Five steps towards excellent Aboriginal and Torres Strait Islander healthcare

Summary sheet

RACGP

Aboriginal and Torres Strait Islander Health

1. Prepare and register for PIP
2. Identify patients
3. Conduct health assessments
4. Register chronic patients with Closing the Gap Payment – PBS
5. Follow guidelines to enhance access

Component Payment		Activity required for payment
(i) Sign-on payment	$1000 per practice	One-off payment to practices that agree to undertake specified activities to improve the provision of care to their Aboriginal and/or Torres Strait Islander patients with a chronic disease
(ii) Patient registration payment	$250 per eligible patient per calendar year	A payment to practices for each Aboriginal and/or Torres Strait Islander patient aged 15 years and over who is registered with the practice for chronic disease management
(iii) Outcomes payment – up to $250	Tier 1: $100 per eligible patient per calendar year	A payment to practices for each registered patient where a target level of care is provided by the practice in a calendar year
	Tier 2: $150 per eligible patient per calendar year	A payment to practices for providing the majority of care for a registered patient in a calendar year

Source: https://www.humanservices.gov.au/sites/default/files/documents/indigenous-health-pip-guidelines.docx

715 Aboriginal and Torres Strait Islander Peoples Health Assessment. Once in a nine-month period. Patients of all ages.

721 Preparation of a GP Management Plan for a patient who has at least one medical condition that is chronic or terminal.

Chronic Disease Management (CDM).

723 Coordinate the development of Team Care Arrangements (TCAs) for a patient requiring CDM.

10997 Service to a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner. Five services per patient in a calendar year. Patient must have GP Management Plan and services must be consistent with the plan.

10987 To assist Aboriginal and Torres Strait Islander patients who have received a health check and has identified a need for follow-up services that can be provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner between further consultations with the patient's general practitioner (GP).

81300–81360 Available to Aboriginal and Torres Strait Islander patients on referral from their GP following a 715. Provides a maximum of five allied health services per patient each calendar year. In addition to allied health services available to eligible patients with chronic disease under items 10950–10970.

10950–10970 Items available to all patients who are assessed as having a chronic or terminal condition. Patients must have a GP Management Plan and TCAs.

PIP Indigenous Health Incentive supports general practices to provide better healthcare for Aboriginal and Torres Strait Islander patients. *Practice Sign-on Payment, Patient Registration Payment, Outcomes Payment*.

The Closing the Gap Pharmaceutical Benefits Scheme Co-payment Programme (PBS CTG) is available to Aboriginal and Torres Strait Islander people of any age who present with an existing chronic disease or are at risk of chronic disease. The PBS CTG measure provides eligible patients with access to cheaper medicines.

ITC The care coordination and supplementary services, or Integrated Team Care (ITC) is run by PHNs. It allows Aboriginal and Torres Strait Islander patients with a chronic disease to access a nurse or health worker who is able to coordinate care across multiple services and appointments. There is a Chronic Disease Prevention and Service Improvement Fund administered by the Department of Health to support initiatives that address the rising burden of chronic disease. Program details vary; your PHN will be able to advise how this works in your area. Examples of funding options include payment for non-GP specialist visits, purchase of medical equipment and transport for patients to attend appointments.

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