MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM INDIGENOUS CHRONIC DISEASE 2009 – 2013

GUIDELINES

CONTENTS

1 BACKGROUND TO THE MSOAP-ICD 3
1.1 Aims and Objectives of the MSOAP- ICD 3
1.2 Medical Specialist Outreach Assistance Program 3
1.3 Council of Australian Governments 3
1.4 National Partnership Agreement on Remote Service Delivery 4
2 MSOAP-ICD SERVICE 5
2.1 Eligibility 5
2.2 Target Communities 5
2.3 Services to be provided 5
2.4 Models of Care 5
2.5 Health Professionals supported by measure 6
2.6 Cultural Awareness and Safety Training 7
2.7 Orientation to the outreach location 7
3 PARTICIPANTS 8
3.1 Department of Health and Ageing 8
3.2 Fundholders 8
3.3 Advisory Forum 9
3.4 Health Professionals 10
3.5 MSOAP-ICD Outreach Service Host 10
4 WHAT CAN MSOAP-ICD SUPPORT? 11
4.1 Remuneration for MSOAP-ICD team members 11
4.2 Registrars and students 11
4.3 Workforce support 11
4.4 Administrative Support for MSOAP-ICD team members 11
4.5 Travel costs 12
4.6 Accommodation costs 13
4.7 Meal and Incidental costs 13
4.8 Equipment lease and transport 13
4.9 Outreach service host location 14
4.10 Absence from Practice Allowance 14
4.11 Backfilling 14
4.12 Upskilling 14
4.13 Professional support 15
4.14 Services to public hospital patients 15
4.15 Telemedicine 15
4.16 Case Conferencing 16
5 PROGRAM OPERATION 17
5.1 Service proposals 17
5.2 Delivery of services 17
5.3 Review of services 17
5.4 Variations to services 17
5.5 Service termination 18
5.6 New resident health professionals 18
5.7 Evaluation 18
6 MSOAP-ICD Department of Health and Ageing Contacts 18
7 GLOSSARY OF TERMS - MSOAP-ICD 19

1 BACKGROUND TO THE MSOAP-ICD

The Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease (MSOAP-ICD) guidelines partner the MSOAP-ICD Policy Framework.

1.1 Aims and Objectives of the MSOAP- ICD

The aim of the MSOAP–ICD measure is to increase access to a range of health services, including expanded Primary Health Care, provided to people in rural and remote Indigenous communities for the treatment and management of chronic disease.

The objectives of the MSOAP-ICD measure are to:

- support health professionals to provide outreach services to rural and remote Indigenous communities;
- increase the range of services offered by visiting health professionals to detect, manage and prevent chronic disease more effectively;
- foster the collaboration between health services in the local Indigenous community and visiting health professionals to target the delivery of essential treatment to patients with chronic disease;
- improve ongoing management and continuity of patient care;
- provide up-skilling opportunities in the outreach location; and
- work with communities to build knowledge and support informed self-care.

The MSOAP-ICD measure will focus service delivery in outreach locations on the following chronic conditions:

- Diabetes;
- Cardiovascular disease;
- Chronic respiratory disease;
- Chronic renal (kidney) disease; and
- Cancer.

1.2 Medical Specialist Outreach Assistance Program

The Medical Specialist Outreach Assistance Program (MSOAP) was established in 2000 to improve the access of rural and remote communities to medical specialist services by complementing outreach medical specialist services provided by state and Northern Territory governments.

The objectives of MSOAP are to:

- increase visiting medical specialist services in areas of identified need;
- support medical specialists to provide outreach services in rural and remote communities;
- facilitate communication between visiting medical specialists and local health professionals about on-going patient care; and
- increase and maintain the skills of health professionals in regional, rural and remote areas in accordance with local need.

1.3 Council of Australian Governments

On 29 November 2008, the Council of Australian Governments (COAG) agreed to a $1.6 billion *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (NPA) to address the first of the COAG Closing the Gap targets – to close the life

expectancy gap between Indigenous and non-Indigenous Australians within a generation. The NPA is centred on the following five priority areas:

- Tackling smoking;
- Primary health care services that can deliver;
- Fixing the gaps and improving the patient journey;
- Providing a health transition to adulthood; and
- Making Indigenous health everyone's business.

The Commonwealth is contributing $805.5 million over four years for an Indigenous Chronic Disease Package that focuses on the first three priority areas of the NPA. State and Territory governments are implementing packages that contribute to all five priority areas.

The Commonwealth's Indigenous Chronic Disease Package will deliver a comprehensive package of measures to reduce chronic disease risk factors; encourage earlier detection and better management of chronic disease in primary care services; improve follow-up care; and increase the capacity of the primary care workforce to deliver effective health care to Aboriginal and Torres Strait Islander peoples.

As part of the Commonwealth's Indigenous Chronic Disease Package, funding of $54.4 million over four years has been allocated to expand the MSOAP to introduce multidisciplinary teams, comprising medical specialists, general practitioners (GPs) and allied health professionals, to better manage complex and chronic health conditions in rural and remote Indigenous communities.

The expansion of the MSOAP program is a component of the Department of Health and Ageing's (the Department) commitment to improving primary health care services for all Australians by increasing access to specialist and multidisciplinary team care under the NPA.

