GPH Integrated Team Care Consumer Pathway

GP Identifies Patient who is Suitable for ITC Program

Eligibility

- Identify as Aboriginal and/or Torres Strait Islander
- Patient lives in South Eastern NSW or ACT
- Has a diagnosed chronic disease lasting or likely to last more than 6 months
- Has GP Management Plan and/ or Team Care Arrangement
- Patient consents to be enrolled.

GP Refers Patient to GPH ITC Program

- By calling 1800 879 096 or 02 444 82200
- GP completes referral form and sends to intake coordinator along with copy of GPMP/ TCA, current 715 Aboriginal and Torres Strait Islander Health check
- Referral faxed (02 4448 2289) or online referral form (Best Practice integrated and securely sent using Healthlink or Argus)
- Where eligible patients contact GPH directly they will be supported to contact their GP to seek referral to the program.

ITC Intake Coordinator Registers Referral and Allocates for Care Coordination

- Reviews referral form and eligibility, contacts the client, introduces the ITC program, explains the process and confirms patient consent to participate
- Registers the client in the clinical information system software
- Allocates client to Care Coordinator based on their geographical location.

Allocated Care Coordinator Completes Assessment and Implements Care Plan

- Facilitates completion of the ‘Informed Consent Form’
- Identifies client’s health priorities, goals and aspirations
- Negotiates suitable service modality (e.g. video consults, telephone support,
- face to face)
- Assesses disease complexity using a chronic condition risk calculator
- Updates care plan focused on self-management, informed by risk assessment and consumer consultation.