



# ABORIGINAL HEALTH QUALITY IMPROVEMENT TOOLKIT

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# INTRODUCTION

## HNECC PHN Aboriginal Health Strategy

**Our PHN's vision is 'Healthy People, Healthy Communities'. We have chosen this vision because it is deliberately inclusive. Nevertheless we acknowledge that Aboriginal specific health strategies are required if Aboriginal people and communities living within our region are to enjoy a level of health and wellbeing that is, at least, equivalent to that enjoyed by other Australians.**

HNECC PHN has an estimated Aboriginal population of 65,200. This represents 5.4% of the total population of the region of just over 1.2 million. In percentage terms, the Aboriginal population of our region is almost two times that of the national average of 2.8% and 2.9% of NSW average (Hunter New England Central Coast PHN, 2018).

## KEY ABORIGINAL HEALTH AND WELLNESS TARGETS

We have identified key Aboriginal health and wellness targets and specific strategic initiatives. A 'whole of PHN' approach will drive efforts to address and respond to Aboriginal health and wellness needs. Over the coming three year period HNECC PHN will develop and implement a balanced scorecard approach to report on our progress in improving the following targets:

1. Increased engagement in positive health behaviours
2. Improved access to high quality health services
3. The provision of greater levels of preventative care
4. Increasing early diagnosis of disease
5. Effective treatment of chronic disease
6. Closing the young child mortality gap

(Hunter New England Central Coast PHN, 2018)



# CLOSING THE GAP - ROLE OF PRIMARY HEALTHCARE

## Closing the Gap - Improving Indigenous Access to Mainstream Primary Care Program

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander communities to close the gap on Indigenous disadvantage. Their Closing the Gap targets include:

- Child mortality
- Early childhood education
- School attendance
- Employment
- Life expectancy

(Department of the Prime Minister and Cabinet, 2019)

The Closing the Gap - Improving Indigenous Access to Mainstream Primary Care Program is one component of this work. Intended outcomes include:

- An increase in the overall health of the Aboriginal and Torres Strait Islander population;
- Improved access to culturally sensitive primary care services for Aboriginal and Torres Strait Islander peoples; and,
- Improved management of chronic conditions experienced by Aboriginal and Torres Strait Islander peoples.

Life expectancy was around 10 years lower for Aboriginal and Torres Strait Islander people in 2010-12 when compared with other Australians. There is strong evidence that the delivery of clinical preventive health services, especially within a primary healthcare context, improves health outcomes.

## Social determinants

Social determinants such as education, employment, income and housing directly affect the target outcomes. Social determinants also operate indirectly by interacting with other influences (such as environmental, ecological and cultural factors) in a broader framework of Indigenous wellbeing. For example, low socioeconomic status (SES) and intergenerational poverty are associated with lower levels of achievement in education, which can result in reduced health and employment outcomes. Some of the targets are themselves social determinants.

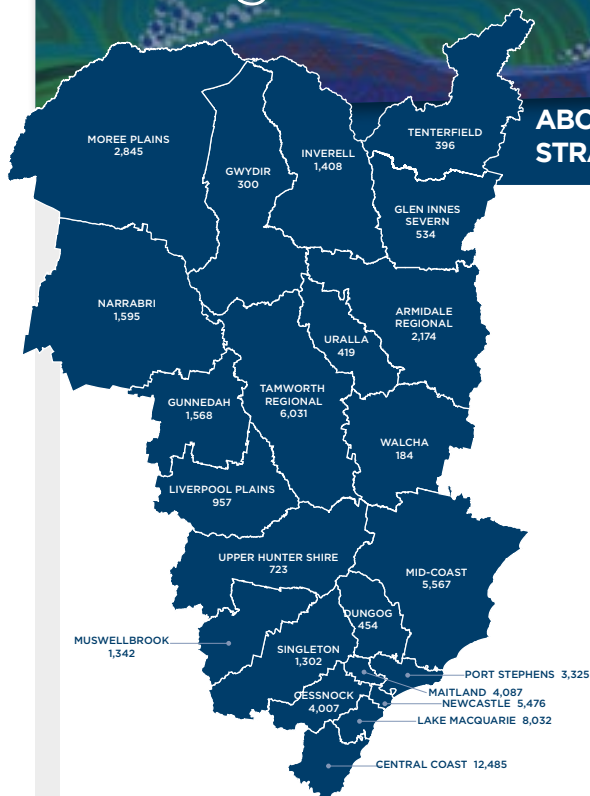
The impacts of social determinants are also

reflected in the higher rates of circulatory disease, respiratory disease, kidney disease and cancer in the Indigenous population. Higher rates of these diseases are linked to the higher prevalence of risk factors such as smoking, poor diet and physical inactivity. These risk factors are mainly associated with differences in SES related to current levels of education, employment, income and housing conditions.



# HUNTER NEW ENGLAND AND CENTRAL COAST PHN Aboriginal Health Profile 2018

## ABORIGINAL AND TORRES STRAIT ISLANDER POPULATION



LGA	%	LGA	%
Armidale Regional	7.4	Upper Hunter Shire	5.1
Central Coast	3.8	Uralla	6.9
Cessnock	7.2	Walcha	6.0
Dungog	5.1		
Glen Innes Severn	6.0		
Gunnedah	12.8		
Gwydir	5.7		
Inverell	8.5		
Lake Macquarie	4.1		
Liverpool Plains	12.4		
Maitland	5.3		
Mid-Coast	6.2		
Moree Plains	21.6		
Muswellbrook	8.3		
Narrabri	12.2		
Newcastle	3.5		
Port Stephens	4.8		
Singleton	5.7		
Tamworth Regional	10.1		
Tenterfield	6.0		



Over 1.2 Million people live in our region

**5.4%**

**(65,183) IDENTIFY AS ABORIGINAL AND TORRES STRAIT ISLANDER** compared with 2.8% nationally

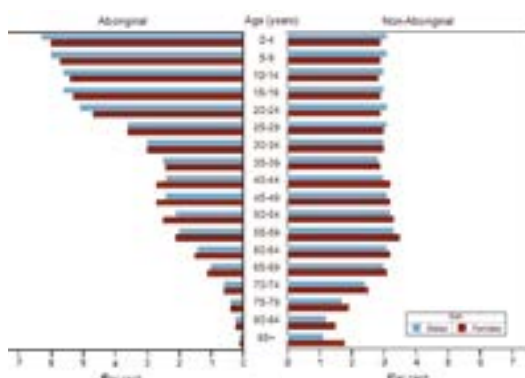
We acknowledge the traditional custodians of the land we walk upon today and respect their continuing culture and the contribution they make to the life of this vast region.

