Closing the Gap is a whole of government initiative aimed at reducing the disparity between Aboriginal and non-Aboriginal life expectancy. Closing the Gap seeks to increase the quality of life for Aboriginal people with chronic health conditions.

At Country SA PHN (CSAPHN) the Closing the Gap Program works at the local level by engaging with community, health care providers and Aboriginal organisations to ensure care is streamlined through an understanding of local health care systems and needs.

What does CSAPHN's Closing the Gap Program do?

- Provides education to general practices and the wider community relating to Aboriginal health matters.
- Provides coordinated care to Aboriginal patients, ensuring follow-up and follow-through of care plans.
- Works closely with general practice staff to ensure participating practices are confident in cultural awareness and sensitivity.
- Assists general practices and allied health professionals to manoeuvre through the health system and Closing the Gap.
- Works closely with local Aboriginal community members to obtain feedback and direction for better health outcomes.

How can CSAPHN's Closing the Gap Program help your practice?

Consult	MBS Item No	Fees
At Risk	Health Assessment 715 Practice Nurse 10997 Acute Consult 23 (only if acute issue is addressed separately)	$212.25 $12.00 $37.05
TOTAL MBS Claim	$261.30	
Chronic Disease	GP M/Plan 721 Team Care 723 (GP + 2 Allied Health Referrals)	$144.25 $114.30
TOTAL MBS Claim	$258.55	
Additional MBS	GPMP Review 732 3/yr TCA Review 732 3/yr PN/AHW 10987 10/yr	$72.05 $72.05 $24.00

The above is a guide only. Please refer to **www.mbsonline.gov.au** for latest information.

Australian Government

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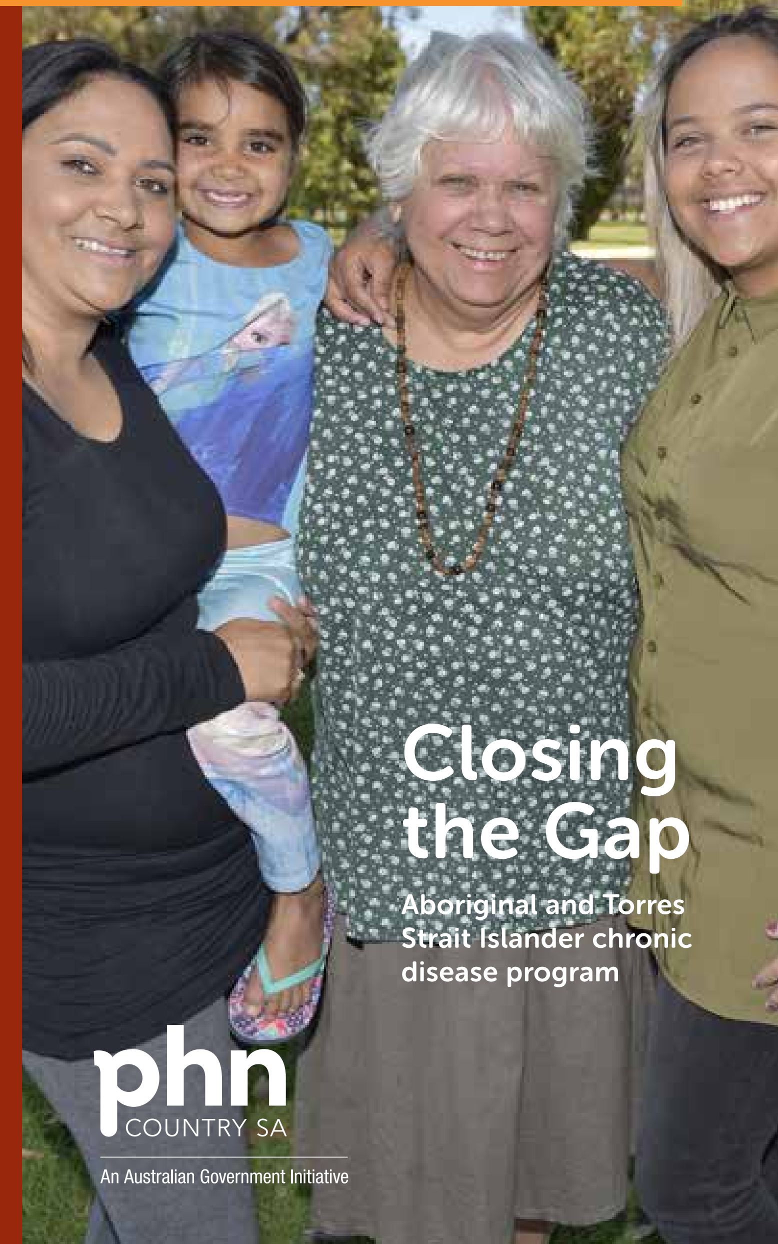
Country SA PHN acknowledges the traditional custodians of this land on which we work and welcome all Aboriginal and Torres Strait Islander peoples to our service.