1.4 National Partnership Agreement on Remote Service Delivery

The NPA on Remote Service Delivery is focused on reforming the way government agencies work together in remote areas, on developing community capacity and improving access to services. Joint Commonwealth-State planning mechanisms will ensure better coordinated service delivery. These mechanisms will also ensure that Aboriginal and Torres Strait Islanders in remote communities will have greatly improved access to government services, including early childhood, health and welfare services that will be provided in a culturally appropriate manner. The NPA includes service delivery principles for programs and services for Aboriginal and Torres Strait Islanders. The MSOAP-ICD measure will be delivered according to these principles. Further information on the NPA is at: www.coag.gov.au

2 MSOAP-ICD SERVICE

2.1 Eligibility

Services delivered to Indigenous communities in Australian Standard Geographical Classification (ASGC) – Remoteness Areas (RA) 2 (Inner Regional) to 5 (Very Remote) are eligible to be supported under this measure. However, where possible the MSOAP-ICD measure will focus the delivery of outreach services in Indigenous communities situated in remote (RA 4) and very remote (RA 5) locations.

Further information on the ASGC can be found at www.abs.gov.au or by accessing the Remoteness Area Locator at www.doctorconnect.gov.au

2.2 Target Communities

The primary focus of the MSOAP- ICD measure will be to deliver services to locations with a majority Indigenous population with a high prevalence of complex and chronic health conditions or where a significant proportion of the Indigenous community in the location have chronic health conditions.

The Advisory Forum in each state and the Northern Territory will consider these target locations and their relative needs in recommending services under the MSOAP-ICD to the Department.

2.3 Services to be provided

The MSOAP-ICD measure will build on existing services and establish new services with a focus on diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease and/or cancer. Services are to focus on the detection, management and prevention of these complex and chronic conditions in people in remote and very remote Indigenous communities.

Services funded under this measure should complement services provided by state and Northern Territory governments or other providers/ funders.

Preventative health services provided by allied health professionals are eligible for support under the MSOAP-ICD following referral by a medical specialist or primary health care service provider. For example, exercise physiologists and health educators could engage with, and provide education in, Indigenous communities to address risk factors associated with diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease and/or cancer.

Under the MSOAP-ICD, a Service is defined as a health professional (i.e. any individual medical specialist, GP and/or allied health), visiting and providing a medical consultation at an approved location.

A Service may be approved for one or more financial years and will be reviewed annually.

2.4 Models of Care

A range of flexible service delivery models may be used under this measure to meet the aim and objectives of the MSOAP-ICD program.

Outreach: service provision provided to remote communities by service providers travelling to these locations from a larger town. This is the preferred model under the current MSOAP-ICD measure.

Cluster: service provision to multiple communities from a variety of service providers located in different communities within the cluster. Coordination is paramount in this model to ensure a united approach to care.

Hub and spoke: service provision provided both in a central town and the service provider(s) travelling to remote communities.

The MSOAP-ICD measure focuses on a team approach to care. However it may not be necessary or possible for team members to deliver an outreach service at the same time. Therefore, issues relating to the coordination and continuity of care of patients, managing the impact on the community and costs related to travel should be considered when planning services to these communities.

The multidisciplinary approach of this measure requires a case management and coordination function.

2.5 Health Professionals supported by measure

The multidisciplinary teams to be funded under this measure may include medical specialists, GPs and allied health professionals. A definition of medical specialists, GPs and allied health professionals is included in the glossary (see Section 7).

The composition of multidisciplinary teams will vary depending on the health and treatment needs of communities and individual patients. In some instances the team may include a medical specialist who is accompanied by relevant allied health professionals (e.g. an endocrinologist with a podiatrist and/or diabetic educator). On other occasions it may be a combination of a GP and/or allied health professionals, or a medical specialist, GP and/or allied health professionals, or it may be allied health professionals alone.

In negotiating with health professionals the fundholder must ensure that those professionals who will be relying on Medicare billing have the appropriate registration to enable them to access Medicare benefits.

2.5.1 Who can be supported?

Any health professional or appropriate support and/or supplementary staff relevant to the chronic diseases targeted will be eligible for support under the MSOAP-ICD measure.

The following criteria would need to be met by health professionals through the MSOAP-ICD:

- have appropriate skills and a clearly defined role relevant to the treatment and management of the chronic diseases identified for this measure;
- are appropriately qualified, registered and/or licensed and adequately insured to practice in their profession both individually and in their area of speciality if appropriate;
- have undertaken cultural awareness and safety training as specified in Section 2.6 of these guidelines; and
- will provide services that are directly related to patient management and not for research or other purposes.

All services must be delivered by appropriately trained, qualified, registered and insured health professionals.

