Grand Pacific Health

GP FACT SHEET

Integrated Team Care: Care Coordination for Aboriginal and Torres Strait Islander Patients with Chronic Disease

Aboriginal and Torres Strait Islander patients living with chronic disease in your practice can receive help to manage their medical care through the **Integrated Team Care Program.**

Managing chronic disease can be difficult. Coordinating appointments, taking medication and understanding chronic disease is overwhelming for many patients. The ITC program supports the patient with a care coordinator in their local region who works with them, their family and carers, their GP and other health clinicians to coordinate their health care.

The care coordinator also works with the patient to improve their health literacy, negotiate fees for specialist and allied health appointments where affordability prevents access to the service and advocate for improved self-management and engagement with the health system.

What do Care Coordinators do?

- Coordinate health services outlined in a GP Management or Team Care Arrangement.
- Work with patients to improve their health literacy.
- Support and encourage the patient and their family to develop self-management skills for their chronic condition.
- Support the patients engagement with the health system.
- Assist the patient to participate in regular reviews from their primary care providers.
- Support the patient’s adherence to treatment (e.g. medication compliance).
- Organise patient transport for appointments (see supplementary services below).
- Link the patient and family with appropriate community-based services providing support for daily living.
- Negotiate specialist and allied health fees where affordability prevents access to service (see supplementary services below).

Who is eligible?

This program is open to people who identify as Aboriginal and/ or Torres Strait Islander and:

- Live in the Illawarra, Shoalhaven, Eurobodalla, Bega Valley, Cooma, Goulburn, Queanbeyan, Yass or Canberra regions.
- Have one or more chronic diseases that has been present or will be present for 6 months or more. This may include one or more of the following; diabetes (including eye conditions associated with diabetes), cancer, chronic respiratory disease, chronic cardiovascular disease, chronic renal disease or mental health conditions.
- Have had an Aboriginal and Torres Strait Islander (MBS 715) Health Assessment completed within the last 9 months.
- Have a current GPMP and/or TCA.
- Are at risk of hospital admission due to their ill health.
- Have trouble accessing and using the right services for their care.
- Have trouble managing multiple health services and appointments.

What can the ITC program fund?

The ITC program has a small amount of funding to assist where cost prevents patients accessing medical specialists, allied health services or necessary medical equipment. Funds may be used to:

- Assist with transport costs to appointments (where there is no local transport available or the cost is prohibitive for the patient).
- Cover allied health provider fees (where MBS rebates are not available).
- Cover the difference between MBS rebates and private specialist or allied health provider fees.
- Cover an ‘urgent appointment retainer’ for providers.
- Purchase specific medical aids – please contact the care coordinator for further information.

ITC funds CAN be used to purchase services that:

- address waiting periods longer than is clinically appropriate.
- reduce the likelihood of a hospital admission.
- assist in reducing patients’ length of stay in a hospital.
- are not available through other funding sources.

ITC funds CANNOT be used to purchase services:

- to cover all follow-up care required by patients.
- when other publicly funded services are available in a clinically acceptable timeframe.

How are ITC funds accessed?

ITC funds are accessed by:

- Referral of an eligible patient by their GP to the ITC program.
- GPH will assess the referral using a triage framework for care coordination and fund allocation.

ITC funds are very limited and are allocated based on the patient’s disease complexity and those with the most urgent need.

How to refer a patient to the ITC program

Complete the GPH ITC referral form:

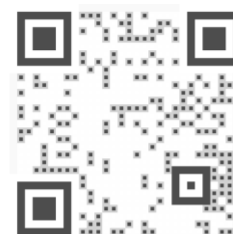
1. via Best Practice or Medical Director templates
   then send via Argus or Healthlink **OR**
2. Download and complete from our website
   (https://www.gph.org.au/our-health-services/chronic-disease-management/)
   Then send by fax or secure message using the contacts below.

Note: You must include the patient’s current 715 Aboriginal and Torres Strait Islander Health Assessment and GPMP and/ or TCA with the referral form.

For new referrals to the program please use the following contact information:

Phone: 1800 879 096 or 02 4448 2200
Argus: Argus.gphsouthern@gph.org.au
Healthlink: gphs8uth

Fax: 02 4448 2289



SCAN HERE TO ACCESS FORMS

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