Country SA PHN gratefully acknowledges the financial and other support provided by the Australian Government Department of Health.

General Practice Resource



Closing the Gap

Aboriginal and Torres Strait Islander chronic disease program

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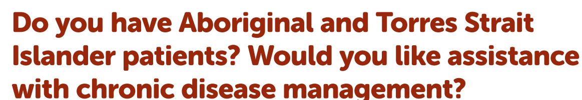

Do you have Aboriginal and Torres Strait Islander patients? Would you like assistance with chronic disease management?

Closing the Gap (CTG) is aimed at reducing the disparity in life expectancy between Aboriginal and Torres Strait Islanders and non-Indigenous Australians by improving access to health care.

The CTG Program encourages both 'at risk' patients and those with a chronic disease to access MBS Health Assessments, GP Management Plans and Team Care Arrangements. Through the referral process, individuals are able to access support, education and services.

Country SA PHN (CSAPHN) can provide information about registering your practice for the PIP Indigenous Health Incentive (PIP-IHI) and provide support to encourage Aboriginal and Torres Strait Islander patients to self identify. We can assist with cultural awareness for practice staff and support patients to attend appointments, ensuring follow-up and follow through of care plans. We can also provide care coordination for patients with chronic diseases.

Health Assessments

All Aboriginal and Torres Strait Islanders patients are eligible for a Health Assessment (MBS item no 715) every nine months. This aims to target 'at risk' patients of any age.

GP Management Plans

Patients with a chronic disease, are eligible for a GP Management Plan (GPMP MBS 721) and Team Care Arrangement (TCA MBS 723). This is designed to provide a care plan for your patient to enable them to self-manage their disease and link in with allied health and other support services such as the CTG Team.

PIP incentives and PBS co-payments

The PIP Indigenous Health Incentive aims to support general practices and Aboriginal health services for better health care outcomes for Aboriginal and Torres Strait Islanders, including best practice management of chronic disease.

GP practices and other health services registered for the PIP-IHI can offer Aboriginal and Torres Strait Islander patients who have a chronic disease, or are at risk of developing one, access to the PBS co-payment scheme. Patients with a concession card will receive PBS medicines for free while those without concessions will pay a reduced rate.

The PIP-IHI includes three components:

- Sign-on Payment: A one-off payment of $1000 to practices that join the PIP-IHI and agree to undertake specified activities to improve the provision of care to their Aboriginal and Torres Strait Islander patients with chronic disease.
- Patient Registration Payment: An annual payment to practices of $250 per calendar year, for each Aboriginal and Torres Strait Islander patient registered with a PIP-IHI practice.
- Outcomes Payment: There are two tiers of outcome payments available to the practice each calendar year per registered patient. Outcome payments can only be made to practices that have signed for the PIP-IHI. Practices may be eligible for either or both Outcomes Payments, even if the patient is currently registered at another practice.

Please talk to us if you are not registered for PIP-IHI or PBS co-payments.

Care Coordination

Care Coordination and Supplementary Services (CCSS) support is available to general practices and Aboriginal health services. Patients who have a chronic disease and a GP Management Plan can be referred to the CNSAML Care Coordinator, who will help them adhere to the plan. This can include assisting clients with appointments and liaising with health care providers.

There is also a funding pool for supplementary services. This is to help patients access urgent and essential allied health and specialist services, to fund transport and the purchase of medical aids specified in their GP Management Plan. Patients most likely to benefit from care coordination are those:

- At risk of avoidable hospital admissions or inappropriate emergency presentations.
- Not using community based services appropriately or at all.
- Who need help overcoming barriers to access services.
- Require more intensive care coordination than currently available.
- Who are unable to manage a mix of multidisciplinary services.