Aboriginal Nations within the HNECC region include;

- Anaiwan
- Awabakal
- Biripi
- Darkinjung
- Dunghutti
- Geawegal
- Kamilaroi
- Kuring-gai
- Ngarabai
- Wonnaru
- Worimi

Areas with the highest proportion of Aboriginal and Torres Strait Islander people include Moree Plains, Gunnedah, Liverpool Plains, Narrabri and Tamworth Regional LGAs.

## AGE PROFILE OF OUR REGION



The Aboriginal population of our region has a **YOUNGER AGE STRUCTURE** than the non-Indigenous population, there are **A LOT MORE CHILDREN THAN ADULTS**

## 715 HEALTH CHECKS

Aboriginal and Torres Strait Islander people are eligible for an annual 715 Health Assessment. In our region, **16,471 OF THESE HEALTH CHECKS WERE PERFORMED** in 2015-16, that's **ONLY ONE FOR EVERY FOUR** Aboriginal and Torres Strait Islander people. Increasing access to these health checks will help close the life expectancy gap.

## CHRONIC DISEASE

**73%**

of Aboriginal and Torres Strait Islander people in our region have **AT LEAST ONE LONG TERM HEALTH CONDITION** (Australia 67.4%),

**21.2%**

have **ONE CONDITION** and **51.9% HAVE TWO OR MORE** (Australia 20.9% and 46.5%)

**22.6%**

of Aboriginal and Torres Strait Islander people in our region **HAVE ASTHMA** (Australia 17.5%)

## MUMS AND BUBS



**39.7% OF ABORIGINAL AND TORRES STRAIT ISLANDER MOTHERS** in our region and 11.3% of non-Indigenous mothers **SMOKE DURING PREGNANCY** (NSW 41.3% and 6.9%)



**74.4% OF ABORIGINAL AND TORRES STRAIT ISLANDER MOTHERS** in our region and 80% of non-Indigenous mothers have an **ANTENATAL VISIT BEFORE 14 WEEKS GESTATION** (NSW 64.6% and 67.8%)



**13% OF ABORIGINAL AND TORRES STRAIT ISLANDER MOTHERS** in our region and 8.7% of non-Indigenous mothers have **PRE-TERM BIRTHS** (NSW 12.7% and 7.7%)



**10.8% OF ABORIGINAL AND TORRES STRAIT ISLANDER MOTHERS** in our region and 6.5% of non-Indigenous mothers have **LOW BIRTH WEIGHT BABIES** (NSW 11.3% and 6.4%)

## SELF-ASSESSED HEALTH

**42.3%** of Aboriginal and Torres Strait Islander people in our region aged 15 years+ **RATE THEIR HEALTH AS VERY GOOD OR EXCELLENT**, **36.8% RATE THEIR HEALTH AS GOOD**, and **21% RATE THEIR HEALTH AS POOR OR FAIR** (Australia 39.3%; 36.5%; 24.2%)

## LIFE EXPECTANCY IN AUSTRALIA



## IMMUNISATION

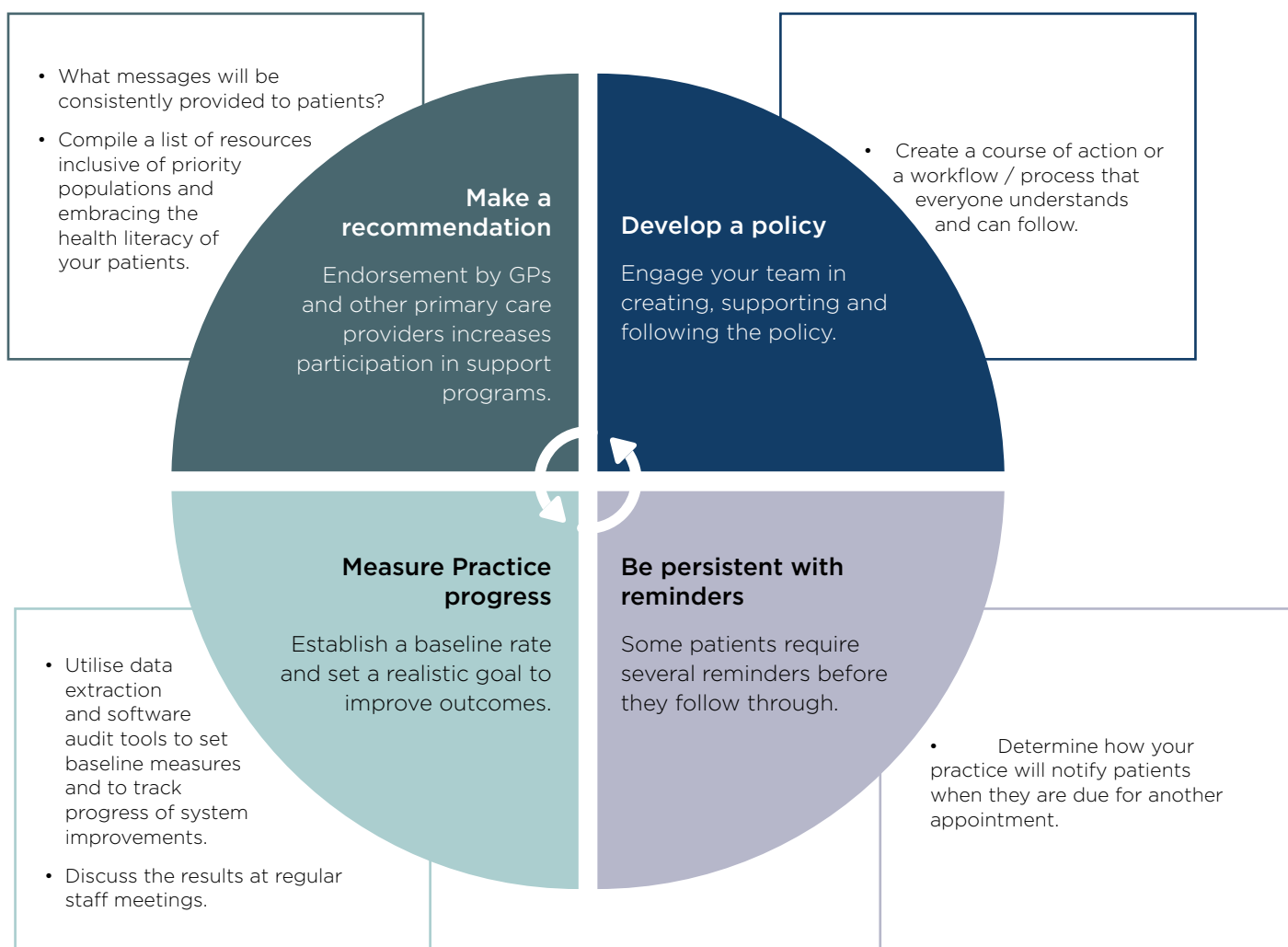


Proportion Fully Immunised by Age	1yr	2yrs	5yrs
Aboriginal and Torres Strait Islander Children	<b>95.3%</b>	<b>92.1%</b>	<b>96.7%</b>
All Children	<b>95.5%</b>	<b>93.2%</b>	<b>95.7%</b>

An Australian Government Initiative

## Four essentials to improving Aboriginal Health in Primary Care

1. Implement practice changes
2. Take a person-centred approach
3. Involve staff and put office systems in place
4. Follow a continuous improvement model to develop and test the changes.





