1. Introduction
This document describes the Care Coordination and Supplementary Services (CCSS) Program and provides guidance for the implementation and management of the Program. It must be read in conjunction with the Medicare Locals Deed for Funding and associated CCSS Program Schedule.

Further advice can be found in the CCSS Program Frequently Asked Questions.

Program Context
The CCSS Program was established in 2009-10 as part of the Commonwealth’s Indigenous Chronic Disease Package (ICDP). The ICDP aims to reduce chronic disease risk factors, encourage earlier detection and better management of chronic disease in primary care services, improve follow-up care and increase the capacity of the primary care workforce to deliver health care to Aboriginal and Torres Strait Islander people. Information about the ICDP is available at http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1. Alternatively, information can be requested via email at ICDP@health.gov.au.

Service Delivery Principles
Medicare Locals are required to consider the following service delivery principles established by the National Indigenous Reform Agreement (Closing the Gap) when implementing the CCSS Program:

- **Indigenous Engagement:** Engagement with Aboriginal and Torres Strait Islander people and communities should be central to the design and delivery of programs and services.
- **Access:** Programs and services should be physically and culturally accessible to Aboriginal and Torres Strait Islander people, recognising the diversity of urban, regional and remote needs.
- **Accountability:** Programs and services should have regular and transparent performance monitoring, review and evaluation.

Aim and Objective of the CCSS Program
The aim of the CCSS Program is to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care.

Program Description
Aboriginal and Torres Strait Islander patients with chronic disease, who are enrolled in and referred by a general practice or Aboriginal Medical Service (AMS)/Aboriginal Community Controlled Health Organisation (ACCHO) participating in the Practice Incentives Program Indigenous Health Incentive (PIP IHI), are eligible for support under the CCSS Program. Where the lack of availability of practices that are eligible for the PIP limits referral to care coordination services, Medicare Locals can apply to the Department of Health and Ageing for an exemption to referral requirements on a case by case basis.

The program has two components:
- Care coordination is provided by qualified health workers (e.g. specialist nurses, Aboriginal Health Workers) to ensure that patients are accessing services consistent with their GP care plan. Activities can include provision of appropriate clinical care, arranging the services required, assisting the patient to attend appointments, ensuring medical records are complete and current and ensuring regular reviews are undertaken by the patient’s primary care providers.
A flexible funding pool (Supplementary Services) is also available for use by Care Coordinators when they need to expedite a patient’s access to an urgent and essential allied health or specialist service (including certain approved medical aids) or the necessary transport to access the service, where this is not publicly available.

Funds for the CCSS Program will be managed by Medicare Locals. Medicare Locals must work with the Indigenous health sector when planning and delivering the program and ensure that patients of both mainstream and Indigenous health services/ACCHOs have access to care coordination.

Medicare Locals may subcontract to organisations such as mainstream and Indigenous Health Services/ACCHOs or other relevant organisations to provide the care coordination services.

2. Care Coordination

Definition of Care Coordination

For the purpose of the Program, care coordination means working collaboratively with patients, general practices and Indigenous health services/ACCHOs, and other service providers to assist in the management of coordinated care for patients with chronic disease.

Definition of Chronic Disease

For the purpose of the CCSS Program, and consistent with the Medicare Benefits Schedule, a chronic disease is one that has been, or is likely to be, present for at least six months. Consistent with the objectives of the ICDP, the CCSS Program targets diabetes, cardiovascular disease, chronic respiratory disease, chronic renal (kidney) disease and cancer.

Benefits of Care Coordination

Effective management of chronic health conditions gives people improved health outcomes, provides better quality of life and keeps people out of hospital.

Care coordinators can:

- assist Aboriginal and Torres Strait Islander people to understand their chronic health condition and how to manage it;
- advise on the importance of following a care plan, which may include structured support for chronic disease self management and assistance with care plan compliance; and
- provide support in identifying signs that the 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. Many general practices have both GPs and practice nurses who are time poor and unable to provide the holistic care and support that would be ideal for patients with complex chronic conditions. A Care Coordinator can take on this role - for example, 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.
Care Coordination Function

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

- providing appropriate clinical care, consistent with the skills and qualifications of the Care Coordinator;
- arranging the required services as 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, assisting with medication compliance;
  - develop chronic condition self management skills; and
  - connect with appropriate community based services such as those providing support for daily living.

Through the Supplementary Services funding, the CCSS Program also enables Care Coordinators to assist patients to access the 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 needed.

