



Australian Government
Department of Health and Ageing

CLOSING THE GAP
tackling
Indigenous
chronic
disease

INDIGENOUS CHRONIC DISEASE PACKAGE

CARE COORDINATION AND SUPPLEMENTARY SERVICES

PROGRAM GUIDELINES

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1. Introduction

This document describes the Indigenous Chronic Disease Package Care Coordination and Supplementary Services (CCSS) Program and provides guidance for organisations and individuals in the implementation and management of the Program.

Program context

In November 2008, COAG agreed to a \$1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes to address the first of the COAG Closing the Gap targets – to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. The Commonwealth is contributing \$805.5 million over four years for an Indigenous Chronic Disease Package that will reduce chronic disease 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 effective health care to Aboriginal and Torres Strait Islander people.

The CCSS Program is one of the measures under the package aimed at improving chronic disease management and follow up care.

It is estimated that Aboriginal and Torres Strait Islander people experience a burden of disease two and a half times that of non-Indigenous Australians. Chronic diseases and their associated risk factors are responsible for about two-thirds of the life expectancy gap between Indigenous and non-Indigenous Australians. Aboriginal and Torres Strait Islander people are more likely to die from these conditions than non-Indigenous Australians with the same condition.

In general, Aboriginal and Torres Strait Islander people tend to under use primary health care services relative to need. Aboriginal and Torres Strait Islander people are much more likely to access hospital services for ambulatory care sensitive conditions, which may be treatable in primary care settings. Issues such as cost, lack of cultural appropriateness of services, location and transport problems are barriers to access to primary care.

Patients with complex chronic conditions require care from a range of health services and health professionals. These services are provided free of charge to patients by state and territory governments but can have significant waiting times. These services may be available in a more timely fashion in the private sector but out of pocket expenses to patients can be high and the costs can put some of these services out of reach of many Aboriginal and Torres Strait Islander people.

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.

The CCSS Program also aims to increase the support to Indigenous patients through their GPs and provide more proactive management.

Program description

The CCSS Program will contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through the following two components:

1. Care coordination provided by qualified healthcare workers to Aboriginal and Torres Strait Islander patients with a chronic disease. Patients must be referred by a GP in general practices or Indigenous Health Services participating in the Practice Incentives Program (PIP) Indigenous Health Incentive; and
2. Supplementary Services. There is a flexible pool of funds that can be used to assist patients receiving care coordination under the CCSS Program. The funds can be used to access medical specialist and allied health services that are in accordance with the patient's care plan. The funds may also be used to assist with the cost of local transport to health care appointments.

Funds for the CCSS Program will be managed by the State Based Organisations (SBOs) of the Divisions of General Practice Network. SBOs may provide care coordination services or may subcontract to Divisions or other nominated fundholders such as Indigenous Health Services, or lead/groupings of Divisions to provide these services.

The CCSS Program will be implemented progressively through a staged approach and will not be available in all locations in the initial years of the Program.

2. Care Coordination

Definition of care coordination

For the purpose of the Program, “care coordination” means working collaboratively with patients, and general practices and Indigenous health services to assist in the provision of care and services that facilitate a person with a chronic condition to manage their health in a way that will result in the optimal health outcome for them.

Definition of chronic disease

For the purpose of the 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 Indigenous Chronic Disease Package (ICDP), the CCSS Program will target 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 coordination can assist people with a chronic condition to access the specialist, allied health and other support services they need to manage their condition effectively.

Successful care coordination connects people with chronic and complex needs to community models rather than acute models of care. Care coordination is most successful when there is a close relationship between the GP and the care coordinator.

Care coordination can assist Aboriginal and Torres Strait Islander people to gain timely access to allied health and specialist services. The CCSS Program will provide assistance to Aboriginal and Torres Strait Islander patients through meeting the costs of some of these services, where necessary, and providing assistance with transport to appointments, where this is a barrier to access.

Care coordination can:

- assist Aboriginal and Torres Strait Islander people in understanding their chronic health condition and managing it on a daily basis;
- advise on the importance of following their 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 their condition may require further assistance from a health professional.

Care coordination function

Care coordination should be in accordance with a care plan developed by a referring GP to assist patients to access services.

