Australian Government

Department of Health

INTEGRATED TEAM CARE

PROGRAM IMPLEMENTATION GUIDELINES

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Contents

1 Introduction

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

Funds for the ITC Program will be managed by Primary Health Networks (PHNs). PHNs should work with the Indigenous health sector when planning and delivering the ITC Program and ensure that eligible clients of both mainstream and Aboriginal Medical Services (AMS)[1] 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 help Aboriginal and Torres Strait Islander people with complex chronic diseases unable to effectively manage their conditions through access to one-on-one assistance by Care Coordinators. Since the establishment of the ITC, the provision of care coordination, expediting access to necessary services, and developing care pathways and service linkages has resulted in an improved quality of life for clients enrolled on the program.

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

1.1 Aims and objectives of the Integrated Team Care Program

The aims of the ITC Program 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 appropriate mainstream primary care services (including but not limited to general practice, allied health and specialists) for Aboriginal and Torres Strait Islander people.

The objectives are to:

1. contribute to better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people enrolled on the program;
2. 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;
3. foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sector;
4. improve the capacity of mainstream primary care services to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people; and
5. 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/teams of Indigenous Health Project Officers (IHPOs), Aboriginal and Torres Strait Islander Outreach Workers (Outreach Workers) and Care Coordinators. The team works in their PHN region, across the Indigenous and mainstream primary care

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

sectors, to assist Aboriginal and Torres Strait Islander people to obtain primary health care as required, provide care coordination services to eligible Aboriginal and Torres Strait Islander people with chronic disease/s who require coordinated, multidisciplinary care, and improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care.

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 4, 5, and 6) will be carried out by the ITC workforce across the PHN region.

The teams work in the following ways:

- IHPOs have a policy and leadership role within a PHN region. As team leaders they ensure there is a focus on Indigenous health and aim to improve the integration of care across the region. This work includes needs assessment and planning, developing multi-program approaches and cross-sector linkages, and supporting both Outreach Workers and Care Coordinators. (See Sections 5 and 6)[2];
- Outreach Workers encourage Aboriginal and Torres Strait Islander people to access health services and help to ensure that services are culturally competent. They have strong links to the community they work in. Outreach Workers carry out non-clinical tasks, e.g. helping clients to travel to their medical appointments. (See Sections 5 and 6); and
- Care Coordinators are qualified health workers (for example, nurses, Aboriginal Health Workers) 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 5 and 6.)

Care Coordinators have access to a Supplementary Services Funding Pool when they need to expedite a client's access to an urgent and essential allied health or specialist service, or the necessary transport to access the service, where this is not publicly available in a clinically acceptable timeframe. The Supplementary Services Funding Pool can also be used to assist clients to access GP-approved medical aids (see Section 9).

1.3 Service delivery principles

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

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

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

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

PHNs and commissioned organisations should be aware of and consider the *Primary Health Network and Aboriginal Community Controlled Health Organisation Guiding Principles 2016*.

2 Primary Health Networks

PHNs will have the flexibility to tailor the role and activities of the IHPOs, Outreach Workers and Care Coordinators to suit the needs of particular communities, taking into account the objectives of the ITC Program, but must adhere to these Program Guidelines.

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

Each PHN has a responsibility to oversee the ITC workforce across its region, including ensuring the workforce receives appropriate support and development as outlined at Section 7.4.

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

2.1 Service delivery and commissioning arrangements

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

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

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

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

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

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

Appropriate workforce placement across a region, and in particular the location of IHPOs as team leaders, may involve IHPOs being placed in strategic locations across areas within a region, including within a PHN itself if appropriate. Decisions on IHPO placement will depend on the outcome of the above decision framework. Care Coordinator and Outreach Worker services should be delivered from the most appropriate service, and wherever possible work between AMSs and mainstream practices.

3 Improving the Cultural Competency of Mainstream Primary Care

Approximately half of those surveyed in the most recent Aboriginal and Torres Strait Islander Health Survey reported visiting a mainstream GP when they sought medical care. This highlights the importance of having a health system that is responsive and culturally appropriate for Aboriginal and Torres Strait Islander health needs.

