

## Care Coordination and Supplementary Services Program

### Service Delivery Model: Guidelines for Use of Supplementary Services Funds

#### Overview

The model has been developed in accordance with the definition and intent of the Supplementary Services funding pool as outlined by the Commonwealth Department of Health and Ageing. The operating guidelines for the Supplementary Services funding are being designed to support implementation and successful application of the model and add further context.

The model provides a methodology for an objective and standard approach to funds allocation through application of the CCSS program guidelines and a responsive and timely process for remittance. The aim is to minimise clinical risk and ensure fair and transparent decision-making using this standardised approach.

The model will enable Care Coordinators to respond to an urgent or time critical situation and will reduce the burden of the administrative and accounts payable component of SS by:

- Establishing basic eligibility criteria
- Providing a simple application form with minimum information requirements
- Vesting approval authority with participating Divisions so that decisions occur at the local level, as close to the client as possible, and allow for flexibility to respond to individual needs
- ensuring applications are complete and meet the guidelines
- executing payments within agreed timelines
- Providing reports to review patterns of service provision for use in future planning
- Reviewing expenditure patterns to reduce inappropriate referrals and ensure accountability and appropriate clinical need.

The framework for the expenditure of the Supplementary Services Funding Pool comprises the following key components (see service model flowchart in table below):

#### 1. Service Focus – Target Population

Supplementary services are provided on a short-term basis, to individuals with complex and critical needs, where there is evidence that additional support will avoid an emergency department presentation, hospital admission or extended stay in hospital.

#### 2. Funding Allocation

Participating Divisions will be provided with an annual allocation of funds for Supplementary Services to administer at the local level. The total NSW allocation of Supplementary Services Funds have been divided equally among the sites. Payments of the SS funds will be released in accordance with contractual arrangements and on the basis of need. In the event that a Division does not spend their SS funds GP NSW may withhold payment until need can be shown through expenditure. It is anticipated that in some areas there may be a greater need for these funds than in others. In the event that GP NSW withholds funds we may also redistribute these to areas where there has shown to be a greater need for use of SS funds.

In the event that a Division experiences high demand for these funds and required additional funds, they should contact Jerry Bacich (CCSS Program Manager) [jerrybacich@gpnsw.com.au](mailto:jerrybacich@gpnsw.com.au) to request additional funds. Divisions will also be required to submit an unaudited financial statement detailing how the funds have been spent.

### 3. Referral Management

Referrals for Supplementary Services will be reviewed by the Care Coordinator, in accordance with the GP Management Plan and/or Team Care Arrangement, in three stages as follows:

- a. **Initial Review:** The initial review will ensure that adequate information (minimum information requirements) about the client has been included in the referral. Minimum information requirements include the minimum data set indicated within the guidelines provided by the Commonwealth Department of Health and Ageing.
- b. **Triage and Assessment:** The referral will then be triaged/assessed by the Care Coordinator according to eligibility criteria and priority ranking as follows:

- i. **Eligibility criteria**

The Care Coordinator will determine whether the client fits the following eligibility criteria (based on Commonwealth guidelines):

- address risk factors, such as a waiting period for a service longer than is clinically appropriate; including lack of available appointment with a publicly funded provider;
- reduce the likelihood of a hospital admission;
- are likely to reduce 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 local transport service.

- ii. **Ranking system to determine priority**

Below is an adaptation of a model utilised by a UK Social Services department for prioritising services which has been amended to suit prioritising the use of Supplementary Services funds. It is acknowledged that the boundaries between these levels are not rigid, but are areas for consideration and consultation.