- Allied health professionals supported under the MSOAP-ICD measure must hold recognised educational and/or vocational qualifications specific to the position for, or jurisdiction, in which they are employed.
- General practitioners supported under the MSOAP-ICD measure must be a person registered or licensed as a medical practitioner under a law of a State or Territory.
- Medical specialists supported under the MSOAP-ICD measure must be a person registered as a specialist under State or Territory law.
- Registered nurses supported under the MSOAP-ICD measure must be registered under a law of a State or Territory (other than South Australia) as a general nurse or registered under a law in South Australia as a nurse.
- A registered nurse with a specialist role is defined as a nurse who holds appropriate tertiary or vocational qualifications or is employed in that specialist area.
- Enrolled nurses supported under the MSOAP-ICD measure must be registered by the nursing/midwifery registration board in each state and territory.
- Aboriginal and Torres Strait Islander Health Workers participating in the MSOAP-ICD measure must have qualifications recognised in their state and territory jurisdictions.

2.6 Cultural Awareness and Safety Training

All health professionals providing services through the MSOAP-ICD must demonstrate that they have undertaken appropriate Cultural Awareness and Safety Training prior to commencing service delivery.

The fundholder will be responsible for verifying and/ or arranging this training.

Should a member of a MSOAP-ICD team need to undertake Cultural Awareness and Safety Training, the MSOAP-ICD will support training costs.

Non-salaried private outreach service providers may claim MSOAP-ICD absence from practice allowance benefits for the time they attend Cultural Awareness and Safety training.

Any attending health students will need to demonstrate they have undertaken or participated in Cultural Awareness and Safety training prior to participating in outreach visits.

2.7 Orientation to the outreach location

Travel and absence from practice payment (see Section 3) will be available for up to four hours orientation. Orientation visits to each new location for each new health provider (excluding students) can be supported under the MSOAP – ICD and would include a briefing on specific Cultural Awareness and Safety training issues specific to the community.

3 PARTICIPANTS

The participants in the MSOAP-ICD measure are:

- The Department of Health and Ageing – central and state/territory offices;
- The Fundholders;
- The MSOAP Advisory Forums;
- Health professionals delivering the services; and
- Host locations for outreach service provision.

Roles and Responsibilities of Participants

3.1 Department of Health and Ageing

Departmental officers have responsibility for the oversight and management of the MSOAP-ICD measure. The Department will:

- develop and revise, as necessary, guidelines for the program;
- chair and provide secretariat services to the Advisory Forum in each jurisdiction;
- prepare funding agreements with fundholders;
- approve strategic service plans, annual plans and progress reports;
- approve services recommended by Advisory Forum; and
- distribute funds to fundholders as agreed in the schedule of the funding agreement.

Officers in the Department's state and territory offices will be the primary program contact for fundholders.

3.2 Fundholders

Fundholder(s) in each state and the Northern Territory have responsibility to auspice on behalf of the Department the MSOAP–ICD to ensure the provision of medical outreach services by a range of health professionals to deliver improved prevention, detection and management of a range of chronic health conditions and promote upskilling in rural and remote Indigenous communities.

The fundholder will ensure that full time personnel are available to provide and maintain the administrative requirements of the Program to fulfil and be responsible for the operation of the MSOAP-ICD. Responsibilities to be managed will include, but not be limited to:

- Undertaking needs analysis at the commencement of this measure, in consultation with the MSOAP Advisory Forums, Indigenous Health Partnership Forums and local health professionals;
- development and implementation of an MSOAP-ICD strategic service plan;
- communication with members of the medical community and the public to inform them about the MSOAP-ICD;
- development and application of strategies to recruit and retain health professionals services;
- monitoring, management and fulfilment of all program obligations;
- accurate collection, collation and appropriate analysis of data and make this data available to the Department;
- administration of payments to participating health professionals in accordance with services provided;
- development and implementation of strategies to market and educate the public and the health care sector about the MSOAP-ICD;

- assistance with the provision of upskilling sessions to health care professionals as required; and
- provide other activities necessary for the effective and efficient operation of the project.

Fundholders are required to ensure that the MSOAP-ICD is coordinated with local health services to facilitate, where possible, continuity of care to patients and coordination and integration with local health services.

Fundholders are required to send a representative to relevant meetings held by the Department, unless otherwise negotiated with the Department.

The Fundholders in each state and the Northern Territory are:

New South Wales	NSW Rural Doctors Network; and NSW Health	02 8337 8100 02 9391 9000
Northern Territory.	NT Department of Health and Community Services	08 8999 2400
Queensland	General Practice Queensland; and Queensland Health.	07 3105 8300 07 3234 0111
South Australia	Rural Doctors Workforce Agency	08 8234 8277
Tasmania	Tasmanian Department of Health and Human Services.	03 6336 4373
Victoria	Rural Workforce Agency Victoria.	03 9349 4899
Western Australia	Rural Health West	08 6389 4518

3.3 Advisory Forum

The Advisory Forum is a state/ territory based forum comprising a broad range of stakeholders, with relevant knowledge and expertise, who provide advice on the suitability of services under consideration by the MSOAP-ICD.

Recommendations regarding service priorities will be made by the Advisory Forum in each state and the Northern Territory. Fundholders will report on this aspect of service planning. The following information may act as a guide to the role and responsibilities of an Advisory Forum.

The Advisory Forum should work as an effective consultative mechanism that informs the fundholder about how to best deploy resources and determine priorities in project plans. The fundholder is to ensure that the selection of services or any changes in the Strategic Services Plan meet the priority health needs of the relevant community and are decided in conjunction with the advisory forum.

