease Management Items (Items 721 to 732)*.

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

Priority should be given to clients with complex chronic care needs who require multidisciplinary coordinated care in order 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.

iv. Can children access ITC?

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

v. Can ITC clients seek treatment across PHN regions?

Yes. Where clients enrolled in ITC seek treatment across PHN regions, the relevant commissioning bodies should work together to develop processes that best meet local circumstances.

2. Care Coordinator Eligibility

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

Wherever possible, Care Coordinator positions should be filled by an individual with the relevant clinical skills. In specific circumstances and in consultation with the

Department of Health, Disability and Ageing, consideration may be given to people who have other appropriate qualifications, training, skills and personal attributes.

3. Travel

i. 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).

ii. 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. client 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.

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

If a client requires a parent, carer or other support provider to enable 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.

iv. Can Supplementary Services be used to cover parking for an ITC client attending a health care appointment?

Yes. Parking costs can be covered for a client attending a health care appointment.

v. Should commissioning bodies contact the FAM or relevant Grant Officer 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 discretion of the commissioning body.

4. Medical Aids

i. 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.

5. Other Services

ii. 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 commissioning bodies.

iii. Can Supplementary Services Funding be used to pay for health services that clients accessed prior to being enrolled in ITC?

No. Supplementary Services Funds cannot be used to pay for costs incurred by clients prior to being referred to and accepted into ITC.

iv. 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.

v. 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.

6. Client Consent and Confidentiality

i. Does client consent need to be obtained for participation in ITC?

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.

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

i. 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.

ii. 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, as long as 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 considered to be private rooms. This advice does not supersede Section 10.2.

iii. 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 ITC.

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 (refer to Sections 9 and 10).

iv. 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.

v. 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 commissioning bodies.

vi. Can Supplementary Services Funding be used to cover the gap following the PBS Co-payment?

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

vii. 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.

viii. 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.

ix. 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 PHN/commissioned organisation must follow the claiming advice provided below. PHNs/commissioned organisations can call 132 150 (Medicare Provider enquiry line) if they have any further questions.

Note: The PHN/commissioned organisation accounts cannot be submitted electronically.

1. Specialist/Allied Health Practitioners issue an unpaid account to the PHN/commissioned organisation.
2. The Primary Health Network/commissioned organisation submits the unpaid account together with the Medicare claim form. When lodging the account and completed claim form, it can be either sent directly to the Services Australia - Medicare, GPO Box 9822 in your capital city or returned to a Service Centre. 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 PHN/commissioned organisation must forward the Medicare cheque along with a PHN/commissioned organisation cheque for the gap amount to the servicing provider.

x. Can Supplementary Services Funding be used for private dental services, including the purchase of dentures?

No. The Commonwealth is currently implementing a number of 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.

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

8. Care Plans

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

The ITC Program Implementation Guidelines specify that Aboriginal and Torres Strait Islander clients must be enrolled for chronic disease management in a general practice or an ACCHS/AMS, have a GP chronic condition management plan (previously known as GP management plan and/or team care arrangement) and be referred by their GP.

> Note: Changes to the chronic disease management MBS items took effect on 1 July 2025, with a two-year transition period to maintain service access for existing patients. The GP management plans (GPMPs), and team care arrangements (TCAs) were replaced with a single GP chronic condition management plan (GPCCMP). Factsheets on the major changes to the MBS framework for chronic disease management in primary care and the impact on providers and patients are linked here.

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) and GP chronic condition management plan (GPCCMP – items 965, 392, 92029, 92060).

The benefits of the GP chronic condition management plan for ITC clients is 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 GPCCMP review process (Review of a GPCCMP – items 967, 393, 92030, 92061) helps ensure an ITC client is receiving the appropriate care for their current health needs.

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

No. The Program Implementation Guidelines state that the client must have a care plan, be enrolled for chronic disease management in a general practice, Aboriginal Community Controlled Health Service or Aboriginal Medical Service and be referred by their GP for care coordination services to be eligible to access ITC. Clients who may be eligible for ITC in remote areas can be referred into the program by a Remote Area Nurse or Outreach Worker, where limited support including transport can be provided to attend GP appointments and enable access to care plans (see Section 2.5).

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 commissioning bodies and the organisations they commission to make more timely decisions about how they prioritise and allocate services and supplementary services funding.

Once you have read the ITC Program Implementation 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 still remain unsure, send your query, together with this completed form to the relevant commissioning body. The commissioning body may forward this request to their FAM or Grant Officer and the department will consider the request. Advice will be provided based on the information in this decision tool.

Key questions

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 escalating 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 commissioning body. The item must be on the client's GP care plan, be considered clinically necessary, take into account client needs, and

funding must be available. If required, the commissioning body may send the request to the relevant Grant Officer or FAM for a decision.

Decision Support Tool for ITC Care Coordination or Supplementary Services

Question	Response
What is your interpretation of the ITC Program Implementation Guidelines in relation to this request?	
Question	**Response**
Do you think the client is likely to improve and benefit from this ITC service/aid?	
Do you think the client'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?	
Are there any potential barriers to the client engaging with treatment and services? If so, how could these be managed?	
Will the client be at risk of an unplanned/avoidable hospital admission/presentation if this request is not approved?	
Will the client's self-management of their chronic disease be significantly compromised if this request is not approved?	
Is there an immediate clinical risk to the client if the service/aid is not provided (i.e. client 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 client's GP Care Plan, and are they willing to support the client'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 clients with a similar case?	
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, Disability and Ageing?	

Question	Response
Have you consulted with your local clinical advisory team? Do they support this request?	

It is the responsibility of the Care Coordinator, Program Manager and commissioning body to justify use of funds for the provision of any service and for the purchase of Medical Aid(s) for a client.

If you have any further questions, please contact your relevant Grant Officer or Funding Arrangement Manager (FAM).

Health.gov.au

All information in this publication is correct as at July 2025