<b>Urgent</b>	<p>The person is suffering or likely to suffer significant harm by delaying treatment or services and that the services are not available through publicly funded means (Medicare or State Health Services) or that the patient cannot access these publicly funded services due to transport requirements.</p> <p>Urgent assessment will be needed involving the client and other agencies, to consider the impact of any harm, the needs of the client and any action or services that may require funding through the SS pool. Appropriate clinical governance processes should be in place to record the factors in decision making for the use of SS funds.</p> <p>Enquiries will need to be made to ascertain that these services cannot be attained in a timely way through any other funding means (Medicare or state funded services) and that the provision of the services through the Supplementary Services Pool of funds would be of benefit to prevent relapse or worsening of the chronic conditions.</p> <p>Local arrangements will need to be in place for the patient to be provided with the access to the SS funds in a speedy way to support treatment.</p>
<b>High</b>	<p>Clients whose health and development is suffering significantly due to complex or critical needs, and that these needs are not being met with the current care plan and locally available services.</p> <p>The Care Coordinator will assess the persons needs in collaboration with the clinical care team, and consider if and what services are needed and how and by whom they will be provided.</p> <p>Where the services are not available in a timely fashion or there is a need to support the patient to be transported to services the Supplementary Services funds should be made available as a matter of high priority.</p>

<b>Medium</b>	<p>As the needs of the person are likely to be less urgent it is likely that supplementary services funding will not be required.</p> <p>It is recognized that there may be circumstances where particular services are not available locally or there may be an issue of workforce shortage for some services. In these circumstances the clinical team need to assess the level of need and risk of harm if the person was to go without or have delayed access to these services locally.</p> <p>Where gaps in services are identified or there are areas of workforce shortage and long waiting lists, sites are encouraged to consider the potential role of MSOAP, USOAP, ISOAP programs which may be a way to address these issues in the future.</p>
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### **c. Application for Supplementary Services**

The results of the triage and assessment will be used by the Care Coordinator to complete the Application for Supplementary Services. The Application will include the Care Coordinator's recommendation and will be used by the participating Division to disburse payments. The Application will be held on record by the participating Division.

## **4. Demand Management - cap per client per quarter**

Supplementary Services funding must ensure that ongoing needs for services and long term care needs are provided by the most appropriate funding source or provider/agency (i.e. regional health service) care pathway as part of the care coordination process. As Supplementary Services is intended to be a short-term measure, Divisions may choose to prescribe a funding cap per client per quarter. This will ensure that Supplementary Services funding is expended in a fair and transparent manner.

## **5. Service Access**

Funding will be provided to expedite access to the following services:

- allied health services - to directly pay fees for services (where MBS rebates are not available and to meet the difference between MBS rebates and fees charged);
- specialist medical services – to meet the difference between MBS rebates and fees charged;
- cost of local transport to access appointments.

## **6. Equipment**

Supplementary service funding is to be used to assist patients to access medical specialist and allied health follow-up services and local transport services. Medical aids and equipment, cannot be purchased with this funding. The fund-holder/ fund manager may like to look into the Medical Aids Subsidy Scheme, which can pay for medical aids in certain circumstances.

## **7. Hospital treatment and surgery**

The supplementary services funding pool is limited. On this basis, use is restricted to funding clinical follow up care provided by primary care providers. Supplementary service funds cannot be used for hospitalisation or surgery.

## **8. The Health Service Directory and how this can assist the CCSS program**

Research and stakeholder consultation has shown that service providers who provide services through outreach or other brokerage type services need to undertake a registration process. In order to facilitate registration, provide a service directory and provide an accreditation check for participating Divisions, GP NSW will utilise the Health Service Directory. The Health Service Directory is an electronic register of service providers within the state including; general practice, specialist and allied health providers.

## **9. Funds Management and Review**

As stated in the CCSS contract, GP NSW requires Divisions to report on the expenditure of the Supplementary Services funds in unaudited and audited financial reports to accompany 6 and 12 month reports respectively. In the event that a Division requires access to additional SS funds they can apply to GP NSW for more funding, but will be required to provide an unaudited financial statement detailing how these funds have been spent.

## **10. GP Clinical Review**

The flexible funding pool aims to provide greater flexibility in resource allocation, but there is risk associated with such flexibility. As such, it is anticipated that there will be a need for independent GP review to ensure the clinical appropriateness and correct allocation of SS funding according to the referral procedures and the priority allocation system devised. It is suggested that a GP Advisor be identified at the local level who can provide clinical advice where referrals fall outside of the program parameters or eligibility criteria. Significant planning has been undertaken in preparation for the implementation of the SS program. However, many of the activities and systems can only be practically tested in the operational phase.

The GP Advisor role will be integral to managing exceptional circumstances that are difficult to anticipate in the planning phases.