The principal role for the Advisory Forum is to evaluate all proposals for MSOAP-ICD funding as they are presented to:

- identify whether the selected region has the need and the capacity to sustain support for a new service;
- determine gaps in services;
- advise on the appropriate types of services to be delivered; and
- link (when appropriate) with the planning mechanisms of other programs to explore possibilities for integrated program implementation.

It is expected that under the MSOAP-ICD measure the membership of the Advisory Forum will include Aboriginal and Torres Strait Islander health representatives and representatives from allied health organisations to ensure proper consideration of issues. The Advisory Forum, which may include an Indigenous Health Partnership Forum representative, will liaise closely with the Indigenous Health Partnership Forums. The Advisory Forum will ensure appropriate consultations, should a specific discipline/ profession not have a role in the Advisory Forum.

3.4 Health Professionals

Health professionals funded under the MSOAP-ICD measure will work in a multidisciplinary team environment to provide treatment and management of chronic conditions for Aboriginal and Torres Strait Islander patients. Health professionals will:

- deliver services as agreed in their contract with the fundholder;
- liaise as necessary with other members of the team to ensure effective coordinated patient care;
- share patient records as appropriate with other members of the team;
- undertake cultural safety and awareness training as required by the program;
- advise fundholders and other team members of changes to scheduling arrangements to ensure these changes are managed by multidisciplinary team members and by the host outreach location;
- maintain appropriate records and submit tax invoices as required by the fundholder within two months of completion of an outreach visit; and
- ensure the timely provision of deliverables as detailed in the contract with the fundholder.

3.5 MSOAP-ICD Outreach Service Host

Outreach Service Hosts are funded through the MSOAP ICD to host an outreach service. The host service will:

- ensure adequate and appropriate access to facilities as required for health professionals delivering health services as members of the MSOAP-ICD team;
- ensure adequate and appropriate facilities and support required for patients receiving health services by members of the MSOAP-ICD team;
- liaise as necessary with the fundholder and other members of the team to ensure effective coordinated patient care;
- share patient records as agreed and as appropriate with other members of the multidisciplinary team;
- demonstrate awareness of cultural safety and training as required by the program;
- advise fundholders and other team members of changes to scheduling arrangements to ensure these changes are managed by multidisciplinary team members and by the host outreach location;
- maintain appropriate records and submit tax invoices as required by the fundholder within two months of completion of an outreach visit; and
- ensure the timely provision of deliverables as detailed in the contract with the fundholder.

4 WHAT CAN MSOAP-ICD SUPPORT?

Allowable use of funding

The MSOAP-ICD measure is able to assist with funding to support new and established services or expand established outreach medical specialist services. The MSOAP-ICD measure will cover the following costs:

4.1 Remuneration for MSOAP-ICD team members

The MSOAP-ICD measure provides funding to address the financial costs to health practitioners (listed in Section 3) of delivering outreach services.

General practitioners, some allied health professionals and medical specialists should claim against the Medicare Benefits Schedule (i.e. direct (bulk) bill or patient bill) for their services where possible.

Consultation rates for services by other health professionals who cannot claim against Medicare will be paid an hourly rate appropriate for their state or territory.

4.2 Registrars and students

Costs (i.e. travel, meals, and accommodation) for registrars and associated health students who accompany multidisciplinary teams in order to gain exposure to rural practice can be supported. Salaries for registrars and students will not be paid under the MSOAP-ICD measure.

The supervising health professional must ensure that adequate/ appropriate insurance is available for health students accompanying them to outreach locations.

4.3 Workforce support

Financial support (at sessional rates) may be available to private specialists and allied health professionals who provide services under this measure. A workforce support payment may be paid in circumstances where:

- MBS payments cannot be claimed or are not assured; and/ or
- Patient compliance with appointments is uncertain.

Members of the visiting team who receive a workforce payment will be precluded from claiming any MBS payments for services at outreach locations. They are also ineligible to receive MSOAP-ICD payments such as the Absence from Practice Allowance if the workforce support payment is being received.

Workforce support may occur <u>only</u> if other payment options have been exhausted.

4.4 Administrative Support for MSOAP-ICD team members

The MSOAP-ICD may pay for one administrative support person associated with the delivery of outreach services, such as the organisation of appointments, processing of correspondence and follow up with patients, at the outreach location.

Only one administrative support person will be funded daily for each team at the service location. MSOAP-ICD can cover the cost of administrative support for up to the same

working hours (consultations/ treatment time) as those hours undertaken by the visiting health professionals.

A sessional coordination payment may be made to either a member of the multidisciplinary team (eg GP) or an administrative officer to ensure that team members have access to up to date information on each patients records on arrival at each outreach location.

It is expected that administrative support staff will be engaged locally and will be paid at a casual hourly rate. It is recommended that the rate payable for administrative assistance is equivalent to the hourly rate for a medical receptionist with three years experience. Locally engaged administrative support staff may require training in the first instance.

The MSOAP–ICD will not pay travel meals or accommodation for administrative support staff. Administrative support staff will not be funded under the MSOAP-ICD during the time the visiting specialist, allied health professional and/or GP provide upskilling.

