



Care Coordination and Supplementary Services (CCSS) Program

Information for General Practices

Background

The CCSS Program is one of the measures under the Australian Government's Indigenous Chronic Disease Package developed to address the first of the Council of Australian Government's (COAG) Closing the Gap targets – to close the life expectancy gap (of up to 17 years) between Indigenous and non-Indigenous Australians within a generation.

The Package 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 peoples.

Aim and Objective

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 GP 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 (IHI); 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.



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.

Role of the Care Coordinator

The Care Coordinator will be responsible for working collaboratively with patients, General Practitioners, General Practices and Community-Controlled Health Service staff and a broad range of other relevant government/non-government services to facilitate provision of appropriate multidisciplinary care for Aboriginal and Torres Strait Islander peoples with target chronic diseases, to help them manage their health in a way that meets their individual needs and will result in optimal health outcomes.

Referring patients to the Program?

Patients must be referred by a GP in general practices or Indigenous Health Services participating in the Practice Incentives Program (PIP) Indigenous Health Incentive (IHI).

A CCSS Program Referral Form is available from Galangoor Duwalami Primary Health Care Service (see contact details on this page).



Contact Details

The Fraser Coast Aboriginal and Torres Strait Islander Care Coordinator is situated at Galangoor Duwalami Primary Health Care Service in Hervey Bay, contact details are:

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For Further Information Contact

CCSS Program

- Kim Henschke, Care Coordinator, Galangoor Duwalami Primary Health Care service, 07 4194 5554.
- Katie Griffin, CCSS Program Coordinator, GPQ (<http://www.gpqld.com.au/>), Ph 07 3105 8300.

PIP IHI and PBS Co-Payment Measure

- Janet Stajic, Indigenous Health Project Officer, Closing the Gap Program, GP Links Wide Bay (www.gplinks.org.au), Ph 07 4124 8311.
- Medicare Australia (www.medicareaustralia.gov.au), Ph 1800 222 032.

Indigenous Chronic Disease Package

- Department of Health and Ageing (www.health.gov.au), Ph 1800 020 103.