ITC plays a key role improving the cultural competency of mainstream primary care services as a means of reducing barriers to access so Aboriginal and Torres Strait Islander people can access appropriate care.

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

- Delivering or organising cultural awareness training for staff;
- Encouraging uptake of Indigenous MBS items such as 715 health checks and ensuring follow-up services are utilised; and
- Helping practices create a more welcoming environment e.g., Indigenous artwork and posters.

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

IHPOs (or ITC workforce equivalent) take the lead role in improving the cultural competency 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 PHNs 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 PHNs include a requirement that these activities will be undertaken in their funding agreements with organisations commissioned to deliver ITC services (See Program Objectives 3 and 4 in Section 1).

4 Indigenous Health Project Officers

4.1 Roles and responsibilities

IHPOs provide leadership on Indigenous health issues.

Responsibilities for IHPOs include:

- working as team leaders in the PHN region, i.e. overall ITC program lead, including providing regional guidance and strategic direction for the team;
- developing and implementing a coordinated team-based approach to Aboriginal and Torres Strait Islander health, especially between the IHPO, Outreach Worker and Care Coordinator positions;
- supporting Care Coordinators and Outreach Workers;
- developing and implementing strategies to improve the capacity of mainstream primary care providers to deliver culturally appropriate primary care services to Aboriginal and Torres Strait Islander people, including taking an advocacy role in:

    - self-identification;
    - uptake of Aboriginal and Torres Strait Islander specific MBS items including item 715 - Health Assessments for Aboriginal and Torres Strait Islander People, care planning and follow up items;
- increasing awareness of and maximising links between services for Aboriginal and Torres Strait Islander people, including those provided by Commonwealth and state/territory governments, AMSs, and other organisations;
- facilitate working relationships and communication exchange between mainstream organisations, AMSs and their peak bodies;
- developing and implementing strategies to improve access to mainstream primary care for Aboriginal and Torres Strait Islander people, including through outreach 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 Council of Australian Governments targets to close the gap in Indigenous disadvantage; and
- collaborating with local Indigenous health services and mainstream health services in a partnership approach for the delivery of primary care services.

As team leader for ITC, IHPOs should provide high level guidance and strategic direction for the ITC workforce at a regional level. 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 a PHN region.

4.2 Activities for Indigenous Health Project Officers

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

- promoting the objectives and outcomes of the ITC Program 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;
- promoting mainstream primary care providers to Aboriginal and Torres Strait Islander people as a valid, trustworthy and accessible first point of health care;
- assisting mainstream primary care providers to manage specific Aboriginal and Torres Strait Islander health needs and issues;
- providing support to mainstream primary care providers to encourage Aboriginal and Torres Strait Islander people to self-identify their Indigenous status when accessing mainstream primary care services;
- delivering or coordinating cultural awareness training and quality improvement activities;
- coordinating relevant education events;
- disseminating information about the availability of 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 Aboriginal and Torres Strait Islander Outreach Workers

5.1 Roles and responsibilities

Outreach Workers will work with the IHPOs to help local Aboriginal and Torres Strait Islander people make better use of available health care services, especially mainstream health services. Outreach Workers, under supervision, will undertake the following non-clinical tasks:

- **community liaison:** establish links with local Aboriginal and Torres Strait Islander communities to promote the importance of improving health outcomes and encourage and support the increased use of health services. This includes MBS Health Assessments for Aboriginal and Torres Strait Islander people, and MBS care planning and follow-up items. They should also identify Aboriginal and Torres Strait Islander people who would benefit from improved access to these health services;
- **administration and support:** assist the IHPO to identify barriers to health services for Aboriginal and Torres Strait Islander people;
- **provide practical assistance:** provide assistance to identified Aboriginal and Torres Strait Islander people to access services and attend appointments (including GP care planning, follow-up care, specialist services and community pharmacies); and
- **provide feedback regarding access problems:** provide feedback to the PHN regarding barriers to health services for Aboriginal and Torres Strait Islander people, and, in conjunction with the IHPO, work to implement solutions.

