Care Coordination and Supplementary Services (CCSS) Program

Program Context

The program was initiated in 2009-10 as a part of the Australian Government's Indigenous Chronic Disease Package.

One of the targets of the Indigenous Chronic Disease Package is to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.

The CCSS Program is one of the measures under the package aimed to improve chronic disease management, follow up care and specialist referral for Aboriginal and Torres Strait Islander people.

Program components

1. **Care Coordination** to ensure the client's chronic disease is managed in accordance with their General Practice Management Plan. Care coordination includes provision of care, arranging services, assisting clients with appointments, assisting clients to adhere to management plan, encourage self-management skills, supporting client to build on their confidence, and communicating care with the general practitioners and other health service providers.
2. A funding pool (**Supplementary Services**) is available to assist patients to access urgent and essential allied health and specialist services, transport and specified medical aids to assist with their self-management of their chronic disease as outlined in their management plan. Please note: Supplementary Service funds should only be used where other services are not available in a clinically acceptable timeframe.

Clients with complex chronic conditions require care from a range of health service providers and the CCSS Program will provide this support in a coordinated way. The Care Coordinator will work collaboratively with clients, general practices, Aboriginal health services and other service providers to assist in the provision of culturally appropriate care and services to result in optimal health outcomes.

Care Coordination and Supplementary Services support is available to general practices or Aboriginal health services.

5 Targeted CCSS chronic diseases

- Diabetes
- Cardiovascular Disease
- Chronic Respiratory Disease
- Chronic Renal Disease
- Cancer

How will Care Coordination Services work?

A General Practitioner can refer a client who has a Chronic Disease and a General Practice Management Plan to the Care Coordinator.

Clients most likely to benefit include:

- Clients at risk of experiencing unavoidable hospital admissions.
- Clients at risk of inappropriate use of services. E.g. emergency presentations.
- Clients not using community based services appropriately or not at all.
- Clients who need help to overcome barriers to access services.
- Clients who require more intensive care coordination that is currently able to be provided.
- Clients who are unable to manage a mix of multidisciplinary services.

Please note: while more intensive support may be required at the onset, as clients become more familiar with and confident in self-managing their condition and accessing services, they may no longer need to participate in the program.

For Further Information please contact:

Closing the Gap Team

Nuriootpa Head Office – 8565 8500
Kadina Office – 8821 6700
Port Augusta Office – 8643 5600