4.4.1 Supplementary support for MSOAP-ICD team members

Under the Commonwealth Indigenous Chronic Disease Package, funding is being provided separately for over 160 Indigenous Outreach Workers (IOW) and Care Coordinators. These workers may, where they are available, have a role in assisting patients to attend medical specialist, allied health and multidisciplinary team appointments.

The MSOAP-ICD will supplement costs equivalent to the administrative support payment for Aboriginal Health Workers (AHW) who assist with the coordination of MSOAP-ICD services where this coordination work is additional to the usual workload of the AHWs.

4.5 Travel costs

MSOAP-ICD will cover the cost of travel by the most efficient and cost effective means to and from the outreach service location. This may include commercial air, bus or train fares, charter flights, which could include private commercial charter arrangements with the Royal Flying Doctor Service, and/or expenses associated with the use of a private vehicle (see Table 1 below for rates).

<u>Private vehicles</u>

Other incidental costs such as fuel for hire cars (see Table 2 below for rates), parking and taxi fares may also be covered.

Table 1: Rates for private vehicle use

Engine capacity (standard)	Rate cents per km (ex GST)	GST	Rate cents per km (inc GST)
1,600cc and under	$0.62	$0.06	$0.68
1,601 to 2,600cc	$0.75	$0.08	$0.83
Above 2,600cc	$0.76	$0.08	$0.84

(Current at October 2009). Rates for Rotary engine vehicles are available on request.

<u>Hire car</u>

If road travel is the most cost effective option, the visiting health professional may elect to travel to/ from the outreach location by a self-drive hire car. The Fundholder will arrange the booking and payment of the hire car. Fuel allowances payable for a hire car are as follows:

Table 2: Fuel rates for hire cars

Engine capacity (standard)	Rate cents per km (ex GST)	GST	Rate cents per km (inc GST)
1,600cc and under	$0.13	$0.01	$0.14
1,601 to 2,600cc	$0.12	$0.01	$0.13
Above 2,600cc	$0.12	$0.01	$0.13
4WD (for remote locations only where travel is undertaken on non-sealed roads)	$0.13	$0.01	$0.14

(Current at October 2009). Rates for Rotary/ Gas engine vehicles are available on request.

Parking and taxi fares are paid on a cost recovery basis only.

4.6 Accommodation costs

Accommodation costs will be paid in accordance with Australian Public Service rates. The suggested range for accommodation rates is between $77.00 and $150.00 per night (GST exclusive). However, as accommodation in some locations may be more expensive due to seasonal variations, or suitable accommodation is scarce, consideration will be given to paying higher rates on a case by case basis.

4.7 Meal and Incidental costs

Meals and incidentals for visiting health professions and approved accompanying staff will be paid at the following rates.

Table 3: Meal and incidental allowances

Meal / Incidentals	Allowance payable (ex GST)	GST	Allowance payable (inc GST)
Breakfast	$19.95	$2.00	$21.95
Lunch	$22.80	$2.28	$25.08
Dinner	$39.30	$3.93	$43.23
*Incidentals	$16.50	$1.65	$18.15

(Current at October 2009) * Incidental allowance payments are only payable for the second and any subsequent days of a visit at the outreach location. Breakfast on the first day and dinner on the last day of outreach services are not payable for any team member.

4.8 Equipment lease and transport

Under MSOAP-ICD, consideration will be given to assisting with medical equipment lease arrangements. Any financial assistance for the lease of equipment for medical purposes must be with the approval of the Department. All lease quotes must include budget for replacement parts and maintenance to ensure equipment meets required standards.

The MSOAP-ICD will not cover the purchase of equipment for use by medical specialists, allied health professionals and GPs on outreach visits nor the lease of portable attractive and/or information technology equipment.

MSOAP-ICD may assist with the cost of transportation of equipment (on commercial transport) for use by medical specialists, allied health professionals and GPs to an approved MSOAP-ICD outreach service.

4.9 Outreach service host location

Fundholders will negotiate the roles and responsibilities of outreach service host locations to ensure appropriate arrangements and in place for outreach visits.

Fees incurred in hiring appropriate venues or facilities to support either outreach service provision or upskilling activities will be paid as appropriate. The suggested maximum facility fee payable for any venue is $200 per day (GST exclusive).

4.10 Absence from Practice Allowance

An Absence from Practice Allowance is payable to non-salaried private outreach service providers to compensate for "loss of business opportunity" due to the time spent travelling to and from a location where they are delivering an outreach service and/or upskilling.

The hourly rate payable for the absence from practice is consistent with the fee-for-service hourly rates paid by the relevant state/Northern Territory government, area health service or local hospital (depending on the organisational level at which these payments are established in the state/ Northern Territory).

4.11 Backfilling

The MSOAP-ICD measure will fund backfilling at the nominated sessional rate for that health profession, for rostered hours absent from their employer for salaried health professionals who provide approved MSOAP-ICD services. Neither backfilling costs, nor an hourly rate, will be paid to registrars and health students who participate in the MSOAP-ICD measure.