# DEVELOPING A SYSTEMATIC APPROACH

## Data cleansing

The information available in clinical software is invaluable when developing streamlined practice systems and providing quality patient care. For practice data to be useful, information within your clinical database must be accurate and up to date.

Ensuring electronic results are received correctly is key to providing effective and efficient patient care.



### HELPFUL TIPS

- Regularly mark patients as 'inactive'
- Merge duplicate patient records
- Ensure pathology results are received in the correct format
- Develop and agree on processes to ensure data quality is maintained
- Clean up reminder lists: Ask your Primary Care Improvement Officer for instructions on 'Bulk Reminder Clean Up'
- Document processes clearly in your Policy and Procedure Manual
- Regularly discuss clinical coding in team meetings to develop clear standards and requirements for patient files.

## Workflow

Workflow is defined as a series of steps, frequently performed by different staff members, that accomplish a task. Workflows represent how work gets done, not the protocols that have been established to do the work.

Workflow mapping is a way of making the invisible "visible" to a practice to improve processes to increase efficiency, reduce errors, and improve outcomes.

Workflow mapping is the process of documenting the specific steps and actions that take place in completing a task. Creating a workflow map allows the opportunity to see what is currently happening, identify opportunities for improvement or change, and design new, more effective processes. It is helpful to consider workflows associated with the following three processes:

1. Perceived process (what we think is happening)
2. Reality process (what the process actually is)
3. Ideal process (what the process could be).



### HELPFUL TIPS

Important rule of mapping: the person who controls the process controls the pen. Meaning whoever carries out the process, maps the steps.

- Be realistic: map what is happening not what is desired.
- Identify each step of the activity and person responsible.
- Communicate: ensure all involved team members involved understands how the activity is executed.



### HELPFUL LINKS & RESOURCES

Train IT Medical have sample workflows for:

[Correspondence Management](#)

[Inbox Management](#)

[Train IT Medical Practice Management resources](#)



## Implementing robust recall and reminder systems

The RACGP Standards for General Practice view a **reminder** as an offer to provide patients with systematic preventative care. A **recall** is when it is paramount for a patient to attend the clinic, usually in the instance of an abnormal result. A recall is further defined as a system to make sure patients receive further medical advice on matters of clinical significance.

**Clinical significance** is determined by:

- the probability that the patient will be harmed if further medical advice is not obtained; and
- the likely seriousness of the harm.

It will be up to each practice to design a system which effectively differentiates between their general preventive reminders and their true recalls (RACGP, 2017).



### HELPFUL TIPS

- Ensure there is a written policy which is communicated to the practice team which outlines a consistent and validated process for recording results, entering recalls and sending reminders
- Define roles and responsibilities for individual team members
- Review systems for managing overdue patient recall and reminders.



### HELPFUL LINKS & RESOURCES

Speak to your Primary Care Improvement Officer to gain access to best practice resources:

[Medical Director: Recall, Reminders Action Fact Sheet](#)

[The Do's and Dont's of Patient SMS](#)

[AMA Recall Systems and Patient Consent](#)

It is recommended that GPs who are coordinating patient-centred care should not assume that clinically significant test results ordered by others have been adequately followed up.

Clear and agreed systems for receiving and following up on test results are needed to ensure safe and effective continuity of patient care. For further information regarding RACGP's position on non-GP initiated testing [click here](#).

## How can PEN CS support patient-based outcomes in General Practice?

When leading change in a General Practice, you will require data to help guide your thinking, discussions and planning.

Pen Clinical Audit Tool (PenCAT) is a user-friendly software tool that interrogates the data contained within GP clinical and management software. The extracted data can be then filtered to select a specific target group and viewed through a range of clinically relevant patient reports to support quality improvement.

### PEN CS and your Practice

A significant number of General Practices across the HNECC PHN already use PenCAT to investigate and report against their patient data. Using PenCAT to extract relevant data provides practices a range of benefits including:

- Improving the quality of patient care by identify patients requiring periodic screening and ensuring the appropriate treatment or referral is delivered proactively
- Identifying patients “at risk” of developing certain diseases or conditions and offering preventative treatment.



### HELPFUL TIPS

- Use current data by performing monthly data collection.
- Ensure correct coding principles are implemented to ensure data can be extracted.
- Upskill; participate in PenCAT and [TopBar webinars](#) and speak with your Primary Care Improvement Officer to assist in understanding your practice data.



### HELPFUL LINKS & RESOURCES

PEN CS has developed ‘recipes’ which are simple step by step guides to extract meaningful data correctly.

Visit [www.pencs.com.au](http://www.pencs.com.au) to source recipes identifying patients eligible for Aboriginal Health services.



# WHAT IS QUALITY IMPROVEMENT?

The RACGP Standards for General Practice describes quality activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of health care delivered by the practice. The Standards recommend practices engage in quality improvement activities that review structures, systems and processes to aid the identification of required changes to increase the quality of healthcare delivery and safety of patients.

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Engaging in quality improvement activities is an opportunity for the practice's GPs and other staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team.

## Standards for General Practice - 5th Edition

The RACGP 5th Edition Standards have been released with a new module specifically identified for Quality Improvement. Criterion QI 1.1 identifies four indicators that relate to Practice based activity around Quality Improvement and reference a team-based approach. The criterion recommends having at least one team member responsible for leading quality improvement in the practice, which establishes clear lines of accountability. Please refer to the guidelines.

Criterion QI 1.3 relates to improving clinical care, specifically practice use of relevant patient and practice data to improve clinical practice. Establishing and utilising robust reminder and recall systems could be a focus under this criterion.

