REFERRAL PROCESS:

- ✓ Ensure your patient is eligible
- ✓ Ensure you have patient consent
- ✓ Fax referral with a GPMP and/or TCA to:

Grand Pacific Health
ACT Care Coordinator
Phone: (02) 6298 2902
Fax: (02) 6298 2982

Referral Forms:
https://www.gph.org.au/our-health-services/chronic-disease-management

Contact our ACT PHN Indigenous Health Program Officer for further information.

You can also arrange a practice visit to discuss measures to improve your clinic's capacity to provide culturally appropriate care for your Aboriginal and Torres Strait Islander patients.

Capital Health Network

PO Box 9
Deakin West ACT 2600
www.chnact.org.au
Phone: (02) 6287 8099

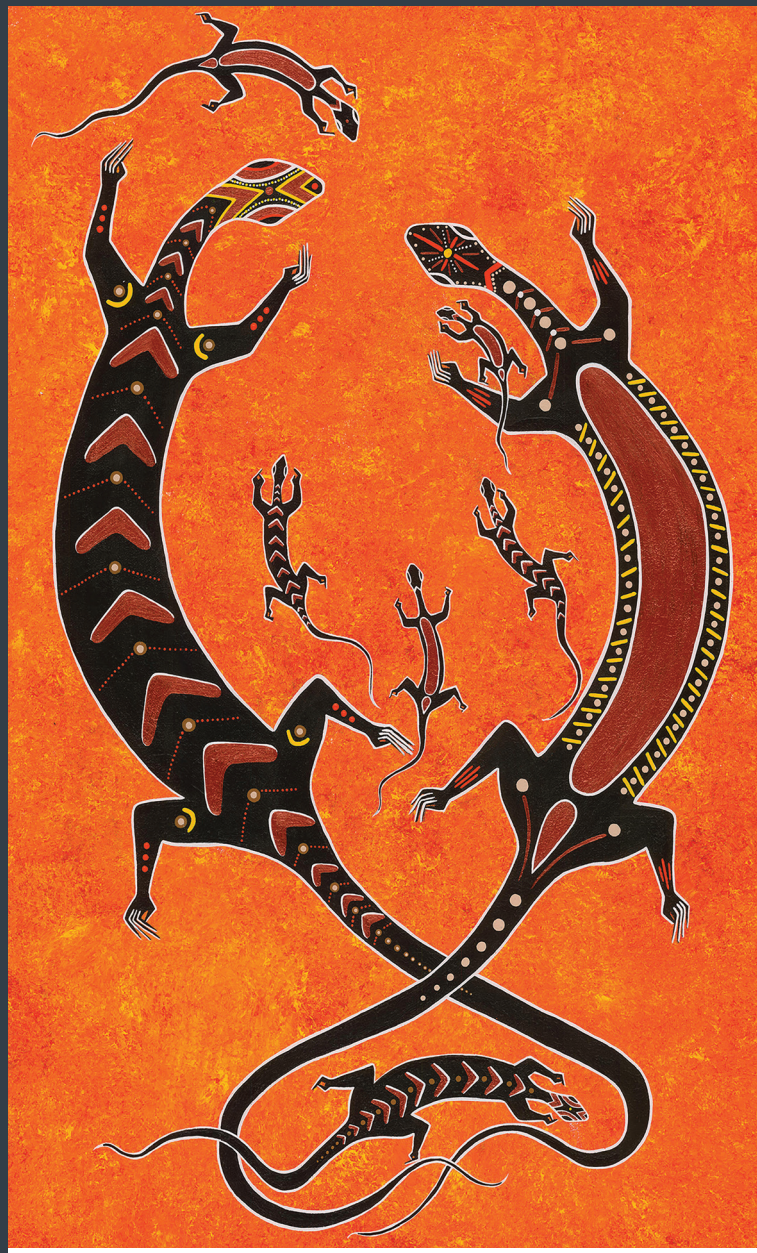
Capital Health Network acknowledges the Traditional Owners of the country on which we work and live, and recognise their continuing connection to land, waters and community. We pay our respects to them and their cultures, and to Elders both past and present.

Further information for health professionals is available on HealthPathways
actsnsw.healthpathways.org.au

Original Artwork on front cover by Joy Cross.
'Rounding the family up to go to the doctors, but the eldest son doesn't want to go'.

INTEGRATED TEAM CARE

Improving health outcomes for Aboriginal and Torres Strait Islander people



WHAT IS INTEGRATED TEAM CARE?

The Integrated Team Care (ITC) Program is one of the current activities under the Indigenous Australians' Health Programme funded by the Department of Health.

Aims:

- Contribute to improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to care coordination and multidisciplinary care, and to support self-management, and;
- Improve access to culturally appropriate mainstream primary care services for Aboriginal and Torres Strait Islander people.

WHO WILL BENEFIT FROM THE PROGRAM?

Aboriginal and Torres Strait Islander patients with complex chronic health conditions who:

- Are at risk of otherwise avoidable hospital admissions
- Have difficulty accessing and utilising appropriate services for their care
- Have difficulty managing multiple services and appointments
- Need help to overcome barriers to access health services, such as cost and transport
- Require more intensive care coordination than is able to be provided by their primary health service provider.

WHO IS ELIGIBLE TO BE REFERRED?

People who identify as being of Aboriginal and /or Torres Strait Islander origin who:

- Are of any age
- Have a chronic health condition
- Have a current GP Management Plan.

Priority is given to patients with complex chronic care needs who require multidisciplinary coordinated care.

WHO CAN REFER TO THE PROGRAM?

GPs can refer patients to the ITC Program if it is considered the patient would benefit from assistance with management of their chronic disease to improve health outcomes.

WHAT CAN ITC PROVIDE?

A Care Coordinator, who is a qualified healthcare worker, will work with patients one-on-one to assist with implementation of the patient's care plan including:

- Arranging health services identified in the GP Management Plan (GPMP) and/or Team Care arrangement (TCA)
- Arranging transport for patients to get to and from appointments
- Assistance with payment for medical specialist and allied health professional service fees
- Funding towards approved medical aids
- Support to develop self-management skills for their chronic conditions
- Assisting patients to participate in regular reviews with their GP
- Supporting patients with adherence to treatment regimens
- Linking patients with appropriate community-based services
- Supporting patients and families to adopt healthy lifestyle choices
- Working with patients to improve their engagement with the health system
- Working collaboratively with the patient's health care team.