5.2 Activities for Aboriginal and Torres Strait Islander Outreach Workers:

The work of Outreach Workers should be tailored to meet the needs of the communities within the PHN region. This work could include, 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;
- encouraging and assisting Aboriginal and Torres Strait Islander people to:
  - 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);
  - collect prescribed medications from the pharmacist;
  - return for follow up appointments with their GP and/or practice nurse; and
  - fill out forms and understand instructions from reception staff.
- encouraging Aboriginal and Torres Strait Islander people to:
  - identify their Aboriginal and/ or Torres Strait Islander status; and

- register for a Medicare card.

- Providing support for outreach/visiting health professionals where required;
- Distributing information to Aboriginal and Torres Strait Islander people about how to access available services (e.g. care coordination, PBS co-payment).

6 Care Coordinators

6.1 The role of Care Coordinators

Care Coordinators should identify when a client's condition may require further assistance from a health professional.

Care Coordinators should develop and maintain a close relationship with their client's 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 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 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 and Care Coordinators ensure that this level of support is provided when needed.

6.2 Activities for Care Coordinators

Care coordination activities undertaken by Care Coordinators must be in accordance with a care plan developed by a referring GP for eligible clients. Care coordination activities may include, but is 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:
  - adhere to treatment regimens - for example, encouraging medication compliance;
  - develop chronic condition self-management skills; and
  - connect with appropriate community-based services such as those that provide support for daily living; and
- providing appropriate clinical care, consistent with the skills and qualifications of the Care Coordinator.

Through the Supplementary Services Funding Pool (refer Section 9), the ITC Program 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, local governments and non-government organisations, in order to link clients with the services they need.

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

7 Qualifications and skill requirements

7.1 Indigenous Health Project Officer

Qualifications, skills and experience are not specified for those undertaking the IHPO role. It is expected that IHPOs will have the qualifications and/or skills and experience in working with Aboriginal and Torres Strait Islander people required for the performance of the roles and responsibilities outlined in Section 4.

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

7.2 Aboriginal and Torres Strait Islander Outreach Workers

Outreach Workers must have strong links with the community in which they work and possess effective communication skills.

The role of an Outreach Worker is to provide non-clinical services and does not require formal qualifications. The achievement of formal qualifications by an individual who is employed as an Outreach Worker will have no bearing on the job description. Outreach Workers are expected to work as part of a team with Care Coordinators and IHPOs.

There is flexibility to tailor the role and activities of the Outreach Workers to suit local needs, taking into account the aims and objectives outlined in these Implementation Guidelines.

It is strongly recommended that Aboriginal and Torres Strait Islander people are recruited to work in Outreach Worker positions. Non-Indigenous candidates can be considered if no suitable Aboriginal and Torres Strait Islander candidates are available. Non-Indigenous candidates need to demonstrate significant links with the community and capacity to fulfil the role as an Outreach Worker.

7.3 Care Coordinators

Care Coordinators will be qualified health workers with a good working knowledge of the health system, such as nurses and Aboriginal Health Workers. Clinical skills allows the Care Coordinator to have a good knowledge of the health system and how best to navigate it for ITC clients, as well as understand the client's health needs and, where appropriate, assist with those needs. Consideration can be given to other appropriate qualifications or training in specific circumstances and in consultation with the Department of Health (the Department).

Care Coordinators are also expected to:

- provide culturally appropriate care;
- advocate on behalf of Aboriginal and Torres Strait Islander 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 IHPOs and Outreach Workers.

Care Coordinators must operate in accordance with the treating GP's instructions.

7.4 Workforce Support and Development

PHNs and the organisations they commission 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 PHNs or the organisations they commission as appropriate. Up to 3% of program funds should to be allocated to support and development of the ITC workforce.

8 Care Coordination

8.1 Definition of Care Coordination

For the purpose of the ITC Program, care coordination means working collaboratively with clients, general practices, AMSs, and other service providers to assist with the care coordination of eligible clients with chronic disease.