[RACGP Standards for General Practices 5th Edition](#)

The Quality Improvement process is divided into two manageable steps, the “thinking part” and “doing part”. This process allows ideas to be broken down into management sections which can be tested and reviewed to determine whether improvement has been achieved prior to implementing on a larger scale.

## The ‘Thinking’ part

The thinking part consists of three fundamental questions that are essential for guiding improvement.

### **1. What are we trying to accomplish?**

**By answering this question, you will develop your aim for the activity.**

Consider exactly what it is you are seeking to change.

- Define the problem. Success comes through preparation, understanding what the problem is and thinking about why there is a problem helps in developing your aim.
- Set realistic objectives which are specific, have a defined timeframe and are agreed (SMARTA). Use plain language and avoid jargon so that the meaning is clear to everyone.
- Include information that will help keep the team focused.



## **2. How will we know that change is an improvement?**

**By answering this question, you will develop measures for tracking your goal.**

Without measuring, it is impossible to know whether the change you are testing is an improvement.

- Communicate to the team what you are measuring, how, when and who is responsible (see 'Measuring Success').
- Make the measurement as simple as possible.
- Only collect the data that is required.

## **3. What changes can we make that will result in an improvement?**

**By answering this question, you will develop ideas for change.**

Encourage the whole team to contribute ideas. Be creative. Think outside the box.

- You know your General Practice and your patients best. Keep this in mind and use your knowledge and experiences to guide your ideas.
- Adapt from others.
- Think small and test. Think about testing a change with one GP or a select group of patients. This will assist in determining if the change had the desired effect and suitable for wider implementation.





## The 'Doing' part

The doing part is made up of rapid, small Plan, Do, Study Act (PDSA) cycles to test and implement change in real work settings.

**Not every change is an improvement, but by making small changes you can test the change on a small scale and learn about the risks and benefits before implementing change more widely. Several PDSA cycles may be required to achieve your improvement goal.**

You will find through PDSA cycles some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

### Step One: Plan

A well-developed plan includes what, who, when, where and your predictions and what data is to be collected.

Make your plan as clear and as detailed as possible:

- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where will it take place?
- What do you predict will happen?
- What data/information will we collect to know whether there is an improvement?

### Step Two: Do

Write down what happens when the plan is implemented (both negative and positive) and other observations.

Collect any data you identified in the plan phase.

### Step Three: Study

Reflect on what happened.

Think about and summarise what you have learnt. Analyse the data collected and compare with your initial predictions. If there is a difference in the data and predictions, consider what happened and why.

### Step Four: Act

Considering the results from your tests; will you implement the tested change or amend and test or try something else?

Write down the next idea you will test. Be sure to start planning the next cycle early to keep up the momentum of change.



### HELPFUL TIPS

- Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care
- Decisions on changes should be based on practice data (PEN CS and clinical database audits, near misses and patient and/or staff feedback).
- Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute.
- Utilise the Readiness Tool to assist identify ideas and areas for improvement.
- No PDSA cycle is too small; keep it simple.
- You may complete a series of PDSA cycles to achieve your goal. Results will be achieved through building on previous cycles.
- Set aside protected time to complete the agreed upon tasks.
- Document your PSDA cycles and present findings at team meetings.
- Improvement is a team effort.

See Criterion C4.1 – [Health Promotion and Preventative Care RACGP 5th Standards](#)

**FOR EXAMPLE - your General Practice may decide to focus on:**  
**Improving identification rates of Aboriginal Torres Strait Islander patients within the practice.**

**You may have an aim like this:** To increase the ethnicity recording of patients.

**Your response may be:** We will measure through PenCAT:  
 • The number of who have no recorded ethnicity.

**Your outcome may include:**

- Use PenCAT to extract the number of patients with no recorded ethnicity.
- Utilise TopBar for prompting of missing ethnicity.
- Provide training to ensure all team members (administration, nurses, GPs understand why the questions around indigenous identity should be asked.
- Cultural Awareness Training for staff.
- Create policies and procedures for collecting cultural identification information.
- Routinely asking patients if they identify as Aboriginal or Torres Strait Islander so that you can provide comprehensive, tailored and culturally appropriate care.

**Idea** Use PenCAT to extract the number of eligible patients with no ethnicity recorded.

**Plan**

**What:** Use PenCAT to extract data  
**Who:** Practice Manager  
**When:** Wednesday 3 April 2019  
**Where:** General Practice  
**Data to be collected:** Record the number of patients who have no ethnicity recorded.  
**Prediction:** Expect 25% of patients within the practice to have no ethnicity recorded.

**Do** Practice Manager extracted data as planned using PenCAT Recipe to ensure correct data was extracted.

**Study** Percentage of patients with no ethnicity was as expected.

**Act** Data presented to practice team to discuss strategies that could be implemented within the practice to increase ethnicity recording.

**FOR EXAMPLE - your General Practice may decide to focus next on:**  
**Identifying eligible patients within the practice who have not had a 715 Health Assessment in the last 9-12 months.**

**You may have an aim like this:** To increase the amount of 715 Health Assessments completed by the practice.

**Your response may be:** We will measure through PenCAT:

- The number of eligible patients who have identified as Aboriginal or Torres Strait Islander who have not had a 715 Health Assessment completed in the previous 9 – 12 months.

[CAT 4 recipe to identify patients eligible for an annual 715 Aboriginal and Torres Strait Islander Health Assessment.](#)

**Your outcome may include:**

- Use PenCAT to extract the number of identified eligible patients for 715 Health Assessment
- Implement a reminder system and support its use
- Utilise TopBar Screening prompts
- Send invitation letters to eligible patients
- Ensure clinicians are aware of MBS guidelines and requirements
- Provide training to ensure all clinicians have the skills to complete a 715 Health Assessment.

**Idea** Use PenCAT to extract the number of eligible patients for a 715 Health Assessment.

**Plan**

**What:** Use PenCAT to extract data  
**Who:** Practice Manager  
**When:** Wednesday 3 April 2019  
**Where:** General Practice  
**Data to be collected:** Extract or record the number of patients eligible for a 715 Health Assessment using PenCat recipe.  
**Prediction:** Expect 80% of eligible patients within the practice to not have had a 715 Health Assessment completed.

**Do** Practice Manager extracted data as planned using PenCAT Recipe to ensure correct data was extracted.

**Study** Percentage of patients with no 715 Health Assessment was as expected.

**Act** Data presented to practice team to discuss strategies that could be implemented within the practice to increase 715 Health Assessment screening.

# QUALITY IMPROVEMENT READINESS

There are various ways in which we aim to improve Aboriginal Health systems and health outcomes for Aboriginal and Torres Strait Islander people within General Practice. To ensure Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, systems are required for early detection and diagnosis; and interventions associated with common treatable conditions are necessary to help prevent morbidity and early mortality.