Care coordination services may include:

- arranging the services required;

- ensuring there are arrangements in place for the patient to get to appointments;
- transferring and updating a patient's medical records;
- assisting the patient to participate in regular reviews by their primary care provider; and
- assisting Aboriginal and Torres Strait Islander patients to:
 - access the range of specialist, primary and allied health services required for their ongoing care in line with their care plan and in close consultation with the patient's home practice;
 - 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.

For care coordination to be effective, the care coordinators undertaking this role need to work collaboratively with the services in their local areas, including mainstream services provided by state/territory governments, local governments and non government organisations, in order to link patients with the services needed to assist them to manage their chronic conditions.

At a local level, many general practices have both GPs and practice nurses who are time poor and may not be able to provide the degree of holistic care and support that would be ideal to assist patients. A care coordinator may take on this role where it is needed, for example, by assisting the patient to access a range of services such as allied health professional appointments, home help and a support group. Information on the services the patient has been connected with will then be fed back to their GP for inclusion in the patient's care plan so that it can be considered in future reviews of the plan.

A number of initiatives being introduced as part of the Indigenous Chronic Disease Package support the development of community based health services. Aboriginal Health Workers or nurses providing care coordination services will need to have an understanding of these initiatives. Further information is contained in Attachment A and at: <http://www.health.gov.au/tackling-chronic-disease>.

Care coordination or service coordination?

In practice, the CCSS Program combines assistance with aspects of clinical care ('care coordination') and assistance with navigation of the health system ('service coordination'). The balance between care coordination and service coordination will vary in different areas and depend upon the time and staffing profile of individual general practices or Indigenous Health Services within the area.

For example, a patient may be referred to the CCSS Program for assistance in coordinating their diabetes care. 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 three month wait for appointments, the patient may require assistance to access a private podiatry provider and funds from the flexible funding pool to pay for the cost of the appointment.

Another patient newly diagnosed with diabetes may require assistance with learning blood glucose monitoring skills. There is not a diabetes educator working in the local area so the care coordinator may undertake this task. The care coordinator provides feedback to the GP when this has been done, including how the patient is managing the blood glucose monitoring and any concerns the care coordinator has noticed while assisting the patient to acquire blood glucose monitoring skills.

How could a Care Coordination Service work?

If a GP in a practice or Indigenous Health Service participating in the PIP Indigenous Health Incentive considers that the patient with a care plan would have improved health outcomes from having care coordination, the GP can refer the patient to a care coordination service under the CCSS Program.

A care coordinator works in consultation with the patient's GP and in accordance with the care plan. The coordinator should provide feedback to the GP about how the patient is managing their condition/treatment and any other issues that may impact on the patient's health. The coordinator may also provide feedback to the GP about the patient's local environment when this information is relevant to the care plan, for example, noting home safety or access issues that have a health implication. Supplementary services funding may be used to help overcome barriers for the patient in accessing services identified in the care plan. More information about supplementary services under the Program is provided later in this document.

Care coordination works best when a care coordinator is able to discuss with each general practice the type of services which are able to be provided by practice staff and those which need to be sourced from elsewhere in the community or provided by a care coordinator.

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. A 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, they are 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.

Aboriginal Health Workers or nurses providing care coordination should work in collaboration with other local services for Aboriginal and Torres Strait Islander people and people with chronic health conditions.

Recognition and inclusion of the patient's family carer is considered an additional element of a care coordinator's role.

For example, a patient has been referred for care coordination to assist in accessing the services of a podiatrist for an urgent appointment. The care coordinator identifies that publicly provided podiatry services have a three month waiting list. The care coordinator liaises with a private podiatrist to provide an appointment for the patient the next day, but there is no available or affordable transport for the patient to get to the podiatrist's rooms. The care coordinator contacts the local Aboriginal and Torres Strait Islander Outreach Worker (where there is one) and, if possible, arranges for them to drive the patient to the podiatrist appointment, or uses funds from the flexible funds pool to assist with the cost of transport to the appointment. The care coordinator may also follow up on whether ongoing podiatrist appointments are needed through the public system and liaises with the private podiatrist for the provision of patient notes to the public provider. The care coordinator also checks with the patient that they are aware of the need to keep regular appointments with the public podiatrist and ensures that they receive assistance with transport to these appointments if required.