Where appropriate, Care Coordinators are required to establish links with other ICDP initiatives (e.g. MSOAP-ICD provides for outreach services provided by multidisciplinary teams, the Flinders Chronic Disease Self-Management Project provides training in self-management – refer http://www.health.gov.au/tackling-chronic-disease or email ICDP@health.gov.au for further information about relevant measures). They are also expected to work in collaboration with Indigenous Health Project Officers and Aboriginal and Torres Strait Islander Outreach Workers funded through the ICDP, where these are available.

Care Coordination or Service Coordination?

In practice, the CCSS Program combines assistance with aspects of clinical care and assistance with navigation of the health system. The balance between these activities will vary.

For example, a patient may be referred to the CCSS Program for assistance in coordinating care for their diabetes. The patient may be in need of urgent podiatry services, in line with the GP’s instructions. Unable to access this through the public health system due to a lengthy wait for appointments, the Care Coordinator may arrange an appointment with a private podiatrist, using Supplementary Services funds to pay for the service and then put in place ongoing care through the public system. There is also no available or affordable transport for the patient to get to appointments. The Care Coordinator therefore contacts the Aboriginal and Torres Strait Islander Outreach Worker employed by the Medicare Local and arranges for the patient to be driven to the appointment, or uses Supplementary Services funds to assist with the cost of other transport to the appointment.
Another newly diagnosed patient with diabetes may require assistance with learning blood glucose monitoring skills and the Care Coordinator may have the necessary skills to undertake this task.

**How might a Care Coordination Service work?**

If a GP in a mainstream practice or Indigenous Health Service/ACCHO that is participating in the PIP-IHI 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 CCSS Program.

Care coordination works best when a care coordinator is able to discuss with each general practice 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 must provide feedback to the GP about how the patient is managing their condition/treatment, the services arranged for the patient and any other issues that may impact on 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 e.g. noting home safety or access issues that have a health implication.

Supplementary Services funding (refer Section 2 below) may be used to help overcome barriers in accessing services identified in the care plan.

While more intensive support may be required at the outset, as patients become more familiar with and confident in managing their condition and accessing services, they may no longer need to participate in the Program. As the patient becomes less reliant on this support, contact with the patient may decrease and ultimately cease over time. The Care Coordinator should ensure this occurs in a managed way, for example, by assisting the patient to develop skills to actively manage their condition and relate to service providers. As the GP remains the primary carer, he/she is able to identify any re-emerging risk of hospitalisation or reduced health care status, through regular consultations and review of the patient’s care plan.

**Care Coordination Service Models**

Models of care coordination services can include:

- full or part time employment of a Care Coordinator;
- “sharing” a Care Coordinator position role across general practices;
- contracting the services of an appropriately qualified clinician to provide care coordination; and
- “topping up” the salary of an Aboriginal Health Worker or a nurse in an Indigenous Health Service/ACCHO to increase the time spent on care coordination activities.

Other models that meet the needs of a community and take account of any related services already operating may be developed. In developing a model, the emphasis should be on planning a cost effective approach that results in maximum services to patients.

**Patient eligibility**

To be eligible for care coordination under the CCSS Program, Aboriginal and Torres Strait Islander patients must have a care plan, be enrolled for chronic disease management in a general practice or Indigenous Health Service/ACCHO participating in the PIP IHI and be referred by their general practitioner. In regions where the lack of availability of practices that are eligible for the PIP IHI limits referral to care coordination services, Medicare Locals can apply to the Department for an exemption to eligibility requirements on behalf of practices and Aboriginal Medical Services in the region.
Not all patients with a chronic condition will need assistance through the CCSS Program. Priority should be given to patients most in need of care coordination services to realise improved health outcomes.

As a guide, patients most likely to benefit include:

- patients who are at greatest risk of experiencing otherwise avoidable hospital admissions;
- patients at risk of inappropriate use of services, such as hospital emergency presentations;
- patients not using community based services appropriately or at all;
- patients who need help to overcome barriers to access services;
- patients who require more intensive care coordination than is currently able to be provided by general practice and Indigenous Health Service/ACCHO staff; and
- patients who are unable to manage a mix of multidisciplinary services.

**Care Coordinators – qualifications and skill requirements**

Care Coordinators will be qualified health workers, such as nurses and Aboriginal and Torres Strait Islander Health Workers. Clinical skills will allow the Care Coordinator to understand the patient’s health needs and, where appropriate, assist with those needs. Consideration could be given to other appropriate qualifications or training in specific circumstances and in consultation with the Department of Health and Ageing.