However, there are often missed opportunities for the prevention of chronic disease and associated complications in the Aboriginal and Torres Strait Islander population. When preventive opportunities are missed, this leads to a higher use of hospital care, which in turn increases health costs. The Aboriginal and Torres Strait Islander population has much higher rates of hospital admission for almost every health problem than other Australians.

This Readiness Tool is designed as a starting point to encourage General Practice to generate ideas and strategies in Aboriginal Health that may be applied to a quality improvement activity. This may assist with the 'thinking part' of the quality improvement cycle.

In working through the Readiness Tool, start by identifying if the practice or clinicians are undertaking activity in the identified area. In the action column identify any ideas you may like to consider changing.

## Aboriginal Health Quality Improvement Readiness Tool

<b>General Practice Name:</b>	
<b>Completed by:</b>	

AREA: Aboriginal Health Change Readiness	Yes/No	Action/Comment (what, when, who)
Prepare your practice: <ul style="list-style-type: none"> <li>Is your practice accredited and registered for the Indigenous Health PIP?</li> <li>Have a minimum of two staff members completed RACGP approved Cultural Awareness training? (One MUST be a GP and one other staff member)</li> <li>Is your practice a welcoming environment?</li> </ul>		

Identify Aboriginal and Torres Strait Islander patients.

- Does your practice routinely identify Aboriginal patients?

AREA: General Practice Systems	Yes/No	Action/Comment (what, when, who)
<p>Are you offering all Aboriginal and Torres Strait Islander Patients a 715 Health assessment and making arrangements for follow up care?</p> <p>Do you have reminder systems for:</p> <ul style="list-style-type: none"> <li>• Annual patient re-registration</li> <li>• Chronic Disease Management</li> <li>• Health Assessments</li> </ul>		
<p>Are you utilising Nurse Item No 10987?</p> <ul style="list-style-type: none"> <li>• 10 per Calendar Year?</li> </ul>		
<p>Are you registering eligible patients for the PIP and the closing the Gap PBS co-payment</p> <ul style="list-style-type: none"> <li>• Are you annotating scripts for Closing the Gap (CTG)?</li> </ul>		
<p>Do all staff have PRODA accounts?</p> <p>Reception <input type="checkbox"/> Nurses <input type="checkbox"/> GPs <input type="checkbox"/></p> <p>Do you use PRODA to :</p> <ul style="list-style-type: none"> <li>• Register patients for CTG online?</li> <li>• To check for MBS eligibility?</li> </ul>		
<p>Is your practice receiving :</p> <ul style="list-style-type: none"> <li>• Patient re-Registration payments (\$250.00)</li> <li>• Tier 1 PIP payments (\$100.00)</li> <li>• Tier 2 PIP payments (\$150.00)</li> </ul>		
<p>Does the practice send targeted reminders to patients (e.g. letters, SMS, email or phone calls) for routine cancer screening?</p> <p>Breast <input type="checkbox"/> Bowel <input type="checkbox"/> Cervical <input type="checkbox"/></p>		
<p>Are all staff using Topbar for prompts?</p> <p>Reception <input type="checkbox"/> Nurses <input type="checkbox"/> GPs <input type="checkbox"/></p>		
<p>Are patients provided with quality information on cancer screening, utilising Patient info, including access to resources for Aboriginal communities?</p>		
<p>Are you aware of support services such as:</p> <ul style="list-style-type: none"> <li>• Integrated Team Care Services (ITC)</li> <li>• Aboriginal Outreach Workers</li> <li>• 5 Allied Health Services available to patients with or without Chronic Disease?</li> </ul>		



Are clinicians using HealthPathways and Patient Info for clinical guidelines, assessment, management and referral information and patient information for Aboriginal Torres Strait Islander patients?

Do you have NACCHO and RACGP Yellow book downloaded onto clinical desktops?

**AREA FOR ACTION (Go to PDSA template in your toolkit or see suggested PDSA activities)**

1.

2.

3.

**ABORIGINAL HEALTH PRACTICE QUALITY IMPROVEMENT TEAM**

Clinical lead (GP):

Administrative lead (PM/PS):

Clinician involvement (GP/PN):

# ABORIGINAL HEALTH QUALITY IMPROVEMENT IDEAS

## 1. Review your process for patient identification to increase ethnicity recording.

- Review new patient form (add additional line to explain – We use this information to review treatment options and ensure highest quality of care).
- Train staff in why it is important to ask about patient ethnicity.
- Train staff in how to ask about patient ethnicity.
- Install Topbar for prompting of missing ethnicity in patient demographics.

## 2. Improve cultural awareness of staff.

- Complete online RACGP Cultural Awareness Training.
- Request visit from PHN Aboriginal Health Access Team to provide in house education session or attend PHN Aboriginal Health Education Events.

## 3. Identify patients who have not had a 715 Health Assessment completed in the past 9 - 12 months.

- Use PenCat to identify eligible patients who have not had a 715 Health Assessment completed in the 9 - 12 months.

## 4. Increase utilisation of Health Assessment follow up service using MBS Item No 10987 to provide patients with preventative health care and education between consultations with GPs.

- Outline in your notes the areas you might reasonably pre-empt the patient may require a 10987 follow up over the coming year and add reminders. For example:
  - examinations and interventions indicated in the health assessment.
  - education on medication compliance and related monitoring.
  - checks on clinical progress and service access.
  - education, monitoring and counselling activities on lifestyle advice.
  - preventative advice for chronic conditions and related follow-up.

## 5. Utilise referral pathways for follow up preventative health care and existing chronic disease.

- Complete approved referral form for follow up Allied Health services under Medicare for People of Aboriginal or Torres Strait Islander descent (up to 5 Services per calendar year).

### Referral Form

## 6. Increase preventative screening activities for Aboriginal Torres Strait Islander patients. For example:

- Diabetic Risk Assessment.
- Hearing Checks.
- GTT testing for Diabetes.
- Cancer Screening.
- Mental Health Screening.
- RACGP Red Book Family History Screening Questionnaire.

7. Review reminder system for 715 Health Assessment and Chronic Disease Management.

- Allocate a staff member to oversee Aboriginal Health systems within the practice.
- Set reminders for reviews of GPMP (732) and TCA (732) for 3-6 months.
- Set new GPMP (+) TCA reminder for 12-24 months.
- Set Aboriginal Torres Strait Health Assessment (715) reminders for 9 - 12 months.

