What is the Closing the Gap Program?

At Country SA PHN (CSAPHN) the Closing the Gap Program works at the local level by engaging with community, health care providers and Aboriginal organisations to ensure care is streamlined through an understanding of local health care systems and needs.

What does CSAPHN's Closing the Gap Program do?

- Provides education to general practices and the wider community relating to Aboriginal health matters.
- Provides coordinated care to Aboriginal patients, ensuring follow-up and follow through of care plans.
- Works closely with general practice staff to ensure participating practices are confident in culture awareness and sensitivity.
- Assists general practices and allied health professionals to manoeuvre through the health system and Closing the Gap.
- Works closely with local Aboriginal community members to obtain feedback and direction for better health outcomes.

Our Closing the Gap Team can:

- Assist health services to support their Aboriginal patients and meet their cultural needs
- Provide support to help Aboriginal people with a chronic disease through the Care Coordination and Supplementary Services (CCSS) Program.

Australian Government

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An Australian Government Initiative

Contact
Head Office: Country SA PHN
Beckwith Park, 30 Tanunda Road, Nuriootpa SA 5355
Ph: 08 8565 8900 Fax: 08 8311 1723
www.countrysaphn.com.au

Country SA PHN acknowledges the traditional custodians of this land on which we work and welcome all Aboriginal and Torres Strait Islander peoples to our service.

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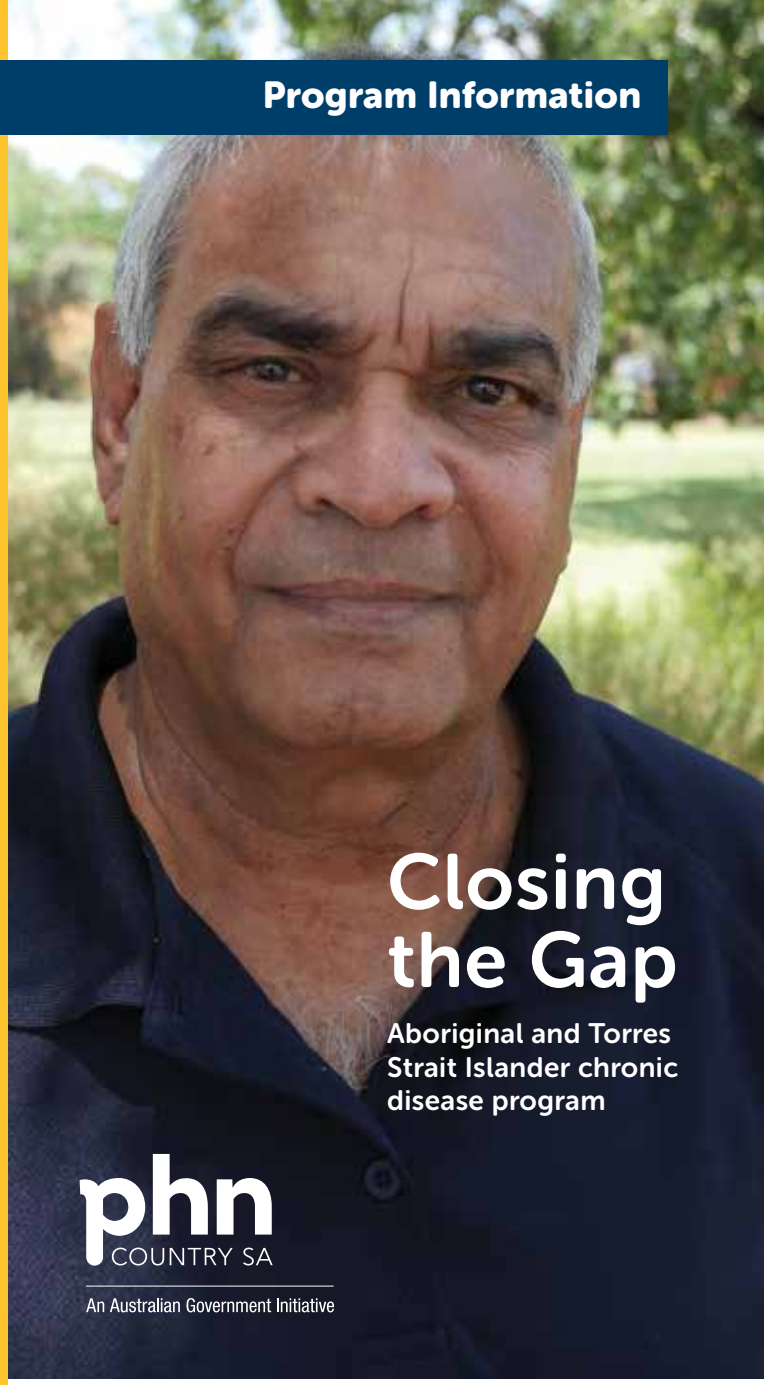
Program Information



Closing the Gap

Aboriginal and Torres Strait Islander chronic disease program

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Closing the Gap is a whole of government initiative aimed at reducing the disparity between Aboriginal and non-Aboriginal life expectancy. Closing the Gap seeks to increase the quality of life for Aboriginal people with chronic health conditions.

The Closing the Gap Project Officer

This role has a particular focus on building and strengthening partnerships and identifying and addressing barriers to Aboriginal people's access to quality health care at a local level.

The objective of this role is to increase access to mainstream primary care services for Aboriginal people and to:

- Improve the capacity of general practice to deliver culturally sensitive primary care services.
- Increase the uptake of Aboriginal specific Medicare Benefits Schedule (MBS) items, including health checks and follow-up items.
- Support mainstream primary care services to encourage Aboriginal people to self-identify.
- Work collaboratively with Aboriginal health services.

Aboriginal and Torres Strait Islander Outreach Workers

Aboriginal and Torres Strait Outreach Workers assist people to make better use of available health care services.

- They assist the Care Coordinators to support patients with their health assessments/care plans.
- Establish links with local Aboriginal communities to encourage and support the increased use of health services.
- Liaise with health providers including GPs, Aboriginal Health Workers and administrative staff to support referral pathways.
- Assist to develop and distribute information and resources to the local Aboriginal and Torres Strait Islander community about available health services.

What is the Care Coordination Supplementary Services Program (CCSS)?

The Care Coordination Supplementary Services Program (CCSS) is aimed at improving chronic disease management and follow-up for Aboriginal Australians and Torres Strait Islander people.

The objectives of this program are to:

- Contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care.
- Increase support for Aboriginal patients through their GPs and provide more proactive management with primary health service providers.
- Access urgent and essential allied health and specialist services.
- Purchase of medical aids.

Patients most likely to benefit from care coordination are those:

- At risk of avoidable hospital admissions or inappropriate emergency presentations.
- Not using community based services appropriately or at all.
- Who need help overcoming barriers to access services.
- Require more intensive care coordination than currently available.
- Who are unable to manage a mix of multidisciplinary services.

The Care Coordinator can assist patients in a number of ways:

- Provide assistance to obtain timely access to allied health, specialist services and meet the cost of some services where necessary
- Access a range of specialist, primary and allied health services required for the patient's ongoing care in line with their GP Care Plan.
- Assist the patient in understanding their chronic health condition and manage it on a daily basis.
- Connect the patient with appropriate community based services such as those providing support for daily living.
- Identify challenges that stop patients from getting care they need.
- Encourage and support patients to follow their care plan.
- Help patients get to their appointments.
- Assist people to access specialist and/or allied health services.