4.12 Upskilling

Visiting and/or host health professionals/organisations may wish to provide incidental or informal educational and upskilling activities, of either a theoretical or clinical nature, to local medical practitioners, health professionals and community members such as carers which are aimed at:

- developing or enhancing specific skills;
- sharing of knowledge; and/ or
- enhancing on-going patient care.

Upskilling activities should take place at the location where an outreach service is being delivered and should aim to complement existing training arrangements within the area. Funding support may be provided for MSOAP-ICD supported procedural and non-procedural upskilling.

Resident medical specialists, general practitioners, local allied health professionals and, where appropriate, other members of the community may attend upskilling sessions provided by the visiting health professional. MSOAP-ICD does not cover any costs associated with the attendance of local resident medical and health professionals, or other community members, at the upskilling sessions.

Stand-alone upskilling may be considered for support under the MSOAP-ICD where an urgent community need is identified. This would be supported on a short-term, time-limited basis only.

Arrangements for formal upskilling activities must be developed in consultation with local medical and health professionals and the health professions providing the service and,

therefore, may vary from region to region. MSOAP-ICD funds must not be used for the administration and allocation of points for Continuing Professional Development.

Where visiting health professions provide upskilling to local medical and health professionals and, where appropriate, other members of the public (such as carers), MSOAP-ICD may cover the cost of the venue/ facility/ room hire.

In addition, non-salaried private outreach service providers may claim an hourly rate which is consistent with the applicable MSOAP-ICD fee-for-service rates for the time required to present the upskilling activity.

Administrative support staff will not be funded under the MSOAP-ICD to assist with preparation of upskilling materials or during the time the visiting health professional provides upskilling.

Upskilling is **not** a requirement of health professionals providing MSOAP-ICD supported outreach services.

4.13 Professional support

For the purposes of the MSOAP-ICD, professional support means the informal support provided by the visiting health professionals to local medical and health professionals through telephone/ email support once the health professional has returned to their principal practice.

Non-salaried private health professionals may claim an hourly rate for providing professional support which is consistent with the fee-for-service rates paid by the relevant state/Northern Territory government, area health service or local hospital (depending on the organisational level at which these payments are established in the state/ Northern Territory).

Any professional support claim must include evidence that professional support occurred.

Professional support is **not** a requirement of MSOAP-ICD supported outreach services.

4.14 Services to public hospital patients

The provision of hospital services to public patients is the responsibility of state and territory governments under the National Healthcare Agreement. Therefore the cost of patient care in hospital, if needed, will not be met under the MSOAP-ICD measure.

4.15 Telemedicine

MSOAP-ICD supports the use of telemedicine services as a supplement, and not as a substitute, to usual face-to-face consultation between patients and medical specialists, GPs and allied health professionals. MSOAP-ICD does not support the capital costs associated with the establishment of telemedicine services but may cover costs, such as hire of venue and equipment, associated with consultations using this medium.

MSOAP-ICD also supports the Australian College of Rural and Remote Medicine (ACRRM) to provide Tele-Derm and Radiology Online free to all GPs practising in locations classified as eligible to receive MSOAP-ICD supported outreach services.

4.16 Case Conferencing

To maximise patient care, case conferences involving a multi-disciplinary team may be convened for the management of patients at MSOAP-ICD locations.

Medicare Benefits Schedule items are available for GPs and consultant physicians to organise or participate in case conferences for patients who suffer from at least one medical condition which have been present for at least 6 months. For the purpose of the MSOAP ICD, this applies to the identified chronic diseases. The "*Notes of the Medicare Benefits Schedule"* should act as the guide to case conferences and must be complied with.

All participants at a case conference must be in communication with each other throughout the conference, either face to face, by telephone, or by video link, or a combination of these.

Private–non salaried MSOAP–ICD team members may claim an hourly rate for participating in case conferencing if it is not claimable from the MBS. Any rate payable will be consistent with the fee-for-service rates paid by the relevant state/Northern Territory government, area health service or local hospital (depending on the organisational level at which these payments are established in the state/ Northern Territory). Where the MBS is not claimable, each multi-disciplinary team member can be supported for up to ten hours case conferencing for each chronic disease, for each location, each year eg a Health Professional to a location as part of a chronic respiratory team =10 hrs support. If they are at the same location as part of a cardiovascular disease team they would be eligible for an additional 10 hrs support for case conferencing if required.

5 PROGRAM OPERATION

5.1 Service proposals

Fundholders, health professionals or organisations can suggest or develop outreach services for consideration by the Advisory Forum in each state. Health professionals or organisations should seek assistance from fundholders in the relevant jurisdiction in the preparation of the proposed MSOAP-ICD service/s proposal.

The fundholder will submit appropriate proposals to the Advisory Forum for consideration on the Service Proposal Form. The fundholder will notify the nominee of the proposal in writing of the outcome of their application.

5.2 Delivery of services

It is anticipated that services will be delivered at appropriate agreed locations in the community such as Aboriginal Medical Services or community health facilities. These facilities will be responsible for supporting the coordination of visits and patients to appointments.

5.3 Review of services

All services supported under the MSOAP-ICD should be reviewed annually by the fundholder and the Advisory Forum to ensure that services continue to meet the aims and objectives of the measure and the needs of the community.