Care Coordinators can:

- assist Aboriginal and Torres Strait Islander people to understand their chronic health condition and how to manage it; and
- assist Aboriginal and Torres Strait Islander people to follow their care plan, which may include support for chronic disease self-management and assistance with care plan compliance.

8.2 Definition of chronic disease

For the purpose of the ITC Program, and consistent with the MBS, an eligible condition is one that has been, or is likely to be, present for at least six months. Dental is **not** an eligible condition for the purposes of the ITC Program. Priority should be given to clients with complex chronic care needs who require multidisciplinary coordinated care in order to manage their chronic disease/s.

8.3 How might a care coordination service work?

If a GP in a general practice or an AMS has prepared a care plan for a 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 a Care Coordinator employed under the ITC Program.

Care coordination works best when a Care Coordinator is able to discuss with each general practice/AMS the type of services that can be provided by practice staff and those that need to be sourced from elsewhere, or provided by a Care Coordinator.

The Care Coordinator will work in accordance with the 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. 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 below) may be used by Care Coordinators to help eligible clients access services that have been identified in their care plan.

8.4 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.

8.5 Client eligibility

To be eligible for care coordination under the ITC Program, Aboriginal and Torres Strait Islander clients must be enrolled for chronic disease management in a general practice or an AMS, have a GP Management Plan and be referred by their GP. Dental is **not** an eligible condition for the purposes of the ITC Program. (See Section 8.2 'Definition of chronic disease'). For the purpose of 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 PHN Mental Health and Suicide Prevention Implementation Guidance and the Primary Health Networks: Indigenous Mental Health Flexible Program in the PHN Program: Primary Mental Health Care Schedule.

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 the ITC Program 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. The ITC program is not intended to supplement an Aged Care Package.

8.5.1 Prioritisation

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

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

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

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 the ITC Program to access medical specialist and allied health services (as well as certain associated medical aids – refer 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 the ITC Program 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 all of the follow up care required by clients who are registered under the ITC Program. 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 allocation of priorities within the funding available is at the discretion of the fund holder / fund manager.

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 clients length of stay in a hospital;
- are not available through other funding sources; and/or
- ensure access to a clinical service that would not be accessible because of the cost of a transport service.

As access to the Supplementary Services Funding Pool may be required in urgent circumstances, local arrangements need to accommodate rapid approval of expenditure and access to Supplementary Services funds.

10 Allowable use of funds for the ITC Program

10.1 Integrated Team Care

ITC funding can be applied to:

- salaries, salary on-costs, and travel associated with the employment of IHPOs, Outreach Workers, and Care Coordinators. It can include travel and accommodation costs for Care Coordinators, IHPOs and Outreach Workers to attend meetings and orientation and training activities. PHNs have the flexibility to allocate funds to employ an appropriate mix of Care Coordinators, IHPOs and Outreach Workers as determined by regional needs;
- care coordination service support costs such as professional indemnity insurance directly attributable to the care coordination service;
- funding may be used to cover travel costs of Outreach Workers who assist Aboriginal and Torres Strait Islander people to attend appointments (e.g. leasing a vehicle or reimbursing staff for use of private vehicles). This 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 IHPOs, Care Coordinators and Outreach Workers;
- Program administration of up to, but no more than, 8% of total funding for PHNs. 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. PHNs 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 PHN core funding not ITC program funding**; and
- needs assessments and market analyses might result in more than one PHN commissioning the same service provider. If this situation occurs the PHNs, and the service provider, would be expected to work together to ensure that the most efficient administrative approach is implemented.

Funding must not be used to provide clinical services, other than those provided by Care Coordinators where appropriate.

Funding must also not be used to purchase assets.

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

Such arrangements would need to be reflected in the Program Work Plans of the PHNs involved. The relevant Health Grants and Network Division Office must be advised of any

such arrangement and PHNs will need to receive prior approval from the Department through the Program Work Plan development process.

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

10.2 Use of Supplementary Services Funds

PHNs will generally 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 PHN 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 PHN, which will include this information in its reporting to the Department.

