



**GP FACT SHEET**

Have you heard?

# The ITC Program is undergoing enhancements

We're here to answer some of your questions.

It is important to know Integrated Team Care (ITC) services are not being changed – access to the delivery of these services is being enhanced. Existing ITC patients will continue to receive the same care coordination through providers Northern Queensland Primary Health Limited (NAPHL) and local Aboriginal Community Controlled Health Organisations (ACCHOs).

## What does ITC Program enhanced delivery mean?

Primary Healthcare Networks (PHNs) commission and oversee the delivery of the ITC Program within their respective regions, in accordance with the Department of Health's ITC Program Implementation Guidelines.

To facilitate further enhancements to the service delivery of the ITC Program across the Northern Queensland Primary Health Network (NQPHN) region, NQPHN appointed independent consultants KPMG to review its identified challenges and provide recommendations to optimise outcomes for future commissioning. The reviewed identified challenges included:

- » poor access to tertiary health services and transport
- » a lack of understanding by mainstream service providers about the role of the ITC Program
- » knowledge and information sharing issues
- » key service type gaps.

NQPHN has been, and will continue, working closely with health care professionals, service providers, and consumers across the NQPHN region, to improve ITC Program service delivery to the Aboriginal and Torres Strait Islander peoples and communities who have, or are at risk of, chronic health conditions within our region.

## About the ITC Program

### Who is Eligible?

Aboriginal and Torres Strait Islander people with chronic health conditions who have a current and completed General Practitioner Management Plan (GPMP) are eligible for ITC services.

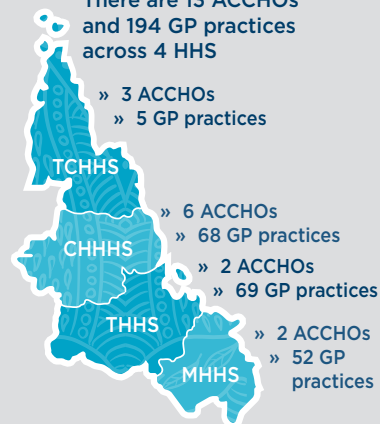
Priority should be given to patients with complex chronic health care needs who require multidisciplinary coordinated care to self-manage their condition. There are no age requirements to access the ITC Program.

When considering prioritisation for ITC support, patients most likely to benefit from the program include those who:

- » experience the greatest socio-economic disadvantage
- » have a history of failure or inability to attend medical appointments
- » are non-adherent with medication or have a GPMP
- » experience frequent admission to hospital and health services

The ITC program is moving to service delivery within ACCHO-led catchments.

There are 13 ACCHOs and 194 GP practices across 4 HHS



## ITC programs will continue.

However, names, service providers, and referral processes may change.



**New services will be introduced**, such as telephone services, at a local level for ACCHO catchment program delivery.

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- » need support to overcome barriers to access primary health care services
- » reside in NQPHN's regional and remote catchment areas.

### What does the ITC Program provide?

The ITC Program provides care coordination which assists patients with:

- » appointments where advocacy and support are required
- » follow-up appointments
- » a GPMP to access ITC Supplementary Services
- » connecting to a long-term support service (e.g. My Aged Care, NDIS, and Taxi Subsidy Scheme).

### What do ITC Supplementary Services include?

- » Access to a private specialist.
- » Transport (based on special circumstances).
- » Assisted breathing equipment.
- » Continence aids.
- » Home visits.
- » Dietary replacements and supplements (as prescribed by a dietitian).
- » Medical footwear (as prescribed and fitted by a Podiatrist).
- » Wound care.

### Who delivers the ITC Program in the NQPHN region?

#### Mainstream General Practitioner (GP)

- » Northern Australia Primary Health Limited (NAPHL)

#### Aboriginal Community Controlled Health Organisations

- » Apunipima Cape York Health Council.
- » Girudala Community Cooperative Society Ltd.
- » Gurriny Yealamucka Health Service Aboriginal Corporation.
- » Mackay Aboriginal and Torres Strait Islander Community Health Service.
- » Mookai Rosie.
- » Mulungu Aboriginal Corporation Primary Health Care Service.
- » Northern Peninsula Area Family and Community Services (NPAFaCS).
- » Townsville Aboriginal and Islanders Health Services.
- » Wuchopperen Health Service.

### Want to know more?

For more information about accessing ITC services, contact your local provider:

- » Northern Australia Primary Health Limited (NAPHL) on (07) 4421 7700
- » Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) on (07) 4054 1113
- » Northern Peninsula Area Family and Community Services (NPAFaCS) on (07) 4212 2500.

# ITC Program referral pathway

NQPHN's ITC Program has an easy referral pathway with service delivery accessible across the Cape York and Torres Strait Islands, Cairns, Townsville, and Mackay regions.

ITC Program referral forms are available through NAPHL, NPAFaCS, AMSs, and ACCHOs.

## INTAKE FLOW CHART FOR NEW PATIENTS

Step

1

### GP REFERRAL

- » Patient Closing the Gap (CTG) Registered.
- » General Practitioner (GP) completed GP Management Plan (GPMP) or Team Care Arrangement (TCA).
- » ITC Program referral form and Patient Consent completed and submitted to ITC service provider.
- » GPMP or TCA attached with referral form and sent to provider.

Step

2

### RECIPT OF REFERRAL

- » Referral received by an **Indigenous Health Project Officer (IHPO)** or **Care Coordinator**. Patient and task will be allocated to the relevant **Care Coordinator** or **Outreach Worker** who will action or seek further clarification from the referring doctor.
- » **Care Coordinator** will notify the GP, confirming receipt of the referral and indicating that they will follow-up with the patient as requested by GP.

Step

3

### PATIENT ENGAGEMENT AND SUPPORT

- » **Care Coordinator** will contact the patient and arrange services requested by GP.
- » **Care Coordinator** will send a letter/email to the referring GP confirming services have been arranged.
- » **Care Coordinator** will provide supplementary service in line with patients GP care plan.
- » **Care Coordinator** will provide continuity of care and link patient with long term support options that meet patient eligibility (e.g. NDIS, NDSS, Taxi Subsidy etc.).