The outcomes of the review of services and any proposed changes should be submitted to the Department as part of the annual review for the upcoming year.

A service no longer meeting the needs of the program will be reconsidered and funds may be allocated to an alternative service.

5.4 Variations to services

A variation to a service is a planned change that affects the costs associated with and/ or the delivery of the outreach service in the medium to long term. The variation may include the increase or decrease of services provided to one or more outreach locations.

Should a change to an approved service be required, the Department must be notified prior to the change. A change which amends the budget must be documented on the MSOAP-ICD Service Proposal Form (include a revised budget) and be submitted to the Department. A change to service frequency or provider does not require Advisory Forum approval. It should be noted for advice for the next Advisory Forum meeting. A change of location (unless previously approved) must be agreed by the Advisory Forum prior to being submitted to the Department for approval.

Fundholders should seek approval from the Department with respect to any changes to intended or operational services. A formal variation to the Funding Agreement between the Department and the fundholder may be required in some circumstances.

5.5 Service termination

It can be expected that over the life of the MSOAP-ICD measure:

- the need in the community for an identified service may change;
- the services provided by state/territory planning governments may change;
- a service may become self-sustaining from a commercial perspective and will no longer require MSOAP-ICD support;
- a service provider may not wish to continue providing outreach services; and
- the priorities of the Department may vary.

The Department retains the right to terminate any service.

In the event that a service is terminated the fundholder should ensure that:

- all patients are advised and informed of the location of their medical records; and
- any agreements/lease arrangements for the provision of consultations, treatments or equipment are terminated within the nominated period.

5.6 New resident health professionals

In the event a health professional establishes a practice in a location where the MSOAP-ICD is supporting an equivalent outreach service, the fundholder should:

- initiate, or facilitate negotiations with the new “resident” health professional for a six month grace period to wind down the MSOAP-ICD service. This could include patients being notified of the location of their health records or for agreements and lease arrangements to be appropriately terminated ; and
- source a suitable location for the services of the “displaced” health professional if they wish to provide an outreach service in another location.

5.7 Evaluation

An evaluation of the Commonwealth’s Indigenous Chronic Disease Package being implemented by the Department of Health and Ageing will be undertaken in 2012-13. The MSOAP-ICD will be part of this evaluation.

6 MSOAP-ICD Department of Health and Ageing Contacts

Address: GPO Box 9848 in your capital city.

Central Office (Canberra, ACT)	02 6289 7291
New South Wales	02 9263 3574
Northern Territory	08 8919 3435
Queensland	07 3360 2597
South Australia	08 8237 8107
Tasmania	03 6221 1540
Victoria	03 9665 8220
Western Australia	08 9346 5463

7 GLOSSARY OF TERMS - MSOAP-ICD

Aboriginal Medical Service: A health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals[1].

Absence From Practice Allowance: An MSOAP-ICD payment made to a non-salaried private health professional for the time spent travelling to and from a location where they are providing approved MSOAP-ICD outreach services and/or upskilling.

Allied Health Professional: Health professionals who:

- are involved in health care/health related care such as direct treatment, assessment, primary health care, community care, heath promotion in ether the public or private sector;
- are tertiary trained at a recognised university course and required to obtain specific qualifications to either be registered or to join a professional association[2]; and
- are registered or licensed as an allied health professional under a law of a State or Territory that provides for the registration or licensing of allied health professionals.

ASGC-RA: Australian Standard Geographic Classification System (ASGC) – Remoteness Areas (RA) system developed by the Australian Bureau of Statistics using 2006 Census data. It uses six categories of remoteness which are:
ASGC-RA1 – Major Cities;
ASGC-RA2 – Inner Regional;
ASGC-RA3 – Outer Regional;
ASGC-RA4 – Remote;
ASGC-RA5 – Very Remote; and
ASGC-RA6 – Migratory (Areas composed of off-shore, shipping and migratory Census Districts).

Administration costs: An MSOAP-ICD payment made to cover the costs of administration directly related to the provision of patient services including reception duties, organising appointments, processing of correspondence, typing of referral letters and making hospital bookings etc.

Backfilling: An MSOAP-ICD payment made for financial relief for a position vacated by a salaried public health professional that is providing approved MSOAP-ICD outreach services.

Chronic Disease: The following elements are used to identify chronic elements for the purpose of the MSOAP-ICD measure. They include:

- Complex and multiple causes;
- Usually have a gradual onset, although they can have sudden onset and acute stages;
- Occur across the life cycle, although they become more prevalent with older age;

- Can compromise quality of life through physical limitations and disability;
- Are long term and persistent, leading to a gradual deterioration of health; and
- While usually not immediately life threatening, they are the most common and leading cause of premature mortality[3].

The MSOAP-ICD measure is currently targeting the following chronic diseases:

- Diabetes;
- Cardiovascular Disease;
- Chronic Respiratory Disease;
- Chronic Renal (Kidney) Disease; and
- Cancer.

General Practice: General practice is the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities[4].

