Grand Pacific Health

GP FACTSHEET

Integrated Team Care:
Care Coordination and Supplementary Services
For Your Aboriginal Patients

Aboriginal patients with chronic disease in your practice can receive help to manage their medical care through the **Integrated Team Care Program** (**Coordinated Care and Supplementary Services).**

Managing chronic disease can be difficult – arranging and getting to appointments, taking medication and better understanding the disease is often overwhelming for the patient.

The ITC (CCSS) program provides the patient with a dedicated care coordinator to work closely with them, their GP, the practice nurse, allied health practitioners and any other community health services they do and can access.

The care coordinator can also negotiate fees and charges for specialist and allied health appointments where affordability prevents access to the service.

What can care coordinators do?

- ✓ arrange the health services identified in a GP Management or Team Care Plan
- ✓ organize patient transport for appointments (see supplementary services below)
- ✓ assist the patient to participate in regular reviews from their primary care providers
- ✓ support the patient's adherence to treatment regimes (e.g. medication compliance)
- ✓ support and encourage the patient and their family to develop self-management skills for their chronic condition
- ✓ 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 Aboriginal and Torres Strait Islander people who:

- live in the Illawarra, Shoalhaven, Eurobodalla, Bega Valley, Cooma, Goulburn, Queanbeyan, Yass or Canberra areas
- have a chronic disease, targeting:
    - diabetes (including eye conditions associated with diabetes)
    - cancer
    - chronic respiratory disease
    - chronic cardiovascular disease
    - chronic renal disease
    - mental health conditions
- includes children under the age of 15 years with early onset of any of these eligible chronic diseases
- 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 services and appointments

What is supplementary services funding?

The ITC (CCSS) program has *supplementary services* funding to assist where affordability 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 medical aids – please contact the care coordinator for further information

Supplementary services 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.

Supplementary service 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

How are supplementary services funds accessed?

Supplementary services funds are accessed by:

1. Referral of an eligible client by their GP.
2. GPH will assess the application using a comprehensive decision making framework for care coordination and fund allocation.

Supplementary Services funds are limited and priority is given to the most urgent need.

How to refer to ITC (CCSS)

1. Complete the ITC (CCSS) referral form available as a Best Practice or Medical Director template and send via Argus *(Eurobodalla, Bega Valley, Cooma, Goulburn, Queanbeyan and Yass regions only*), **OR** complete the referral form available online (www.gph.org.au) and fax to the relevant care coordinator (see below).
2. The patient's GPMP and TCA must also be attached to the referral form.

Care coordinator contacts are:

Illawarra
Phone 0408725319
Fax 02 4226 6489

Eurobodalla
Phone 02 4474 9900
Fax 02 4474 9988
Argus Argus.gphsouthern@gph.org.au

Goulburn, Yass & Queanbeyan
Phone 02 4824 4905
Fax 02 4824 4990
Argus Argus.gphsouthern@gph.org.au

Shoalhaven
Phone 02 4448 2203
Fax 02 4448 2289

Bega Valley & Cooma-Monaro
Phone 02 6492 3768
Fax 02 6494 7314
Argus Argus.gphsouthern@gph.org.au

Canberra
Phone 0436 189 481
Fax 02 4474 8587