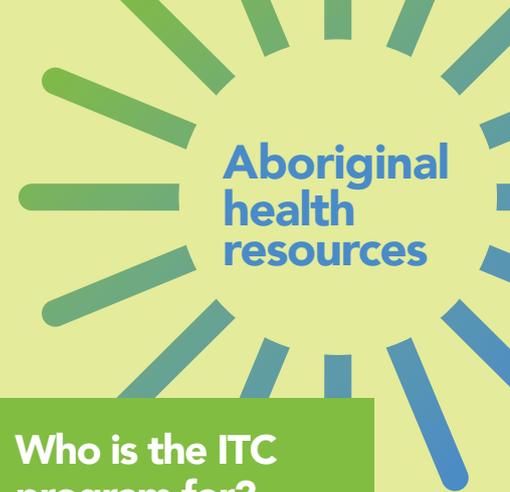


The Integrated Team Care (ITC) program for Aboriginal and Torres Strait Islander people



What is the Integrated Team Care (ITC) program?

The Integrated Team Care program aims to:

- **improve health outcomes for Aboriginal and Torres Strait Islander clients with chronic health conditions** through better access to coordinated and multidisciplinary care.
- **close the gap in life expectancy** by improving access to culturally appropriate mainstream primary care services for Aboriginal and Torres Strait Islander clients.

The program provides eligible Aboriginal and Torres Strait Islander clients with a dedicated care coordinator to work closely with them, their GP, practice nurse, allied health practitioners and specialists that they need to access as part of their ongoing care. Outreach workers are also available to assist with transport to appointments.

Primary Health Tasmania has commissioned a range of providers to deliver the ITC program throughout the state.

How do I refer to the ITC program?

Complete the ITC referral form available as a Best Practice or MedicalDirector template on the Primary Health Tasmania website. If an online form isn't accessible, use a paper form from one of the following ITC providers:

- Circular Head Aboriginal Corporation (Smithton)
- Flinders Island Aboriginal Association Inc (Flinders Island)
- Karadi Aboriginal Corporation (Goodwood/Derwent Park)
- Rural Health Tasmania — No. 34 Aboriginal Health Service (Ulverstone)
- South East Tasmanian Aboriginal Corporation (Cygnet, Kingston)
- Tasmanian Aboriginal Corporation (Hobart, Launceston, Burnie, Bridgewater, Devonport).

The online forms can be downloaded onto your software for most of the Aboriginal Community Controlled Health Organisation's ITC programs you are referring your client to.

A General Practitioner Management Plan or Team Care Arrangement must accompany the referral as an attachment.

Who is the ITC program for?

The ITC program is for clients who:

- Are Aboriginal and/or Torres Strait Islander
- have a chronic health condition as defined by Medicare
- have a completed General Practitioner Management Plan or Team Care Arrangement
- would benefit from care coordination due to:
 - difficulty self-managing a lot of appointments or specialties
 - high risk of inappropriate hospital emergency presentation
 - barriers to access services, such as financial or transportation barriers.

Please note: When referring a client to an Aboriginal Community Controlled Health Organisation (ACCHO) they may be asked:

- if they identify as Aboriginal and/or Torres Strait Islander
- to show proof of Aboriginal and/or Torres Strait Islander ancestry
- if they are known within the Aboriginal or Torres Strait Islander community in which they live or formerly lived

before they will be able to access services from the ACCHO.