CCSS Program – 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 Services participating in the PIP Indigenous Health Incentive and be recommended by their general practitioner.

Not all patients with a chronic condition will need assistance through the CCSS Program.

General practitioners will need to be made aware of the criteria for determining who could gain most benefit from this assistance and take these into account in deciding who to refer for care coordination. Priority should be given to patients most in need of care coordination services to obtain improved health outcomes.

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

- patients who are at greatest risk of experiencing otherwise avoidable (lengthy and/or frequent) 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 staff; and
- patients who are unable to manage a mix of multiple community based services.

It is not expected that it will be possible to provide care coordination services for all people with a chronic condition in the area serviced by a care coordinator.

Patients who manage their condition well are less likely to benefit from coordination of their care. For example, people who consistently make appointments to have their care plans reviewed, follow up on the need for the provision of repeat prescriptions and make and attend appointments with specialists and allied health providers as recommended by their GP, are unlikely to gain significantly improved health outcomes from care coordination under the CCSS Program.

Patients who tend to wait until they are very ill before returning to the general practice or until they are so ill that they need to attend the emergency department of the local hospital are a priority group for receiving care coordination services that focus on ongoing monitoring and proactive management of their condition.

Other patients who may benefit most from care coordination services include those who do not access recommended follow up care such as specialists and allied health professionals, have difficulty complying with medication regimens, or have low health literacy, and would benefit from more intensive chronic disease self management training, or from being put in contact with other community based services such as home help services.

Care coordinators – qualifications and skill requirements

It is expected that people providing care coordination to patients will be health workers focused on Indigenous health care, such as specialised nurses and Aboriginal and Torres Strait Islander Health Workers. Care coordinators must operate in accordance with the treating doctor's instructions.

In addition to being a health professional with a clinical understanding of chronic disease, a care coordinator should have the ability to:

- provide support in a culturally sensitive way;
- advocate on behalf of Aboriginal and Torres Strait Islander patients;
- work with specialists, GPs, nurses and allied health professionals;
- work across program boundaries, for example, with Indigenous Health Project Officers and Aboriginal and Torres Strait Islander Outreach Workers; and
- capture and share clinical information with relevant health care providers, including in electronic formats.

People in a care coordination role need to have relevant clinical skills to undertake the care coordination role effectively.

They need to understand the need for the services outlined in a patient's care plan, particularly if the requirement is for a service to be provided within a specified time frame, so that access to this assistance can be negotiated with other service provider/s.

Care coordinators with appropriate clinical skills may be in a position to identify a patient who is showing signs of their condition deteriorating between the scheduled times for review of their care plan. The care coordinator may then be in a position to encourage the patient to return to their GP to consult them about their condition.

Consideration could be given to other appropriate qualifications and training, other skill requirements and personal attributes in specific circumstances and in consultation with the Department of Health and Ageing (the Department).

Care coordination – allowable use of funding

New care coordination services or extension of existing services may be supported under the Program. Care coordination services are expected to be delivered in a way that best meets the needs of patients. The Department supports using models of care coordination that are practical and acknowledge the local characteristics, for example, the geographic or demographic of the area. The Department also encourages building on any existing services that currently provide care coordination type services.

Program funding can be applied to:

- The salary costs of employing a care coordinator, or the salary costs of extending the role and employment of an existing staff member who is undertaking the care coordination role.
- Service support costs – related to the direct provision of the service coordination role. These may include:
 - Reasonable travel costs for care coordination staff to liaise with general practices, Indigenous Health Services and community care providers in the region, including overnight accommodation if necessary;
 - Costs related to renting office space for staff undertaking care coordination and associated administration expenses for the care coordination service; and
 - Professional indemnity insurance costs directly attributable to the care coordination service.
- Reasonable recruitment costs.
- Program administration – costs relating to the administration of the Program such as contract management, data collection and reporting, convening annual care coordinators meetings, provision of mentoring and professional support, and education and skills development for care coordinators.

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/care coordination 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 to increase the time spent on care coordination activities.

This is not an exhaustive list and different models may be combined or developed to meet the needs of a community and take account of any related services already operating. In developing a model, the emphasis should be on planning a cost effective approach that results in maximum services to patients, as opposed to administration.

