NUKAL MURRA

SYSTEM, PROCESS & PORTAL PROCEDURES MANUAL

May 2022

Cunnamulla
Aboriginal Corporation for Health
ICN:3193

Gidgee
Healing

CWAATSICH
Charleville and Western Areas Aboriginal and Torres Strait Islander
Community Health Limited

goondir
health services

Contents

Nukal Murra acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters, and community. We pay our respects to them, their cultures, and to Elder's past, present and future.

Background

In late 2016, Western Qld PHN commissioned Nous Group, an independent consultancy firm to review the effectiveness and efficiency of the Integrated Team Care (ITC) Program in each site across the region and identified that best practice was often delivered through and provided by Aboriginal & Islander Community Controlled Health Services. Charleville and Western Areas Aboriginal and Torres Strait Islander Corporation for Health (CWAATSICH) was identified as the preferred brokerage service to deliver the ITC program across Western Qld from 01st July 2017-30th Jun 2018.
The naming of the Nukal Murra Health Support Services combines two traditional languages from the Western Queensland catchment: Nukal meaning 'plenty or many' in the language of the lower gulf and Murra meaning 'hand or hands' in the language of Central West and Southwest.

Integrated Team Care program Brief

The Integrated Team Care (ITC) Program is to improve the way chronic diseases are managed for Aboriginal & Torres Strait Islander people in the Western Queensland region, comprising of Care Linkage and Supplementary Services program strands.
Funding components include: -
Care Linkage: Care Link staff enables clients to follow their care plan and provide support where required.
Supplementary services: are used to pay for clients to access allied health or specialist services (including medical aids), transport in the way of fuel cards & cab vouchers.

Nukal Murra Health Support Service (NMHSS) is an alliance of six bodies:

- Western Queensland Primary Health Network (WQPHN),
- Queensland Aboriginal and Islander Health Council (QAIHC),
- Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health (CWAATSICH),
- Cunnamulla Aboriginal Corporation for Health (CACH),
- Goondir Health Services (Goondir) and
- Gidgee Healing Aboriginal Medical Services (Gidgee).

Nukal Murra Health Support Service (NMHSS) is responsible for:

- Delivering Integrated Team Care (ITC) services throughout Western Queensland
- Overseeing the Nukal Murra Health Support Service
- Contributing to greater clinical and cultural leadership by the Western Queensland Aboriginal Community Controlled Health Organisation (ACCHO) sector to enable greater quality and capability in services for Aboriginal and Torres Strait Islander people of the catchment.
- Maximising the pool of funds available to support Supplementary services for Aboriginal and Torres Strait Islander people with complex chronic conditions.

Project Information - Integrated Team Care

NMHSS is overseeing a process of transitioning the delivery of ITC in Western Queensland towards community control under an alliance structure. The new alliance structure will deliver ITC Supplementary Services through a brokerage model. The model works as follows:

- WQPHN provides a pool of funding into a brokerage fund, to be managed by the Care Access Manager.

- For each year, the pool of Supplementary Services funding is allocated through ACCHOs operating in each region.

- When a GP makes a referral for a patient to receive supplementary services, the Care Access Manager determines whether the patient is eligible for Supplementary Services funding under the Integrated Team Care Guidelines.

- If a patient is deemed eligible by the Care Access Manager, a local Care Link Worker employed by an ACCHO coordinates the Supplementary Service and makes the upfront payment.

- At the end of each month, ACCHs invoice the Care Access Manager for approved Supplementary Service purchases and are reimbursed out of the brokerage fund.

Responsibilities

- The ACCHO is responsible for providing ITC support services to GPs (mainstream and AMS) in the Western Queensland Region.

- The ACCHO is responsible for receiving client referrals, brokering the services required to address the client referral and communicating the outcome back to the referring doctor.

(Please note: GP will represent General Practitioner in an ACCHO, Private Practice; an Aboriginal Medical Centre; a Hospital and Health Service Practice (Claiming under 19.2B and the Royal Flying Doctor Services across the WQPHN Region)

Integrated Team Care Program Implementation Guidelines - 2018-19 to 2020

https://www.natsiha.org/site/user-assets/docs/ITC%20Program%20Implementation%20Guidelines%20-%202018-