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

Dental is **not** considered an eligible condition for the purposes of the ITC Program, 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 appropriate way, or providers who agree to bulk bill clients being referred under the ITC Program, may be established at the local level.

PHNs and the organisations they commission should refer to the information outlined in the ITC Frequently Asked Questions at Appendix 1 for more detail. For further information relating to claiming Medicare items, please contact Medicare Australia at www.humanservices.gov.au, or telephone 132 011. For provider enquiries, telephone 132 150.

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 https://www.ndss.com.au/CGM.
- Dose administration aids;
- Medical footwear that is prescribed and fitted by a podiatrist; and
- Mobility aids (e.g., crutches, walking frames, or non-electric wheel chairs) or shower chairs.
- Spectacles (see Section 10.2.3 for conditions)

Where possible, spacers should be used rather than nebulisers.

Dose administration aids, blood sugar/glucose monitoring equipment and most assistive breathing equipment is currently available under the Quality Use of Medicine Maximised for Aboriginal and Torres Strait Islander People (QUMAX) program for clients of participating AMSs. **For eligible clients of AMSs, QUMAX must be used to acquire these items rather than making an application to use Supplementary Services funding**.

Care Coordinators will be required to include in the six monthly progress reports to the department the details of Supplementary Services funding used to acquire approved medical aids (e.g. type of aid, cost, full cost or contribution, 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 years;
- The maximum Supplementary Services spend for entire product is $250. This includes multi-vision, bifocal, anti–glare, polarising, frames etc.;
- The Outreach Worker or Care Coordinator must attend the appointment with the 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;
- Where Supplementary Services funded spectacles have been lost, broken or stolen, replacement using further Supplementary Services funds is not allowable; and
- All of these conditions must be clearly communicated to the 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 PHN. The item must be on the client's GP Management 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. PHNs 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, the PHN may send the request to the relevant Grant Officer in the Department's Health Grants and Network Division for a decision. 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. patient assisted travel schemes) have been exhausted and that the most cost effective means of transport (and any essential accommodation) is used. For example, Supplementary Services funds may be used to fund the difference between the full cost of travel and any funds provided through alternative funding mechanisms.

Travel beyond the closest available regional service can be supported in cases of extreme urgency.

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

Financial reports must provide a breakdown by the following categories: fees for medical specialist and for allied health services, medical aids and transport (see Section 13).

11 Management of funds

PHNs are the fund holders for the ITC Program, and will be responsible for reporting all ITC Program 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 process for undertaking a needs assessment is provided in the *PHN Needs Assessment Guide, December 2015* http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Needs_Assessment_Guide

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

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

13 Reporting

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

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

- PHN-employed and Commissioned Care Coordinator, IHPO and Outreach Worker expenses;
- Supplementary Services; and
- Program administration.

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

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

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

PHNs must make themselves familiar with all of the reporting requirements and ensure that they have systems in place to collect and collate the necessary information/data from all commissioned organisations, 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 PHNs will be dependent on approval of deliverables by the Department. In assessing Needs Assessments, Activity Work Plans, annual budgets and six monthly performance reports for the Program, the Department will consider:

- how well the objectives of the ITC Program 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 Program outcomes.

15 Maintenance of information and data

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

16 Further information

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

Appendix 1 – Frequently Asked Questions (FAQs)

The FAQs are not meant to be an exhaustive list on what is excluded/out of scope of ITC funding. On first principles, the Implementation Guidelines provides information on what is in-scope. If you have any questions on activities and items eligible for ITC funding, please consult with your relevant PHN contact.

Medicare Australia, located in the Department of Human Services, should be contacted for all questions regarding claiming Medicare rebates for services.

Website - www.humanservices.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 must be referred by a GP from the practice that is responsible for providing the majority of care for the client and developing the client's care plan. This can be in a mainstream general practice or Aboriginal Medical Service.

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

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

The ITC Program uses the Medicare Benefits Schedule (MBS) definition of a chronic disease, which is: a disease that has been, or is likely to be, present for at least six months.