Professional/peer support for people undertaking the care coordination role

Opportunities for peer support, professional guidance and mentoring of people undertaking care coordination roles will be important. Depending on uptake, a care coordinator may be the only person employed in that role within their organisation and 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.

Peer support and professional networking models that are relevant to local contexts will be funded as part of the Program. The Australian Government is also looking into the establishment of a national information sharing service to provide the opportunity for care coordinators to receive role-specific information, and to seek and share ideas and information.

SBOs will be required to convene meetings at least annually for care coordinators in their state/territory to support skill enhancement, information sharing and facilitate peer support.

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 immediately accessible due to the lack of an available appointment with a publicly funded provider or the lack of affordable local transport. When barriers such as these exist, and a delay is clinically inappropriate, the coordinator may use the CCSS Program supplementary services funding to expedite the patient's access to these services in the private sector.

The supplementary services pool provides funds that can be used flexibly to assist patients in the CCSS Program to access medical specialist and allied health services where these services are in accordance with the patient's care plan. The pool may also be used to assist with the cost of local transport to health care appointments.

The supplementary services pool cannot fund all of the follow up care required by patients in the CCSS Program. Pool funds should only be used where other publicly funded services are not readily available.

Priority allocation of Supplementary Services funding

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 local transport service.

Allowable use of funds

Supplementary service 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 care coordination 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.

Care coordinators can draw on supplementary services funding to assist patients to access services in a timely fashion where this will assist in reducing the need for inappropriate hospital services.

For example, the GP refers a patient to the CCSS Program for assistance with coordinating care required to manage diabetes. The GP has identified an urgent need for the patient to access a diabetes educator. The care coordinator ascertains that the waiting time for diabetes education services at the local community health centre is three months. The care coordination service is able to use supplementary services funding to purchase a private diabetes education service immediately to meet the patient's needs. The patient receives a timely service which may prevent their condition from deteriorating and later presenting at the hospital for treatment.

Local arrangements for managing the supplementary services pool may vary. However, as access to the supplementary services pool will often be required in urgent circumstances, local arrangements need to accommodate rapid approval and access to supplementary services funds.

4. Management of Funds

Funds for the CCSS Program will be managed through the State Based Organisations (SBOs) of the Divisions of General Practice Network. SBOs may provide care coordination and supplementary services or may subcontract to Divisions or other organisations such as Indigenous Health Services, or lead/groupings of Divisions to provide these services.

Organisations delivering care coordination and supplementary services should have the ability to work with Aboriginal and Torres Strait Islander communities, primary care providers in general practice, medical specialists, Indigenous Health Services and allied health and community services.

SBOs will be required to work with relevant stakeholders, including Indigenous health organisations to develop a plan for implementation of the CCSS Program in their state/territory. It is expected that this plan would draw on the needs assessments undertaken under the Closing the Gap Improving Indigenous Access to Mainstream Primary Care – Indigenous Health Project Officer Program (where this is operating) and take account of the priority locations identified by the Office of Aboriginal and Torres Strait Islander Health as during implementation of the Indigenous Chronic Disease Package measures. These priority locations are being identified in consultation with representatives of Indigenous organisations, including the Indigenous Health Partnership Forums in the states and territories.

The CCSS Program will be implemented progressively through a staged approach and will not be available in all locations in the initial years of the Program.

SBOs 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.

Over time, SBOs will be required to consult with relevant stakeholders to undertake refinements to their initial program plans to reflect changing patterns of uptake and demand for the Program.

SBOs may choose to manage the supplementary services pool arrangements directly or to subcontract to care coordination service delivery organisations. However, SBOs will retain overall responsibility for reporting on the number and type of services purchased and how the supplementary services pool funds are expended.

Service delivery principles

SBOs 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.

Funding allocations

The funding for care coordination services will initially be allocated to SBOs on the basis of the Aboriginal and Torres Strait Islander population in the state/territory. The allocations may be adjusted over time to reflect the actual uptake of the PIP Indigenous Health Incentive.