NUKAL MURRA

SYSTEM AND PROCESSES

Service Map Area
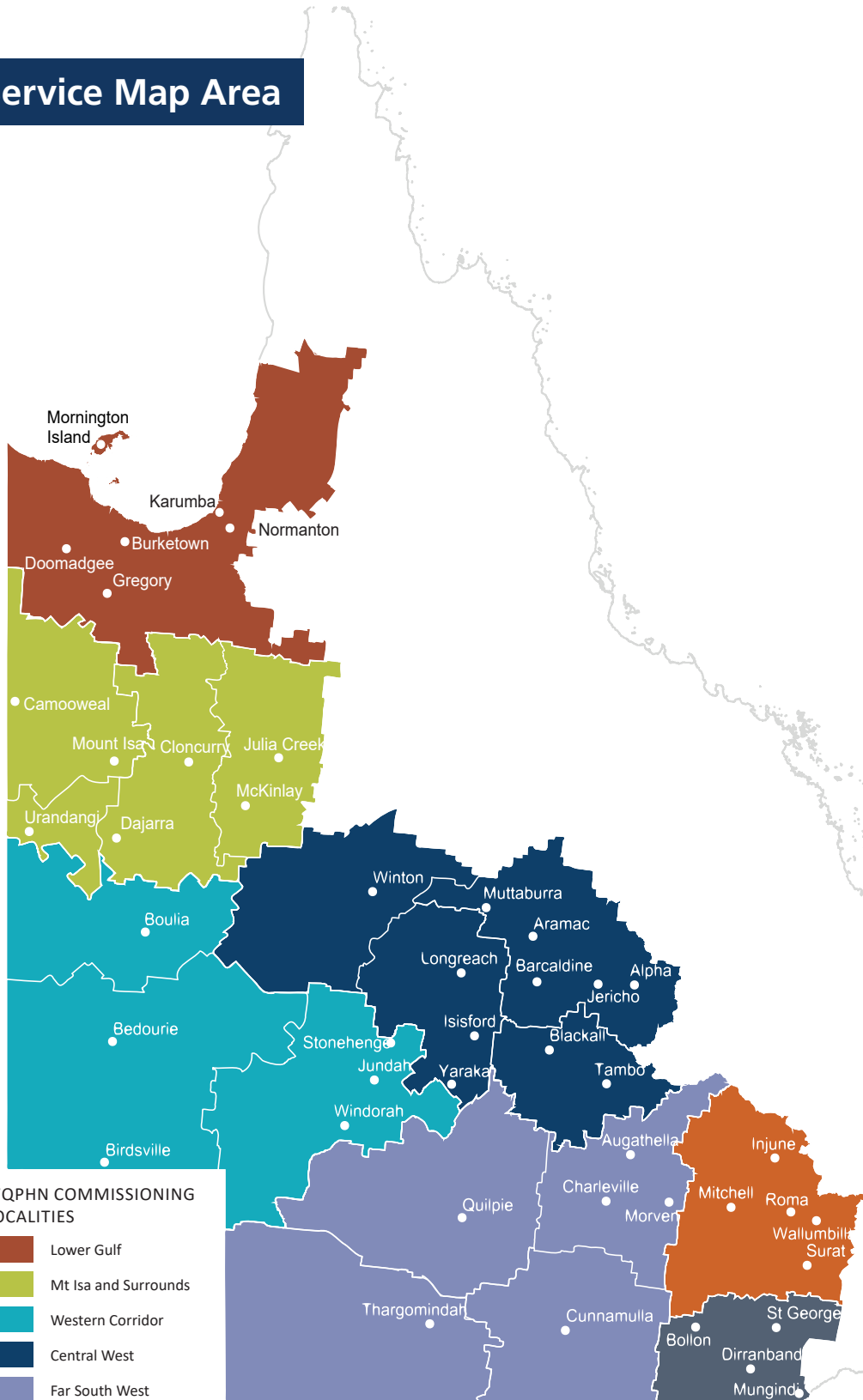
WQPHN COMMISSIONING LOCALITIES

- Lower Gulf
- Mt Isa and Surrounds
- Western Corridor
- Central West
- Far South West
- Maranoa
- Balonne

CACH
Thargomindah
Eulo
Cunnamulla

Gidgee Healing
Mount Isa
Cloncurry
Urandangi
Camooweal
Mornington Island
Normanton
Dajarra
Doomadgee

Goondir
St George
Dirranbandi
Bollon
Mungindi
Thallon

CWAATSICH
Charleville
Quilpie
Roma
Surat
Mitchell
Wallumbilla

Central West
Longreach
Barcaldine
Blackall
Tambo
Jericho
Alpha
Aramac
Muttaburra
Ilfracombe
Winton

