

**Orange** indicates HNEH/  
GP/ Community Service  
**Grey** indicates GP Access

Care Coordinator & Supplementary Services Flow Chart

**Patient Identified for the program**

- 15yrs or over
- have a current GP Management Plan and/or Team Care Arrangement;
- be registered for chronic disease management in a general practice or Indigenous Health Service participating in the PIP Indigenous Health Incentive: and be recommended by their general practitioner
- Diseases : Chronic Respiratory Disease, Cardio Vascular Disease, Diabetes, Chronic Renal Disease and Cancer

**Referral Sources**

- HNEH Connected Care Service Care Coordinator selects "eligibility" of patients from "ED Frequent Presenter" Report
- GP or community service referral to CCSS Coordinator or TL

Click [here](#) for the CCP Position Description

**Closing the Gap (CTG)**

Registering for PIP Indigenous Health Incentive

- Complete Medicare registration forms both patient and practice
- Refer to GPA CTG team

**Further investigations of patient eligibility**

- Identifies self as Aboriginal or Torres Strait Islander
- Diseases : Chronic Respiratory Disease, Cardio Vascular Disease, , Diabetes, Chronic Renal Disease and Cancer

**Referral Process**

- Patient service request for "Connected Care +", "48hrs Follow Up +", GP and or Community Service referral attended +(Ensuring all future correspondence are linked to the Connected Care Service Request) conducted by HNEH Connecting Care team
- Verbal Consent form attended
- GP and or Community Service fax request, consent, GPMP/TCA, Health Summary, items numbers billed in last 12months\_to CCSS Team fax no. 02 49252268

**HNEH Connected Care Services contacts patient to explain service**

**GP & or Community contacts patient to explain service to patient**

- Verbal Consent form attended
- Request, consent, GPMP/TCA, Health Summary, items numbers billed in last 12months to CCSS Team fax no. 02 252268

Click [here](#) for the CCSS Consent Form  
Click [here](#) for the Request Form

**Consented to service**

- Connected Service info mailed to patient (Pamphlets, Privacy Leaflets, Rights & Responsibilities, and 'A Health Record')

**GP & or Community Services**

**Not consented**

**Referral to GP Access Connecting Care Coordinator**

**Patient undecided**

**Definite no**

**CCSS cont.**

**Chime information gathered +**

**Connected Service info mailed to patient**  
(Pamphlets, Privacy Leaflets, Rights & Responsibilities, and 'A Health Recorded')

**Connected Service info mailed to patient**  
(Pamphlets, Privacy Leaflets, Rights & Responsibilities, 'A Health Recorded', Referral Information Centre phone number & pamphlet) and phone number provided

**Referral to GP Access Connecting Care Coordinator**

**∞ Identify if patient has a GP & or confirm reported**

**HNEH Care Coordinator recontacts patient for patient's decision & consent**

**Use of Supplementary Funding**

Assess factors that indicate:

- Waiting periods for services longer than clinically appropriate
- Likelihood of a hospitalisation
- Likelihood of a reduce hospital LOS
- Funding not available through other funding sources
- Service not accessible because of the cost of local transport service

**No**

**+ Yes**

**No**

**Yes +**

**Chime information gathered by CCSS CC +**

**Refer to GPA list of GPs accepting new patients**

**Care Coordination facilitates a GP**

**Care Coordinator makes appointment with practice to discuss program (PN/PM/GP) ^**

**Complete**



- 75 Health Assessment 701-707
- ATSI 715
- GPMP 721
- TCA 723
- GPMP Review 732
- TCA Review 732
- DACC 2517, 2521, 2525
- Asthma Acc 2546, 2552, 2558
- Case Conference 735, 739, 743

**GP Practice Contract \***

- Discuss program
  - Establish activity level required
  - Patient information shared
  - Establish available assessments to patient
  - Plan approach and service level
  - Establish immunisation history
  - History previous health professional services involved
  - History evidence from patient, family or significant others
  - Obtain dates of previous MBS item numbers billed
- Click [here](#) for information on CCSS

Contact patient

**Document identified risk in GP Access Connecting Care patient file**

Mark CCP file with red "R" to denote identified risk  
Report risk

**Home visit Risk Assessment attended on the phone and made home visit appointment**

Click [here](#) for Program Visit Risk Assessment

**Report risk to HNEH for CAPS Update**

**Initial GP Visit Checklist**

CHECKLIST FOR INITIAL GP VISIT			
Patient/ GP/Practice:	YES	NO	DATE
Are you aware of any history of substance abuse?			
Do you consider the numbers of the CCP to visit your patient in terms of the assessment provided in the GPMP/TCA and relevant assessments?			
Are the patient's vaccinations up to date?			
Has the patient had a previous 75 Health Assessment?			
Has the patient had a previous GPMP/TCA?			
Are the GPMP/TCA staff aware that the CC will need to see the GP again for a review and signing of the GPMP/TCA assessment as required by the CCP?			
Would you like the CCP to do more 75 HA if appropriate and appropriate?			
Would you like us to review our care plans to ensure appropriate care for the patient?			
Are there any services in the GPMP/TCA in the GPMP/TCA that you are unsure of at the moment? Is there anything the GPMP/TCA would like to do for the patient at this stage?			
Has the Advanced Care Planning been discussed and reviewed with the patient?			
Has the CCP program information been provided to the GPMP/TCA staff?			
Copy of signed consent shown and signed by GP?			
Are you happy for the patient to have an ACCRAT assessment?			

**Consent for Connecting Care Program Service**

**Care Coordinator completes GP checklist**

**Ring prior to appointment to confirm**

**Biannual CCP Risk Management Review**

Conduct home visit

**Care Coordinator investigates "CAP"**

**Care coordinator refers to level of contact form for service support**

**Consent form**  
Click [here](#) for the CCSS

**Care coordinator follows up incomplete tasks**

**Home visit Assessments #**

- GP Access assessment form
- Carers assessment
- Pain assessment
- K10 Depression scale

For all assessments click [here](#)

**HNEH tasks identified**

**Case conference identification need**

**Care coordinator ensures shared care plan complete and shared to HNEH & GP**

**Contact HNEH Care Coordinator regarding progress**  
Weekly fax – end of week

**GPA CCP task identified**

**Identified organiser coordinates case conference**

**Practice contact to inform of eligible billable item numbers for GP**

**GPMP & TCA draft by Care Coordinator**

**Follow MBS scheduled time frames as a guide to continue service**

**Progress contact to HNEH Care Coordinator -also occurs weekly**  
Written report occurs weekly

**Return to ^ if patient health outcomes change or condition deteriorates**

**Care Coordinator refers to service contact form**  
Re: Advanced Care Planning, time frame activities & outstanding issues

**Appointment with practice**  
To discuss assessment/billable item numbers

**Completion of GPMP, TCA & associated services/assessments**

**Identified person completes same**