Care Coordinators are also expected to:

- provide culturally sensitive 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 across program boundaries, for example, with ICDP funded Indigenous Health Project Officers and Aboriginal and Torres Strait Islander Outreach Workers.

Care Coordinators must operate in accordance with the treating doctor’s instructions.

**Professional-peer support for people undertaking the care coordination role**

Opportunities for peer support, professional guidance and mentoring are essential. However, Care Coordinators may be geographically distanced from others undertaking the same role. Provision of peer support and professional networking opportunities, e.g. case-discussions and models of care, is likely to enhance on-the-job learning, quality of service and retention rates. Medicare Locals are expected to ensure that appropriate ongoing peer support and guidance is provided for Care Coordinators.

Medicare Locals are also required to convene a meeting at least annually for Care Coordinators in their region to support skill enhancement, information sharing and facilitate peer support.

The Australian Government is also developing arrangements for national workforce support for Care Coordinators, Indigenous Health Project Officers and Aboriginal and Torres Strait Islander Outreach Workers.
3. Supplementary Services

Definition of the Supplementary Services Funding Pool

Patients in the CCSS Program may be referred by their GPs to services that are not accessible due to the lack of an available appointment with a publicly funded provider or the lack of affordable transport. When barriers such as these exist, and a delay is clinically inappropriate, the Care Coordinator may use the Supplementary Services funding to expedite the patient’s access to these services in the private sector.

The Supplementary Services funds can be used flexibly to assist patients in the CCSS Program to access medical specialist and allied health services (as well as certain associated medical aids – refer Section 4 below) where these services are in accordance with the patient’s care plan. The funds may also be used to assist with the cost of transport to appointments.

Priority allocation of Supplementary Services funding

The supplementary services pool cannot fund all of the follow up care required by patients in the CCSS Program. Supplementary Services funds should only be used where other services are not available in a clinically acceptable timeframe.

As the Supplementary Services funding is a limited resource, priority for the use of these funds should be given to responding to urgent needs. The funds should be used to purchase services that:

- address risk factors, such as a waiting period for a service longer than is clinically appropriate;
- reduce the likelihood of a hospital admission;
- are likely to reduce 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 pool may be required in urgent circumstances, local arrangements need to accommodate rapid approval of expenditure and access to Supplementary Services funds.

4. Allowable use of funds

The program has two elements:

- Care Coordination; and
- Supplementary Services

Care Coordination

New care coordination services or extension of existing services may be supported under the CCSS Program. Models that are practical, build on any existing services and acknowledge local characteristics (e.g. geographic, demographic, referral pathways) are encouraged.

Program funding can be applied to:

- the salary costs of employing Care Coordinators, or the salary costs of extending the role of existing staff members who are undertaking the care coordination role;
- care coordination service support costs – related to the direct provision of the care coordination role. These may include:
- reasonable travel costs for Care Coordinators to liaise with patients, health services and community care providers in the region;
- costs related to renting office space for Care Coordinators and associated administration expenses for the care coordination service.
- professional indemnity insurance costs directly attributable to the care coordination service.

- reasonable costs to provide administrative assistance for the Care Coordinator. This could include help with activities such as reporting, making appointments, managing payments from the Supplementary Services fund and sourcing alternative funding streams for patient care.
- reasonable recruitment costs;
- program administration - up to 20% (unless otherwise approved by the Department) of the allocation for Care Coordination can be used for costs relating to the administration of the Program such as contract management, MMEx licences, provision of mentoring and professional support, and education and skills development for care coordinators.

Proposed budgets and financial reports must provide a breakdown of these items.

**Supplementary Services**

**Fees for service**
Care Coordinators can draw on Supplementary Services funding 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 (where MBS rebates are not available), or to meet the difference between MBS rebates and fees charged by private specialists or allied health providers. In some areas it may be reasonable to pay providers a retainer for making urgent appointments available to CCSS Program patients or for undertaking sessional work in a particular location. “Panels” of preferred providers and organisations that provide services in a culturally safe way may also be established at the local level.

**Medical Aids**
Supplementary Services funds can be used by Care Coordinators to access the following medical aids:

- Dose Administration Aids (DAAs);
- Assistive 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; and
- Medical Footwear that is prescribed and fitted by a podiatrist.