Western Corridor
Windorah
Birdsville
Boulia
Bedourie
Jundah

Nukal Murra Alliance Structure and Executive Committee

Nukal Murra Alliance Structure

Gidgee · CACH · CWAATSICH · Goondir · WQPHN

NUKAL MURRA ALLIANCE
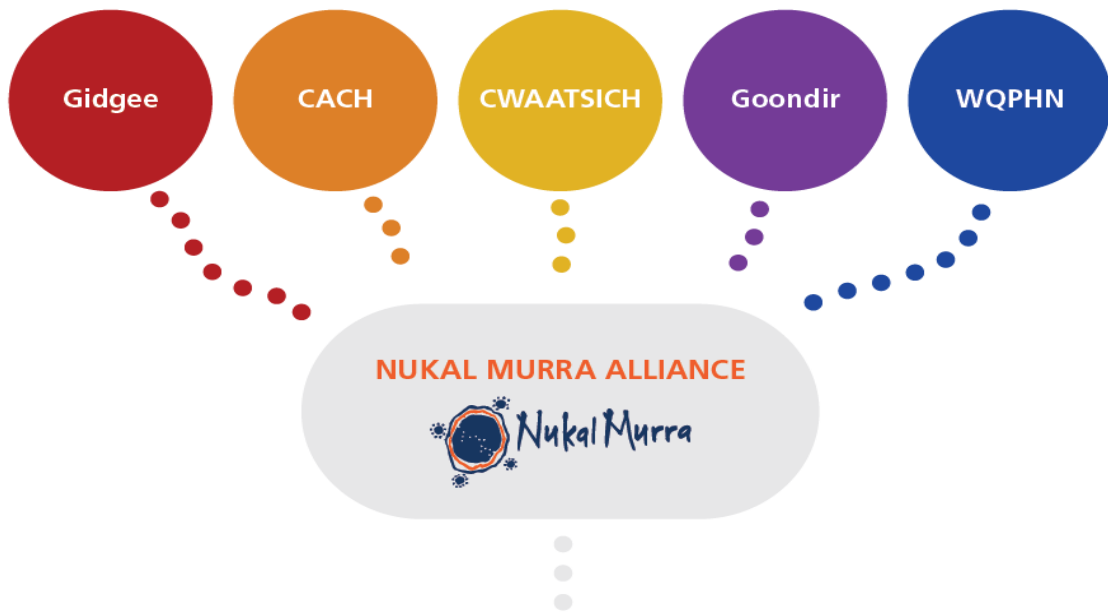
NUKAL MURRA EXECUTIVE COMMITTEE

Nukal Murra Alliance Initiatives

SEWB Management Team	ITC Management Team	Other Management Teams
SEWB	ITC	Other
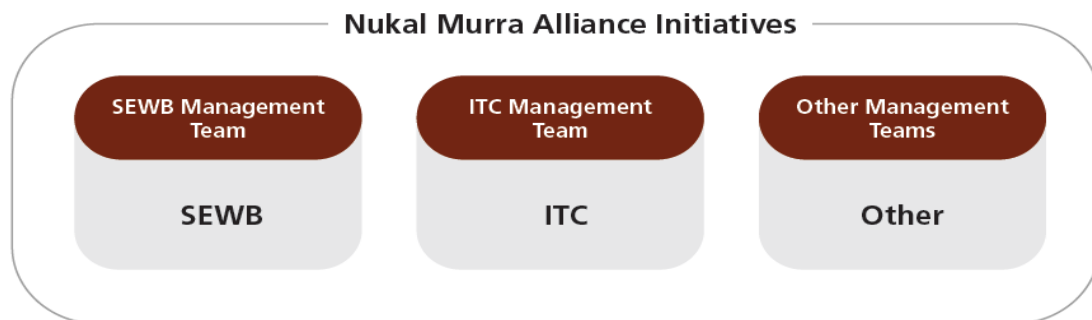
Brokerage Approach