In addition the GP Advisor could also be involved in overseeing an audit of referrals to ensure that they are meeting the eligibility criteria of the Commonwealth and the guidelines established by GP NSW and the Division. An audit would support sites to:

- Reduce inappropriate referrals.
- Commence assessment and treatment for clients more quickly.
- Reduce duplication of services.
- Reduce waiting times for services based on clinical priority.

**Appendix 1: Example Referral for Care Coordination and Supplementary Services**

*This form may be useful if you have referrals from other organisations for the use of Supplementary Services – e.g. if referrals come through the Aboriginal Medical Service or through mainstream GP Service. The form was developed by Riverina Division of General Practice.*

**Fax referral with GPMP to Fax <<insert fax no.here>>**

To: CtG Care Coordinator  
From: <<organisation name>>  
Re: <<patient name>> DOB \_\_\_/\_\_\_/\_\_\_

Service required:

- Care Coordination
- Supplementary Services
  - Specialist Care
  - Allied Health
  - Transport

Patient eligibility (essential):

- Patient is registered for the PIP Indigenous Health Incentive
- Chronic Care Plan Completed (please attach to referral) MBS 721
- Patient has a Team Care Arrangement MBS 723

Chronic Disease Details: (Patient must have a chronic or terminal medical condition which has been or is likely to be present for six months or longer)

- Diabetes
- Cardiovascular Disease
- Chronic Respiratory Disease
- Chronic Kidney Disease
- Cancer
- Stroke
- Musculoskeletal
- Other: (please detail).....

Patient Barriers:

- Non-compliant
- Inability to self-manage
- Functional Disability
- Has the patient identified to you or has a history of not attending follow up care due to cost of service or cost of transport? If yes, please identify patient’s barrier or history of not attending appointments. ....

Priority Allocation of Supplementary Services Funding:

- Likelihood that the patient will experience a hospital admission due to the chronic condition if follow up care is not accessed.
- Waiting period for a service longer than is clinically appropriate.
- Service requested unavailable through other funding sources.

Name of referring/treating GP:.....GP Signature:.....Date:.....

Appointment Details:

Service provider:.....  
Date:.....Time:.....

***NB: Supplementary Services is a limited pool of funds and cannot fund all the follow up care required by patients in the CCSS Program. Supplementary Services cannot fund equipment needs for patients. Priority for the use of funds will be given to responding to urgent needs and funding availability.***

## Appendix 2: Example Form for recording clinical decisions about use of Supplementary Services funds

This form can be used by the Division and clinical advisors to record clinical reasoning about use of Supplementary Services funds and to support consistent transparent decision making processes. This form could be used to guide the process for a clinical team to make a decision about the use of the SS funds in individual cases. It is recommended that there are a minimum of two clinicians to discuss and record these case discussions – with one being the independent GP Advisor.

Patient details	<b>Name:</b> <b>DOB:</b> <b>Address:</b>
GP details	<b>Name:</b> <b>Address:</b> <b>Contact phone number:</b>
Care Coordinator or other CTG worker	<b>Name:</b> <b>Contact details:</b>
Reason for referral – what service has been requested?	<i>Eg: transport and accommodation to specialist in another town as well as funding for cost of private cardiologist appointment</i>  <i>Or: to meet the upfront cost of expense to travel to capital city for cancer treatment. Patient plans to be able to reimburse part of the funds on return home from treatment.</i>
Approximate cost of service(s)?	<i>Eg: Specialist cost=</i> <i>Return transport =</i> <i>Accommodation =</i> <i>Total cost =</i>
How will follow up care be funded and provided?	
What is the patient need for the services?	<b>Urgent</b> <b>High</b> <b>Medium</b>
Is there a waiting time for this service through Medicare or state funded services? If so what is the waiting time	
What would be the likely clinical consequences of this patient not being funded through Supplementary Services for this service?	<i>Eg exacerbation of condition and possible hospital admission or worse prognosis if not assessed and treated now.</i>
Decision to meet funding request	<b>Yes /No</b>
Rationale for decision to fund	
Names and designations of clinicians involved in decision process	
Care Coordinator signature and date	<b>Signed:</b> <b>Date:</b>