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

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 the ITC Program?

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

v. Can ITC clients seek treatment across PHN regions?

Yes. Where clients enrolled on ITC seek treatment across PHN regions, the relevant PHNs and commissioned organisations 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 relevant clinical skills. In specific circumstances and in consultation with the Department of Health, 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. Patient Assisted Travel Schemes) have been exhausted and that the most cost effective means of transport (and any essential accommodation) is used. For example, Supplementary Services funds may be used to fund the difference between the full cost of travel and any funds provided through alternative funding mechanisms.

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 this is required to enable a care coordination client 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 a care coordination client attending a health care appointment?

Yes.

v. Should Primary Health Networks contact the Department's Health State Network Office 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 Primary Health Network level.

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

i. 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 the fund holder / fund manager.

ii. Can Supplementary Services funding be used to pay for health services that clients accessed prior to being enrolled in the ITC Program?

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

iii. 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.

iv. 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 the ITC Program?

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 8.1

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 the ITC Program.

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 Section 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 fund holder / fund manager.

vi. Can Supplementary Services funding be used to cover the gap which may remain after the subsidy is provided through 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 Primary Health Network/commissioned organisation must follow the claiming advice provided below. Primary Health Networks/commissioned organisations can call 132 150 (Medicare Provider enquiry line) if they have any further questions.

Note: The Primary Health Network/commissioned organisation accounts cannot be submitted electronically.

1. Specialist/Allied Health Practitioners issue an unpaid account to the Primary Health Network/commissioned organisation.
2. The Primary Health Network/commissioned organisation submits the unpaid account together with the Medicare claim form (available at http://www.humanservices.gov.au/customer/forms/pc1). When lodging the account and completed claim form, it can be either sent directly to the Department of Human Services, GPO Box 9822 in your capital city or placed in a 'drop box' at one of Medicare's Service Centres. 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 Primary Health Network/commissioned organisation must forward the Medicare cheque along with a Primary Health Network/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

On this basis 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 Implementation Guidelines specify that Aboriginal and Torres Strait Islander clients must be enrolled for chronic disease management in a general practice or an AMS, have a GP Management Plan and be referred by their GP. 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), GP Management Plans (GPMP – MBS item 721) and/or Team Care Arrangements (TCA – MBS item 723).

The benefits of the GP Management Plan (MBS item 721) for ITC clients are 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 GPMP review process (Review of a GPMP – item 732) 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 Guidelines state that the client must have a care plan, be enrolled for chronic disease management in a general practice or Aboriginal Medical Service and be referred by their GP for care coordination services. An Aboriginal and Torres Strait Islander Outreach Worker may be able to assist with transport to attend GP appointments.

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 Primary Health Networks and the organisations they commission to make more timely decisions about how they prioritise and allocate services and supplementary services funding.

Before using this tool

Before using this tool, first read the Department of Health ITC Implementation Guidelines and ITC Frequently Asked Questions (FAQs).

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

Once you have read the ITC 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 your PHN. The PHN may forward this request to their relevant Program Officer and the department will consider the request. Advice will be provided based on the information in this decision tool.

Question	Response
What is your interpretation of the ITC Implementation Guidelines in relation to this request?	
Question	**Response**
Do you think the patient is likely to improve and benefit from this ITC service/aid?	
Do you think the patient's access to this ITC service/aid is justified – from both a clinical and ethical perspective?	
Have you explored other publically funded/affordable programs relevant to this request?	
Do you think the patient will adhere to treatment and attend services?	
Will the patient be at risk of an unplanned/avoidable hospital admission/presentation if this request is not carried through?	
Will the patient's self-management of their chronic disease be significantly compromised if this request is not carried through?	
Is there an immediate clinical risk to the patient if the service/aid is not provided (i.e. patient 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 patient's GP Care Plan, and are they willing to support the patient'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 patients 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?	

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 Primary Health Network (or commissioned organisation) to justify use of funds for the provision of any service and for the purchase of Medical Aid(s) for a patient.

If you have any further questions, please contact your relevant Program Officer.