Figure 1 – The Health Support Service Structure

Brokerage fund

WQPHN
Commissioning funding

Supp. Services $$

ITC coordination $$

CWAATSICH   Goondir   Gidgee   CACH

Care Access Manager

Care Link Workers
Receive referrals and approvals
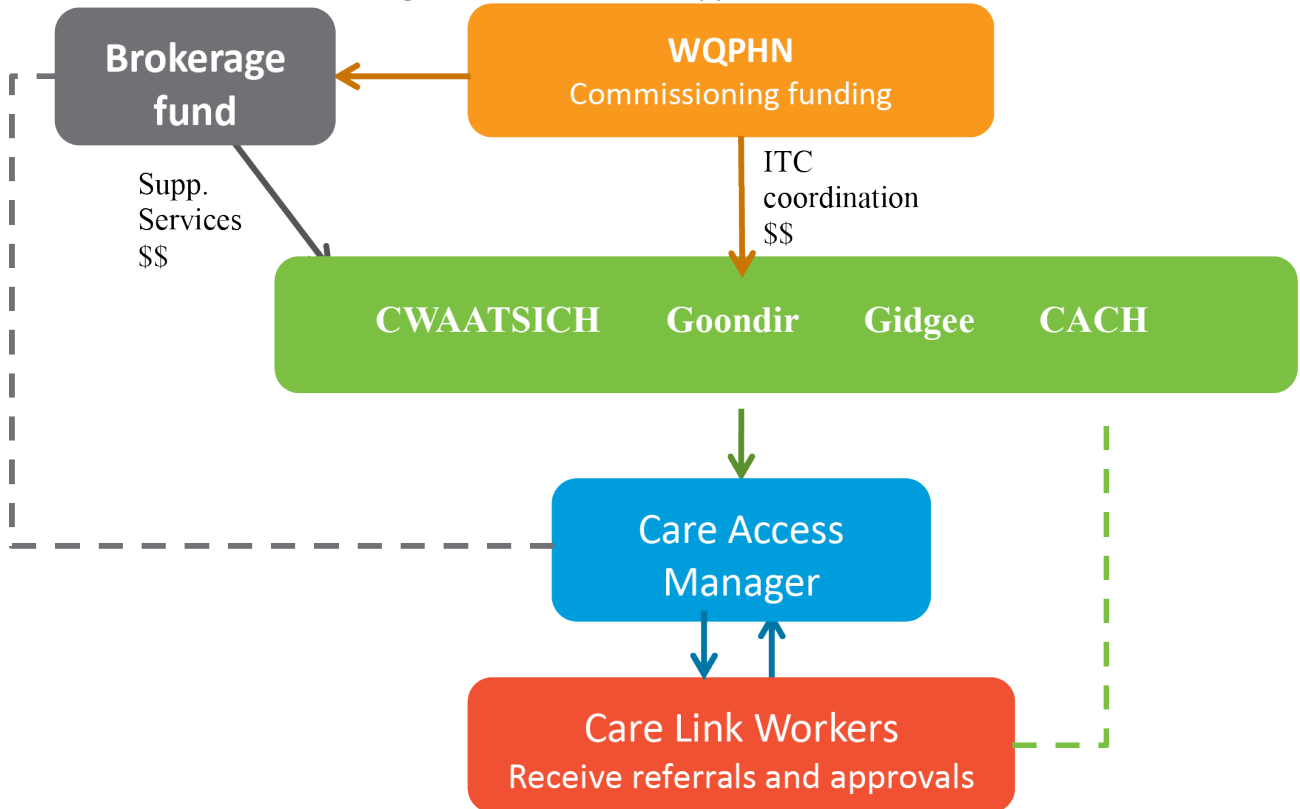
Health Support Service Brochure

How is the program accessed?

Step ONE
GP completes ATSI health check (715).

Step TWO
GP completes GP management plan (721).

Step THREE
GP assesses the patient's needs for extra services and refers an eligible patient to Nukal Murra to arrange/purchase extra services.

Step FOUR
Nukal Murra review the referral. If accepted, a Local **Care Link Worker** is assigned to follow-up with the patient and referring doctor.

WQPHN and Alliance for Nukal Murra acknowledge Marrabinya Indigenous Health Support Service for use of their material and overall support.

Cycle of care

GP Review
During the year patients see their GP to review their GPMP, review medication, review care plan, talk about test results, arrange to see medical specialists.

START: Cycle of care starts with twelve monthly CTG sign up. This includes an ATSI Health Check and follow-up by a health worker and access to cheaper medicines.

In the cycle of care Nukal Murra fits here

Follow-up care
Health workers visit or contact regularly to arrange follow-up care. During the 12 month cycle, patients usually need to visit specialists and/or have more tests done.

Patients with a chronic disease, access extra care and education to stay well. Extra care is mapped out in a 12 month care plan known as a GPMP

Medication
GPMP includes medication review and management. This includes a Home Medication Review (HMR) and may include a Webster Pack.

Phone: 1800 653 339
Fax: 07 4409 4510
Email: cam@nukalmurra.com

Nukal Murra is supported by funding from the Australian Government under the PHN Program.

phn WESTERN QUEENSLAND
An Australian Government Initiative

Version Sept 2023

Nukal Murra
HEALTH SUPPORT SERVICES

ABORIGINAL AND TORRES STRAIT ISLANDER

Providing support to General Practice to improve access to specialist services for Aboriginal patients with chronic disease.