8. Review system for annual Closing the Gap patient registration.

- Change to HPOS for re-registration of patients instead of faxing.
- Complete script annotation to assist patients to access free or low cost medications (not necessarily chronic disease related).

9. Review system for PIP IHI annual patient registration.

*Registration is a \$250 payment per eligible patient per calendar year to practices for each Aboriginal or Torres Strait Islander patient aged 15 years and over who are registered for Chronic Disease Management*

- Set a recall in your system to re-register all PIP IHI registered patients for the next calendar year in November.

10. Review PIP Statements to determine if practice is receiving PIP IHI outcome patients and implement systems to help meet targeted care:

***Tier 1 Outcomes payment*** - A \$100 payment to practices for each registered patient where a targeted level of care is provided by the practice in a calendar year; and

***Tier 2 Outcomes Payment*** - A \$150 payment to practices for providing the majority of care for a registered patient in a calendar year.

- Use PenCat to search for patients who have identified as Aboriginal or Torres Strait Islander who have not had a 715 Health Assessment.
- Use PenCat to search for patients who have identified as Aboriginal or Torres Strait Islander who are eligible for Care Plan, Team Care Arrangement or review of same.



# CHANGE IDEAS TO CONSIDER

These ideas are suggestions only, with the concept adaptable across the Aboriginal Health area.

**Idea: Encourage person centred care by encouraging patients to discuss Aboriginal Health management with their GP.**

- Display promotional material in the waiting room.
- Have the reception team give eligible patients a flyer explaining to them the importance of having a 715 Health Assessment entails and what it involves. The patient can then take the flyer into their appointment with them, opening the door for a discussion with their Doctor or Nurse.

---

**Idea: Engaging the General Practice Team - Develop and maintain an effective recall and reminder system: staff education.**

There is often a lot of work that needs to be done to improve how practices use software to maintain effective recall and reminder systems. Staff education is the first step towards improvement. Ask your Primary Care Improvement Officer to provide a short information session to staff and provide reminder and recall resource manuals.

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**Idea: Appoint a staff member who is responsible for overseeing Aboriginal Health and maintaining reminder systems. Add this role to their job description.**

This staff member may become the Practice Champion for Aboriginal Health. Providing professional development opportunities to this staff member will assist with rewarding and recognising this person's contribution to the team.

**Idea: Have a team meeting to brainstorm how recall and reminder systems could improve income generation and patient care.**

Dedicate some time at a staff meeting to discuss how during 715 Health Assessments you can:

- Outline in your notes the areas you might reasonably pre-empt the patient may require a 10987 follow up over the coming year and add reminders for those.
- Set reminders for reviews of GPMP (732) and TCA (732) for 3-6 months.
- Set new GPMP (+) TCA reminders for 12-24 months.
- Set Aboriginal Torres Strait Health Assessment (715) reminders for 9 - 12 months.

---

**Idea: Draft a written procedure for recall and reminder systems.**

If your Practice has a policy/procedure for recalls and reminders, check that there is a process for Aboriginal Health.

---

**Idea: Send 715 Health Assessment reminder letter to eligible patients due for assessment.**

- Following the establishment of your Aboriginal Health patient register, identify patients due for a 715 Health Assessment.
- There are two key times where Practice reminders can really add value:
  1. For patients who have never had a 715 Health Assessment.
  2. On a patient's actual annual Health Assessment due date.

# RESOURCES FOR UNDERTAKING QUALITY IMPROVEMENT

## Quality Improvement Goal Setting

### 1. What are we trying to accomplish?

*By answering this question, you will develop your goal for improvement.*

### 2. How will we know that a change is an improvement?

*By answering this question, you will develop measures to track the achievement of your goal.*

### 3. What changes can we make that can lead to an improvement?

*List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal.*

IDEA 1.

IDEA 2.

IDEA 3.

IDEA 4.



## Quality Improvement Action Worksheet

### *PLAN, DO, STUDY, ACT*

Please complete a new worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

**Describe the idea you are testing.**

IDEA

**Must include what, who, when, where, predictions & data to be collected.**

**What:**

**Who:**

PLAN

**When:**

**Where:**

**Data to collect/record:**

**What do we think will happen?**

**Was the plan executed? Document any unexpected events or problems.**

DO

**Record, analyse and reflect on the results.**

**Extract same data to measure for improvement:**

STUDY

**What will you take forward from this cycle (next step or next PDSA cycle)**

ACT

## Steps to MBS Claiming pathways for Aboriginal and Torres Strait Islander Patients (Updated September 2018)

### Step 1) Ask the Question!

Are you of Aboriginal or Torres Strait Islander Origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander

For clients of both Aboriginal and Torres Strait Islander origin, both 'yes' boxes should be marked.

### Step 2) Do an Aboriginal and Torres Strait Islander Health Assessment

715

Child  
Health Check  
(0-14)

Adult  
Health Check  
(15-64)

Older person  
Health Check  
(65+)

Fee: \$212.25 Benefit: 100% = \$212.25  
1 per calendar year (minimum of 9 months)

### Step 3) If patient is eligible, annotate to PBS Prescriptions with CTG!

Does the patient have a chronic disease or chronic disease risk factor?

and

Would the patient experience setbacks in the prevention / ongoing management of chronic disease without medication and be unlikely to adhere to their medication regime without financial assistance?

Concession card patients will receive their PBS medicines free of charge.

No non-concession card patients pay \$6.40 per prescription for all PBS medicines.

### NO CHRONIC DISEASE IDENTIFIED in Health Assessment:

Patient is any age (and needs follow up care)

Follow-up Allied Health Services  
(Aboriginal and Torres Strait Islander specific)  
**81300 - 81360**  
5 per calendar year  
(claimed by allied health provider)  
Fee: \$62.25 Benefit: 85% = \$52.95

Service provided by a practice nurse or registered Aboriginal Health Worker\*  
\*Aboriginal Health Workers in South Australia are unable to be accredited and registered until 2012

10987

10 per calendar year  
Fee: \$24.00 Benefit: 100% = \$24.00

*Don't forget step 3 - annotate the script!*

### CHRONIC DISEASE IDENTIFIED in Health Assessment:

Patient is 0 - 14:

May prepare GPMP and TCA, however patient cannot participate in IHS PIP (Don't forget step 3 - annotate the script)  
You may wish to establish a procedure to notify staff when a patient participating in the PBS co-payment measure turns 15 and may be eligible to participate in the PIP.

Patient is 15 or over:

Are they a regular patient of your practice?