Program monitoring and reporting – performance indicators

SBOs will be required to collect and report data for monitoring the performance of the Program. Reporting requirements, including financial reporting, will be outlined in the funding agreement with the SBOs and should be reflected in any subcontracting arrangements. Information collected for the Program will include:

- number of GPs referring to care coordination services;
- 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;
- skills and qualifications of persons occupying positions;
- number of and type of services supported through the supplementary services pool, specifically
 - allied health;
 - specialist; and
 - local transport services; and
- gender and age groups of patients in the Program.

Program evaluation

The Department will conduct a formal evaluation of the Closing the Gap CCSS Program as part of an overall evaluation of the Commonwealth's Indigenous Chronic Disease Package. SBOs and subcontracted service delivery organisations will be required to contribute to the evaluation of the Package by providing qualitative or quantitative data as agreed with the department.

Attachment A

Complementary Measures – Indigenous Chronic Disease Package

PIP Indigenous Health Incentive

The Practice Incentives Program (PIP) Indigenous Health Incentive will support general practices and Indigenous health services to provide better health care for Indigenous Australians, including best practice management of chronic disease.

The PIP Indigenous Health Incentive will provide access to sign-on, patient registration and outcomes payments for participating general practices and Indigenous health services.

Increasing Specialist Follow-up Care

This program will provide funds to assist with the cost of follow up specialist care for Aboriginal and Torres Strait Islander people with a chronic disease and support private specialists to provide outreach services to Aboriginal and Torres Strait Islander patients in urban areas.

Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease Measure

The Medical Specialist Outreach Assistance Program (MSOAP) is being expanded under the Indigenous Chronic Disease Package to support outreach by multidisciplinary teams, comprising specialists, general practitioners and allied health professionals, to better manage complex and chronic health conditions in rural and remote Aboriginal and Torres Strait Islander communities.

Pharmaceutical Benefits Scheme (PBS) Co-payment Measure

From the 1 July 2010, this measure will assist Aboriginal and Torres Strait Islander people to better access Pharmaceutical Benefits Scheme (PBS) medicines by providing co-payment relief. Increased access to PBS medicines will help improve prevention and management of chronic disease for Aboriginal and Torres Strait Islander people.

Primary Health Care Resource

The aim of the Primary Health Care Resource is to support and promote individual primary health care workers in the mainstream and Indigenous sectors to better prevent, identify and manage chronic disease in Indigenous Australians.

The resource will be developed over the 2 year period, 2009-10 to 2010-11. It will collate and present in a single resource existing tools, guides and other information that promote best practice in the prevention, identification and primary care management of chronic disease in Indigenous Australians.

Engaging Divisions Of General Practice To Improve Indigenous Access To Mainstream Primary Care

This measure provides funding to the Divisions Network to employ Indigenous Health Project Officers (Project Officers) and local Aboriginal and Torres Strait Islander people to work as Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers).

Project Officers in the Divisions Network will take a lead role in increasing access to, and cultural sensitivity of, mainstream primary care for Aboriginal and Torres Strait Islander people. They will also increase awareness and understanding of the range of Closing the Gap initiatives relevant to mainstream primary care. Project Officers will work closely with other organisations providing services to Aboriginal and Torres Strait Islander people in the region.

Outreach Workers in Divisions of General Practice and Aboriginal Community Controlled Health Organisations will work to better connect Aboriginal and Torres Strait Islander people to health services. The role will involve providing practical assistance to Aboriginal and Torres Strait Islander people to help them make contact with local health services and access follow up treatment. This may include assisting Aboriginal and Torres Strait Islander people to travel to and from appointments, collecting prescriptions and distributing information about relevant Closing the Gap measures, including how to access available services.

Healthy Lifestyle Workers

Under this program, Healthy Lifestyle Workers will provide interventions to encourage lifestyle change by Aboriginal and Torres Strait Islander individuals and families who are at risk of developing preventable chronic diseases.

Training in Chronic Disease Self Management

Under this program, existing health professionals will receive training in chronic disease self management programs tailored for Aboriginal and Torres Strait Islander individuals and families who have established chronic disease.

Additional information

Additional information about the Commonwealth's Indigenous Chronic Disease Package can be found at:

Website: <http://www.health.gov.au/tackling-chronic-disease>

or

Email: ICDP@health.gov.au