What is Nukal Murra?

Nukal Murra is funded under the Commonwealth's Integrated Team Care (ITC) program by Western Queensland Primary Health Network (WQPHN). The ITC program aims to improve outcomes for Aboriginal and Torres Strait Islander people through better access to multidisciplinary care and improved access to culturally appropriate services in mainstream primary care services.

Eligibility Criteria:

Aboriginal & Torres Strait Islander patients who:
- Live in the Western Queensland PHN region
- Have a diagnosed chronic disease.
  Nukal Murra focuses on the key lifestyle diseases causing excess mortality & morbidity

- Cardiovascular disease
- Diabetes
- Chronic respiratory disease
- Chronic kidney disease
- Cancer
- Mental Health

  Exceptional circumstances will be considered on a case by case basis.
Patients are referred by their usual treating doctor and need to have a current GP Management Plan (GPMP).

Brokerage Services include:

- Gap fees associated with health appointments e.g., allied health, specialist appointments
- Travel (e.g., taxi vouchers) and accommodation to attend health appointments
- Assisted breathing equipment – Asthma Spacers, Nebulisers, CPAP & CPAP Accessories,
- Blood Sugar/Glucose Monitoring Equipment
- Medical footwear prescribed and fitted by a Podiatrist
- Mobility aids
- Spectacles

Nukal Murra will provide these services, if documented as a need in patients' GPMP and where they are not available under other programs.

Referring doctors need to be aware:

- Nukal Murra focuses on organising scheduled planned care in advance
- We require a minimum of 48 hours notice to review, assess, respond to your referrals and arrange / purchase agreed services
- Nukal Murra is not set up to address crisis/acute issues
- The service is for patients, not carers
- Doctors should utilise EPC items in the first instance to refer patients for allied health services and refer to Nukal Murra after exhausting EPC appointments
- Patients referred for assistance with CPAP equipment may be assisted only after prerequisite sleep study and diagnosis are completed
- Nukal Murra should be seen as a program for last resort after all alternative programs have been exhausted.

ABORIGINAL AND TORRES STRAIT ISLANDER SUPPORT

What is Nukal Murra Health Support Service?

Nukal Murra is an Aboriginal Alliance that helps **Aboriginal & Torres Strait Islander** people who have a chronic disease (like breathing & heart problems, sugar disease, cancer etc).They work with your doctor, as part of the Care Plan, to make sure you can get the appointments and services you need – if it is not available locally in a good timeframe.

How do I get the Support?

You must visit your Doctor, who will make a Care Plan and send a request (referral) to the Nukal Murra team. They will contact you and help you organising what the doctor asks. Example:

- Health appointments – including in city areas
- Some travel - if Patient Travel from Hospital Service cannot help or taxi voucher when away from home
- Equipment eg for sugar measuring and breathing Machines
- Some Aids like walkers and shower chairs etc

Is there a Cost?

No – if your doctor sends us a request telling us what you need, and we have enough funds, we provide this at no cost to you.   (The Government through WQPHN are funding this as part of Closing the Gap)

How do I get in touch?