GPMP 721

Fee: \$144.25  
Benefit: 75% = \$108.20  
100% = \$144.25

Review of GPMP 732

Fee: \$72.05  
Benefit: 75% = \$54.05  
100% = \$72.05

TCA 723

Fee: \$114.30  
Benefit: 75% = \$85.75  
100% = \$114.30

Review of a TCA 732

Fee: \$72.05  
Benefit: 75% = \$54.05  
100% = \$72.05

Chronic Disease Allied Health Services  
(non Aboriginal and Torres Strait Islander specific)

10950 - 10970

5 per calendar year (Claimed by allied health provider)  
Fee: \$62.25 Benefit: 85% = \$52.95

Don't Forget!

729

Contribution by a medical practitioner to a multidisciplinary care plan prepared by another provider.

Fee: \$70.40 Benefit: 100% = \$70.40

To access IHS PIP Payments for CDE:

Tier 1: Target level of care: \$100 per calendar year:

- Prepare a GPMP or TCA, undertake at least one review of the GPMP or TCA
- Undertake two reviews of a TCA or a GPMP
- Contribute on two occasions to a 731 (multidisciplinary care plan for person in aged care)

Tier 2: Majority of care: \$190 per calendar year:

- Providing the majority of eligible MBS services, with a minimum of 5
- Include but are not limited to attendances by GPs (1-51, 193, 195, 197, 199, 801-803, 2501-2509, 5000-5067) and Chronic Disease Management Items.

This resource is only a guide. It should be used in conjunction with the item descriptor and explanatory notes for all items as set out in the Medical Benefits Schedule

# HEALTH ASSESSMENT FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE ITEM 715



## Eligibility Criteria

- Patients 0-14 years use “child” assessment
- Patients 15-54 years use “adult” assessment
- Patient 55+ years use “older adult” assessment
- May be provided once every 9 months.

## Clinical content: mandatory

- Explain health assessment process and gain parent’s/carer’s consent.
- Information collection – take patient history and undertake or arrange examinations and investigations as required
- Overall assessment of patient
- Recommend appropriate interventions
- Provide advice and information.
- Keep a record of the health assessment and offer a copy of the assessment with recommendations about matters covered to the patient and/or carer.

## Clinical content: non mandatory

- Discuss eating habits, physical activity, speech and language development, fine and gross motor skills, behaviour and mood.
- Other examinations considered necessary by GP/Practice Nurse.

## Essential Documentation Requirements

- Record parent’s/carer’s consent to health assessment
- Record the health assessment and offer the parent/carer a copy
- Update parent held child record for children under 5
- Record immunisations provided.

## Claiming

- All elements of the service must be completed to claim 715.
- May be completed over several sessions but do not claim 715 until all components are complete.
- Can claim item 10993 (PN immunisation ) on the same day as 715.

(USE “Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent”)

**NB:** once the patient has had a 715 health assessment they are eligible for 10x follow-ups by the practice nurse. Item Number = 10 x 10987

**NB:** once the patient has had a 715 health assessment they are eligible for 5 x “at risk” allied health visits (Separate / additional to the 5 allied health visits under TCA if the patient is diagnosed with a chronic disease). Item Number = 81300, 81305, 81310, 81315, 81320, 81325, 81330, 81335, 81340, 81345, 81350, 81355, 81360

MBS item	Name	Age Range	Recommended Frequency
715	ATSI Health Assessment “Child”	0 – 14 years	Every 9 months
715	ATSI Health Assessment “Adult”	15 - 54 years	Every 9 months
715	ATSI Health Assessment “Older Adult”	55 + years	Every 9 months

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients.





# Five steps towards excellent Aboriginal and Torres Strait Islander healthcare

## Summary sheet



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.

**10097** Service to a patient 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.

**10087** 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 10050–10070.

**10050–10070** 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.





# General Practice Readiness Checklist for Aboriginal and Torres Strait Islander Health

**phn**

HUNTER NEW ENGLAND  
AND CENTRAL COAST

An Australian Government Initiative



## 1. CREATE A WELCOMING ENVIRONMENT

- Artwork/signage/ appropriate posters
- Display Aboriginal and/or Torres Strait Islander flags
- Acknowledgement of Traditional Owner plaque

Provide culturally appropriate health resources and reading materials e.g. Koori Mail newspaper.

1

## 2. PREPARE PRACTICE SYSTEMS

**Prepare practice systems** such as recall reminders for Aboriginal and Torres Strait Islander clients and update Aboriginal and Torres Strait Islander status for all registered clients.

2

## 3. ESTABLISH A STANDARD PROCESS

Establish a standard process for **asking all patients about their Aboriginal and Torres Strait Islander status**, including patient family members. Further support and guidance can be found at:

- RACGP Identification of Aboriginal and Torres Strait Islander people in Australian general practice

<http://www.racgp.org.au/youracgp/aboriginal/gides/identification>

3

## 4. COMPLETE A HEALTH ASSESSMENT

Complete a **Health Assessment for Aboriginal and Torres Strait Islander People** (MBS Item 715) to assess patient for chronic disease and risk factors.

4

## 5. REGISTER YOUR PRACTICE

5. Register your practice with Medicare Australia for the **Practice Incentives Program-Indigenous Health Incentive (PIP IHI)** - At least two staff members (one must be a GP) must undertake **cultural awareness training** as required within one year of registration for the PIP IHI.

5

## 6. SEEK PATIENT CONSENT

Seek **patient consent and register patient for PIP IHI and/or PBS Co-payment measure**.

Offer assistance to complete registration forms where appropriate.

6

## 7. ANNOTATE PBS PRESCRIPTIONS

**Annotate PBS prescriptions** with Closing the Gap (CTG) for registered patients for access to more affordable medicines.

7

## 8. DEVELOP A CARE PLAN

Develop a **care plan** for your patient if they have a chronic disease. Refer to **specialists and allied health providers** if appropriate.

8

## 9. REFER ELIGIBLE PATIENTS

Refer eligible patients to the ITC program, more information can be found on program providers at

<http://www.hneccpnh.com.au/commissioning/commissioned-services-in-our-region/>

9

## 10. RE-REGISTER PATIENT

Re-register patient annually for PIP IHI.

10

For Assistance related to Aboriginal and Torres Strait Islander Health Initiatives, please contact HNECC PHN on 1300 859 028 and talk with the Aboriginal Health Access Team

[www.hneccpnh.com.au](http://www.hneccpnh.com.au)



## Appendix 2A. Family history screening questionnaire

The use of a simple family history screening questionnaire (FHSQ) can help identify individuals who may require a more detailed assessment of their family history of cancer, heart disease or diabetes.<sup>1</sup>

This tool can be used as part of the patient's assessment at their first visit to a practice. If patients are uncertain about their family history, they can be asked to discuss the FHSQ with their relatives prior to completing the questionnaire. For patients with low literacy, the FHSQ may need to be completed with the support of a healthcare professional.