DAAs, blood sugar/glucose monitoring equipment and most assistive breathing equipment is currently available under the Quality Use of Medicine Maximised for Aboriginal and Torres Strait Islander People (QUMAX) Program for patients of participating Aboriginal Community Controlled Health Services. For eligible patients, QUMAX must continue to be used to acquire these items.

Where possible, spacers should be used rather than nebulisers.

The above medical aids may only be acquired using Supplementary Services funding where:
- the medical aid is not available through any other program in a clinically acceptable time;
- the need for the medical aid is related to one of the five chronic diseases targeted by the program (diabetes, cardiovascular, cancer, chronic respiratory and chronic renal) 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 Australian Medicare Locals Alliance will work with Medicare Locals to assist with guidance around matters such as clinical governance, risk management and sourcing and management of medical aids.

**Transport**

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

In such cases, the manager of the Supplementary Services fund must ensure that all other funding options (e.g. patient assisted travel schemes) have been exhausted and that the most cost effective means of transport (and any essential accommodation) is utilised. 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.

Medicare Locals are encouraged to liaise with the relevant fundholder for the Medical Specialist Outreach Assistance Program (MSOAP) – Indigenous Chronic Disease (ICD) and the Urban Specialist Outreach Assistance Program (USOAP) regarding opportunities to access outreach services.

Proposed budgets and financial reports must provide a breakdown of fees for service, medical aids and transport.

**5. Management of Funds**

Funds for the CCSS Program will be managed by Medicare Locals. These organisations may subcontract to other organisations such as mainstream and Indigenous health services/ACCHOs or other relevant organisations to provide the care coordination services. Organisations delivering the CCSS Program must be able to work with Aboriginal and Torres Strait Islander communities, the full spectrum of primary health care providers and relevant community services.

Medicare Locals must ensure that patients of both mainstream and Indigenous health services/ACCHOs have access to care coordination under the CCSS Program and must consult with the Indigenous health sector in developing plans for delivery of the program.

Medicare Locals and subcontracted service delivery organisations will need to establish consultative mechanisms to engage appropriate state/territory and local stakeholders in planning, managing and monitoring program delivery, including the development of a plan for implementation of the CCSS Program in their region. It is expected that this plan will draw on the needs assessments already undertaken by the Medicare Local, including under the Closing the Gap *Improving Indigenous Access to Mainstream Primary Care Program*, where this is operating.

Over time, Medicare Locals will be required to consult with relevant stakeholders to undertake refinements to their initial implementation plan, to reflect changing patterns of uptake and demand for the Program.
Medicare Locals may choose to manage the supplementary services pool arrangements directly or subcontract to care coordination service delivery organisations. However, Medicare Locals will retain overall responsibility for reporting on the number and type of services purchased and how the supplementary services pool funds are expended.

6. **Reporting**

**Financial reports**

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

- Care Coordinator expenses;
- Supplementary Services; and
- Program Administration.

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

**Program monitoring and reporting – performance indicators**

Medicare Locals must collect and report data for monitoring the performance of the Program. Reporting requirements will be determined by the Department of Health and Ageing and will include:

- Number of FTE Care Coordinators recruited;
- Skills and qualifications of persons occupying positions;
- Number of GPs referring to Care Coordinators;
- Number of patients who have received care coordination services;
- Number and location of care coordination services funded by the program;
- Types of service delivery models;
- Number of and type of services supported through the Supplementary Services funds, specifically:
  - allied health;
  - specialist;
  - other relevant support services (specify);
  - medical aids and equipment (purchased and hired); and
  - transport services.

Medicare Locals must use the National Online Reporting Tool and Minimum Data Set (MMEx Platform) for reporting purposes.

**Program Evaluation**

The Commonwealth is conducting a formal evaluation of the CCSS Program as part of an overall evaluation of the Commonwealth’s ICDP. Medicare Locals may be required to contribute to this evaluation by providing qualitative or quantitative data on the CCSS Program. In addition, the Medicare Locals may be required to contribute to the Sentinel Sites Evaluation, which is designed to provide local baseline data, identify early outcomes from the ICDP and contribute to the overall evaluation of the ICDP outlined above. Should a location included in the region covered by the Medicare Local be designated to be a sentinel site, the Medicare Local will be required to work cooperatively with the consultant engaged by the Commonwealth to manage the Sentinel Sites Program.

Medicare Locals may also be required to participate in additional evaluation activities established by the Commonwealth.