If you have a question you can call the Care Access Manager who will be able to answer your questions. Please call:
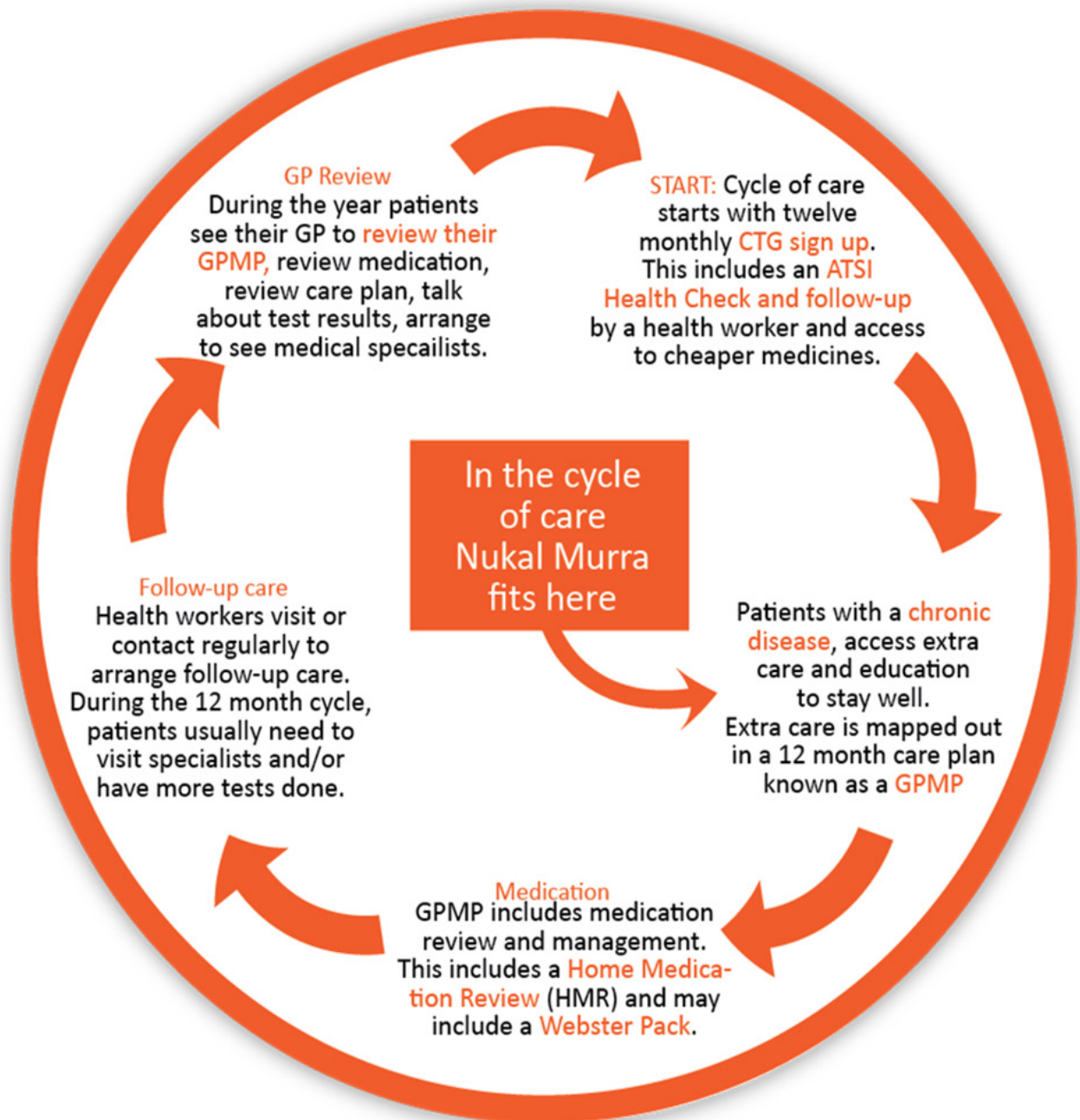
1800 653 339

Nukal Murra is supported by funding from the Australian Government under the PHN Integrated Team Care (ITC) Program.

Circle of Care

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START: Cycle of care starts with twelve monthly CTG sign up. This includes an ATSI Health Check and follow-up by a health worker and access to cheaper medicines.

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Nukal Murra

Intake flowchart 4.07.2017 V2

Nukal Murra
HEALTH SUPPORT SERVICES

1800 653 339
Intake Flowchart
for new patients

STEP 1
GP Referral

- Patient CTG Registered
- GP completed GP Management Plan (GPMP) or Team Care Arrangement (TCA)
- **Nukal Murra Health Support Service** Referral Form and Patient Consent completed and submitted to FAX 4409 4510
- GPMP or TCA MBS billing confirmation attached with Referral Form (screen snapshot

STEP 2
Receipt of Referral

- Referral received by **Care Access Manager** – patient & task will be allocated to relevant **Care Link Worker** who will action or seek further clarification from referring doctor
- **Care Link Worker** will notify GP - confirming receipt of referral and indicating they will make contact with patient and follow-up as requested by GP

STEP 3
Patient Engagement

- **Care Link Worker** will contact the patient and arrange services requested by GP
- **Care Link Worker** will send a letter/email to referring GP confirming services have been arranged
- **Care Link Worker** will complete satisfaction survey with patient (by phone or in person)

Referral Form

Nukal Murra Health Support Services
Support Services Referral Form

FAX: (07) 4409 4510
Phone: 1800 653 339

To be eligible for the service, Aboriginal and Torres Strait Islander patients must be enrolled for chronic disease management in a general practice or an Aboriginal Community Controlled Health Organisation (ACCHO).
A new referral is required for each new service requested. However, patients are only required to consent once.