A positive response to any question requires follow-up with a more detailed assessment of the family history. As family history can change it is recommended that the FHSQ be repeated at least every three years.

This risk assessment focuses on your close relatives including parents, children, brothers and sisters who are either living or dead.	Yes	No
Have any of your close relatives had heart disease before 60 years of age? *Heart disease* includes cardiovascular disease, heart attack, angina and bypass surgery.		
Have any of your close relatives had diabetes? *Diabetes* is also known as type 2 diabetes or non-insulin dependent diabetes.		
Do you have any close relatives who had melanoma?		
Have any of your close relatives had bowel cancer before 55 years of age?		
Do you have more than one relative on the same side of the family who had bowel cancer at any age? Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.*		
Have any of your close male relatives had prostate cancer before 60 years of age?		
Have any of your close female relatives had ovarian cancer?		
Have any of your close relatives had breast cancer before 50 years of age?		
Do you have more than one relative on the same side of your family who has had breast cancer at any age? Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.*		

\*Only first-degree and second-degree relatives need be considered in this screening questionnaire  
Reproduced with permission from Emery JD, Reid G, Prevost AT, Ravine D, Walter FM. Development and validation of a family history screening questionnaire in Australian primary care. *Ann Fam Med* 2014;12(3):241–49. Available at [www.aafpmed.org/content/12/3/241.long](http://www.aafpmed.org/content/12/3/241.long)



## Measuring Success

The overall aim of undertaking an Aboriginal Health Quality Improvement activity is to increase participation in Aboriginal Health.

Choosing an activity or idea to explore will have its own measure of success. It is important to identify in each activity what you are wanting to change and how you will know WHEN the change has occurred. This is identified in Question 2.

Applying a SMARTA (Specific, Measurable, Attainable, Realistic, Timebound and Agreed) goal setting process will assist you.<sup>1</sup>

### SMARTA Goal Setting

- Specific. Goals that are too vague and general are hard to achieve, for example 'be a better parent'. Goals that work include specifics such as 'who, where, when, why and what'.
- Measurable. Ideally goals should include a quantity of 'how much' or 'how many', for example, drinking 2 litres of water per day. This makes it easy to know when you have reached the goal.
- Achievable. Goals should be challenging, but achievable. Goals work best when they are neither too easy or too difficult. In many cases setting harder goals can lead to better outcomes, but only if the person can achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.
- Relevant. The goal should seem important and beneficial to the person who is assigned the goal.
- Time-related. 'You don't need more time, you just need a deadline.' Deadlines can motivate efforts and prioritise the task above other distractions.
- Agreed.

Reflect on the Aboriginal Health activity identified on page 17. Here you have undertaken a data analysis utilising PenCAT and this has shown the percentage of active patients who identify as Aboriginal or Torres Strait Islander. This forms your baseline measure.

The next step is to decide on an activity and set a goal. For this example, you may like to set a goal to Increase 715 Health Assessments by 10% in the next 6 months. When this has been implemented within a set time frame, you can then repeat the data analysis to see if the percentage has increased

<sup>1</sup>Health Direct November 2016 <https://www.healthdirect.gov.au/smart-goals>

**An Example of Measuring Success in increasing 715 Health Assessments.**

Practice X has 170 patients identified as Aboriginal. By using PenCat it is identified that only 50 of these patients have had a 715 Health Assessment completed in the past 12 months.

**Numerator:** The number of identified Aboriginal patients with a 715 Health Assessment recorded is 50.

**Denominator:** The number identified Aboriginal patients is 170.

[Numerator of 50] ÷ [Denominator of 170] = 30%

Practice X then decides as a QI activity to undertake a quality improvement activity to increase the number of completed 715 Health Assessments. The measurement of change will be the increase in recording by 20%. This could be a measure after 3 months as this is a measurement of data management and system change.

**Measurement for Aboriginal Health**

Aboriginal Health Measure	
NUMERATOR	The number of identified Aboriginal patients with a 715 Health Assessment recorded.
DENOMINATOR	The number of identified Aboriginal patients.
Aboriginal Health Measure	
NUMERATOR	
DENOMINATOR	
Aboriginal Health Measure	
NUMERATOR	
DENOMINATOR	
Aboriginal Health Measure	
NUMERATOR	
DENOMINATOR	

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- Your guide to Medicare for Indigenous Health Services <http://www.medicareaustralia.gov.au/indigenoushealthservicesguide.pdf>
- National Guide to a preventative health assessment for Aboriginal and Torres Strait Islander people <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/national-guide>
- MBS Flow Chart for Chronic Disease – Aboriginal and Torres Strait Islander <https://ahcsa.org.au/app/uploads/mp/files/resources/files/ahcsa-mbschart-new-final-1jul13.pdf>
- Five Steps towards excellent Aboriginal and Torres Strait Islander Healthcare <https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/ATSI/Five-steps-guide.pdf>
- Desktop Guide to Chronic Disease Management and Medicare Benefits Schedule (MBS) Item Numbers <https://www.hneccpnh.com.au/media/14146/new-desktop-guide-to-cdm-and-mbs-item-numbers-revised-february-2017.pdf>
- Pencat recipe to Identify eligible patients for an annual 715 Aboriginal and Torres Strait Islander Health Assessment. <http://help.pencs.com.au/display/CR/Identify+patients+eligible+for+an+annual+715+Aboriginal+and+Torres+Strait+Islander+Health+Assessment>
- Improving Identification rates of Aboriginal and Torres Strait Islander Consumers <https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf>
- National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018 -2013 <https://www.naccho.org.au/naccho-cqi-framework-2019/>
- Practice Incentives Program Indigenous Health Incentive Guidelines <https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program/guidelines/pip-indigenous-health-incentive>
- RACGP Family History Screening Questionnaire <https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Red%20Book/Appendix-2A.pdf>
- RACGP Cultural Awareness and Cultural Safety Training <https://www.racgp.org.au/the-racgp/faculties/aboriginal-and-torres-strait-islander-health/education/post-fellowship/cultural-awareness-and-cultural-safety-training>
- Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent [https://www.health.gov.au/internet/main/publishing.nsf/Content/61D28A6649DBD87FCA257BF0001F954E/\\$File/Indigenous%20follow%20up%20referral%20form.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/61D28A6649DBD87FCA257BF0001F954E/$File/Indigenous%20follow%20up%20referral%20form.pdf)



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