General/Medical Practitioner:

- Vocationally recognised General Practitioners under Section 3F of the *Health Insurance Act 1973* [5];
- a person registered or licensed as a medical practitioner under a law of a State or Territory that provides for the registration or licensing of medical practitioners;
- A holder of the Fellowship of the Royal Australian College of General Practitioners who participates in, and meets the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Medical Education Program; or
- Undertaking an approved placement in a general practice as part of a training program for general practice leading to the award of the Fellowship of the RACGP, or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of equivalent standard.

Health professional: A general term for a person with tertiary qualifications in a health related field, eg. doctor, dietician, nurse, pharmacist, physiotherapist, psychologist.

Health Student: A person enrolled (or with multiple enrolments) in a higher education program or programs related to the health disciplines supported through the MSOAP-ICD.

Indigenous Health Partnership Forum: These forums oversee the:

- Increased level of resources allocated to reflect the level of need;
- Joint planning;

- Access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related services which reflect their higher level of need; and
- Improved data collection and evaluation.

Advice from the Indigenous Health Partnership Forum operating in each state and the NT reflects local knowledge and insights into community needs while also using an evidence based approach for priority identification for elements of the Indigenous Chronic Disease Package. Forums are one of the three consultation mechanisms the Commonwealth is using to inform the development and implementation of the Commonwealth Indigenous Chronic Disease Package, with the other two being the National Indigenous Health Equality Council (NIHEC) and technical reference groups.

Indigenous Outreach Worker: Indigenous Outreach Workers will undertake non-clinical tasks including assisting Indigenous people to visit a MSOAP-ICD service location and to attend follow up appointments.

Medical Specialist: A medical practitioner who:

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a recognised specialist college; or
- is considered eligible for recognition as a specialist or consultant physician by a specialist recognition advisory committee.

Models of Care: Outreach: service provision provided to remote communities by service providers travelling to these locations from a larger town. This is the preferred model under the current MSOAP-ICD measure.

Cluster: service provision to multiple communities from a variety of service providers located in different communities within the cluster. Coordination is paramount in this model to ensure a united approach to care.

Hub and spoke: service provision provided both in a central town and the service provider(s) travelling to remote communities.

Multi-disciplinary Care: For the purposes of the MSOAP-ICD measure, multi-disciplinary care refers to specific services provided by identified and approved medical specialist, GP, allied health and appropriate support staff which enables the management and improvement of health services of Indigenous communities in rural and remote Australia.

Need: Need would include consideration of issues such as the burden of disease, level of disadvantage, services currently available locally, linkages and integration with other services and effect on local planning and initiatives.

Nurse:	Enrolled nurse - a nurse who is on the roll maintained by the nursing/midwifery registration board in each state and territory. Enrolled nurses include mothercraft and dental nurses where the educational course requirements are less than a 3-year degree course or equivalent. Enrolled nurses usually work with registered nurses to provide patients with basic nursing care, undertaking less complex procedures than registered nurses[6]. Nurse Practitioner – a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. Their role includes referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations[7]. Practice Nurse – a qualified registered or enrolled nurse who delivers primary health care in a general practice setting[8]. Registered Nurse – a) a person registered under a law of a State or Territory (other than the State of South Australia) as a general nurse; or (b) a person registered under a law of the State of South Australia as a nurse.
Outreach service:	Where a health professional provides medical services in a location that is not the location of their principal practice.
Professional support:	An MSOAP payment made for informal support provided by the visiting health professional to the general practitioner and/or other local health professionals through meetings and/or telephone/email support once the health professional has returned to their main practice.
Registrar:	A person training in a recognised training placement to become a medical specialist. A person in this stream must possess qualifications admitting him/her to registration as a medical practitioner under the laws of one of the States or Territories of the Commonwealth of Australia.
Service:	A single health professional (whether medical specialist, general practitioner or allied health) visiting a single town or community (e.g. Endocrinologist, Podiatrist, Nurse Practitioner etc.).
Telemedicine:	a patient-doctor interaction using technology that focuses on clinical care or connecting the patient and physician for the delivery of clinical care. The key criterion being, however, that the interaction via technology is between a physician (or health professional) for the purposes of delivering clinical care. Regardless of the type of technology used, say telephone, video or e-mail, doctor to patient consultations fall into this category. Under this term, however, can be grouped specific types of telemedicine, for example, tele-psychiatry, tele-dermatology.

Acknowledgements

1.National Aboriginal Controlled Community Health Organisation - http://www.naccho.org.au/definitions/ams.html

2. Ann O'Kane & Rob Curry (2003) Unveiling the secrets of the allied health workforce. Presentation to the 7th National Rural Health Conference.

3. National Chronic Disease Strategy, AHMC (2005).

4. The Royal Australian College of General Practitioners (http://www.racgp.org.au/whatisgeneralpractice).

5. *Health Insurance Act 1973*

6. Nursing and Midwifery Labour Force 2005 (AIHW) - http://www.aihw.gov.au/publications/hwl/nmlf05/nmlf05.pdf

7. Australian Nursing Federation - http://www.anf.org.au/pdf/Fact_Sheet_Snap_Shot_Nurse_Practitioners.pdf

8. Australian Nursing Federation - http://www.anf.org.au/pdf/Fact_Sheet_Snap_Shot_Practice_Nurses.pdf