PRACTICE DETAILS

Practice/ACCHO Name:	
Practice/ACCHO Address:	
Doctor's Email:	
Phone Number:	
Fax Number:	
Referring GP:	

PATIENT DETAILS

Name:		
Gender:	Male ❑ Female ❑ Intersex/Other ❑ Not stated ❑	
Residential Address:		
Postal Address:		
Date of Birth:	/ /	**Medicare Number #:** / *Exp:*
Phone Numbers:	*Home:*	*Mobile:*
Next of Kin or Support Person	*(Name & phone):*	
Health Care Card:	❑ YES ❑ NO	**Pension Card:** ❑ YES ❑ NO
DVA:	❑ YES ❑ NO	**Private Health Insurance:** ❑ YES ❑ NO
Smoking Status:	❑ YES ❑ NO	**Willing to engage in Telehealth?** ❑ YES ❑ NO

PROGRAM ELIGIBILITY

Does the patient identify as Aboriginal and/or Torres Strait Islander? ❑ Aboriginal ❑ Torres Strait Islander ❑ Aboriginal and Torres Strait Islander	**Patient must be Aboriginal and/or Torres Strait Islander to be eligible**
Does the patient have a current GPMP and/or TCA (<12months old) ❑ YES ❑ NO	**Patient must have a GPMP and/or TCA in place to be eligible**
Please list the patient's Chronic Condition/s *(NB: Private dental services are not covered)* ❑ CANCER ❑ CARDIOVASCULAR DISEASE ❑ CHRONIC KIDNEY DISEASE ❑ CHRONIC MENTAL HEALTH ❑ CHRONIC RESPIRATORY DISEASE ❑ DIABETES ❑ Other Chronic Disease (List) …………………………………………………	**Patient must have a chronic condition to be eligible**

***Please detail all Support Services required, including Specialist Appointments, over Page ***

Billing Date: …………………….   GP Signature: ………………………………………………………………………………………
To be eligible for this Service the patient must have a current GP Management Plan and/or Team Care arrangement. Please confirm – attach billing confirmation (e.g., screen shot) (MBS 721 or MBS 723).

1

SUPPORT SERVICES REQUIRED AS PER CARE PLAN		
	Select	COMMENTS
Assisted breathing equipment	❏	
Blood sugar/monitoring equipment	❏	
Dose administration aids	❏	
Medical footwear (prescribed and fitted by a podiatrist)	❏	
Mobility aids or shower chairs	❏	
Spectacles (if not eligible for MASS - SSS)	❏	
Other:	❏	
	❏	
	❏	
	❏	
	❏	

If travel is required, has PTSS been organised? *If so, please attach details to this referral.*
❏ YES   ❏ NO
Please note: Transport assistance will be determined by available funding

Does the patient require consultation fees to be covered by this fund? *If so, please include details in each appointment box below. Leave blank if not applicable.*
❏ YES   ❏ NO

Appointment 1 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	❏ YES ❏ NO
Date/Time:	
Level of urgency:	❏ Urgent ❏ High ❏ Moderate ❏ Low

Appointment 2 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	❏ YES ❏ NO
Date/Time:	
Level of urgency:	❏ Urgent ❏ High ❏ Moderate ❏ Low

Appointment 3 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	❏ YES ❏ NO
Date/Time:	
Level of urgency:	❏ Urgent ❏ High ❏ Moderate ❏ Low

Appointment 4 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?	❏ YES ❏ NO
Date/Time:	
Level of urgency:	❏ Urgent ❏ High ❏ Moderate ❏ Low

2

Reasons these Support Services are required	
To address risk factors, such as a waiting period for a service longer than is clinically appropriate	❑
To reduce the likelihood of a hospital admission	❑
To reduce the patient's length of stay in hospital	❑
As services/equipment is not available through other funding sources	❑
To ensure access to a clinical service that would not be accessible because of the cost of a local transport service	❑

PATIENT CONSENT

My GP/Nurse/Health Worker has told me about Nukal Murra Health Support Services and I want to participate.
I understand what I have been told and any questions I have had have been answered.
I understand that services (Service providers including my GPs and/or Aboriginal Medical Service staff, Specialists, Hospitals, Allied Health Workers) might have to share my information for care planning and to assess my eligibility for chronic care services. I know that wherever possible you will ask for my verbal consent to share information with other services before doing so.
I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to my Care Link worker. The withdrawal will be valid as soon as the Worker gets my note, but will not apply to information that has been shared since my initial consent.
I agree that some information about me (but not my name) will be kept and used so that you can improve the way care is provided to Aboriginal and Torres Strait Islander People.

Patient name and signature:	Name: Signature: --- Date: ___/___/_____

AUTHORISATION

I have discussed the proposed referral to Nukal Murra Health Support Services with the patient and am satisfied that the patient understands and is able to provide informed consent to this.

Consent explained and referral authorised by:	Name: Signature: --- Provider Number: _____ Date: ___/___/_____

DISCLAIMER: Approval of the Support Services requested will be on a priority basis and contingent on staff capacity and available funding.

Please FAX the signed Referral to: (07) 4409 4510

3

NUKAL MURRA

Data Entry Administration Officer

Purpose of the Position

The purpose of Data Entry Administration Officer position is to work within the Nukal Murra Health Support Service- Integrated Team Care (ITC) Program. The Data Entry Administration Officer is responsible for transferring data from paper formats into computer files or database systems, typing in data directly from clints, creating data spreadsheets, and ensuring the data is entered accurately, efficiently and in a timely manner. The Data Entry Administration Officer works independently and cooperatively in a dynamic team.

Care Link Coordinator

Purpose of the Position

The purpose of Care Link Coordinator position is the first point of contact for Aboriginal and Torres Strait Islander chronic disease clients. It is also responsible for quality administrative and office support services to enable the provision of high-level clinical care. Including the processing of appointments and administration of client's data is to work within the Nukal Murra Health Support Service- Integrated Team Care (ITC) Program. The Care Link Coordinator works independently and cooperatively in a dynamic team.

Care Access Manager

Purpose of the Position

The purpose of Care Access Manager position is to ensuring that referrals for Supplementary Services meet ITC guidelines, approving service expenditure prior to purchase, monitoring the finances of the brokerage fund and providing regular reports to NMHSS Alliance, promoting the ITC to all GPs and allied stakeholders across the Western Queensland region, providing support and guidance on best practice models for Chronic Disease Management, implement strategies to improve processes and provide training to Care Link Coordinators through quality assurance activities including introducing patient reported outcome measures (PROMS), mentoring and case reviews (patient journeys)

Other Services Access Links

- Medical Aids Subsidy Scheme Guidelines (MASS)- https://www.health.qld.gov.au/mass

- Patient Travel Subsidy Scheme Guidelines (PTSS)- https://www.health.qld.gov.au/__data/assets/pdf_file/0033/848706/qh-hsdgdl-050-2.pdf

- Heart of Australia (HOA)- https://www.heartofaustralia.com/

- ResMed- https://shop.resmed.com.au/?utm_term=resmed&utm_campaign=Search+-+AU+-+Brand&utm_source=bing&utm_medium=ppc&hsa_acc=2827588382&hsa_cam=6519796942&hsa_grp=1360096522300811&hsa_ad=&hsa_src=o&hsa_tgt=kwd-85006386655800:loc-4050&hsa_kw=resmed&hsa_mt=e&hsa_net=adwords&hsa_ver=3&msclkid=6295a933962215bdfb2fc990afac0b25

- CPAP Direct Sleep Apnea Specialists- https://cpap.com.au/

- My Aged Care Guidelines - https://www.health.gov.au/contacts/my-aged-care

- CheckUp Australia Guidelines- https://www.checkup.org.au/

- The National Disability Insurance Scheme Guidelines (NDIS)- https://www.ndis.gov.au/about-us/operational-guidelines

- National Diabetes Services Scheme Guidelines (NDSS)- https://www.health.gov.au/initiatives-and-programs/national-diabetes-services-scheme-ndss

- Roma Community and Allied Health Service- https://www.healthdirect.gov.au/australian-health-services/20074742/roma-community-and-allied-health-service/services/roma-4455-arthur

- Roma Hospital - South West Hospital and Health Service (Visiting Specialists)- https://www.health.qld.gov.au/services/southwest

- 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

- Roma Pathology Services- https://www.healthdirect.gov.au/australian-health-services/results/roma-4455/tihcs-aht-12171/pathology?pageIndex=1&tab=SITE_VISIT

- Roma Radiology Services- https://www.healthdirect.gov.au/australian-health-services/results/roma-4455/tihcs-aht-12483/radiology?undefined&pageIndex=1&tab=SITE_VISIT

- Vital Health- https://vitalhealthqld.com.au/ https://vitalhealthqld.com.au/services/

- Indigenous Respiratory Outreach Care (IROC)- https://metronorth.health.qld.gov.au/tpch/healthcare-services/indigenous-respiratory-outreach-care-iroc

- Indigenous Cardiac Outreach Program (ICOP)- https://metronorth.health.qld.gov.au/tpch/healthcare-services/cardiology/indigenous-cardiac-outreach-program-icop

Nukal Murra Health Support Service Contact Directory

Service Providers.xlsx