INTERGRATED TEAM CARE (ITC)

This program can assist you to access Specialist services, and to provide close coordinated care in relation to your chronic disease.

Our program boundaries include assistance for Aboriginal and TSI people with a chronic disease from **Ceduna, Koonibba, Scotdesco, Yalata, Oak Valley, Smoky Bay and Wirrulla.**

The team consists of two people; **Jodie Milne-ITC Care Coordinator** and **Kristen Bobyk-ITC Outreach Worker**.

Jodie can assist you in understanding your chronic disease, how to better self manage, assist your GP in understanding your cultural needs, talk to you about your care plan and your health care needs. She can inform you of visiting specialists, book appointments with services to assist with your chronic disease, and provide access to CCSS funds

Kristen can do home visits for various support services.
Assist the practices/doctor understand your needs.
Helping your doctor or practice staff provide a culturally appropriate environment for you to attend.
Kristen can collect prescriptions and deliver information as needed and in some cases, she can transport you to your appointments if circumstances prove no other means.

ITC can provide transport and accommodation for expenses to and from specialist appointments, medical aids, and assist you with access to these services to provide education about better health and wellbeing in regards to your chronic disease.

CKAHSAC
PH: 08 86262500
FAX: 08 86262530

CKAHSAC
Integrated Team Care Program (ITC)

CEDUNA KOONIBBA ABORIGINAL HEALTH SERVICE ABORIGINAL CORPORATION

WHAT YOU NEED TO BE ELIGIBLE?

A CARE PLAN/ GP MANAGEMENT PLAN

A care plan is a written document that outlines the care needed to manage your chronic condition. It involves your GP, a clinic nurse or health worker, and yourself. Together you will decide what your health care issues and needs are, what result you would like from the plan, how you will achieve that result and what other health care services you need.

LIST OF CHRONIC DISEASES

DIABETES
HEART DISEASE
RESPIRATORY DISEASE
KIDNEY DISEASE
MENTAL HEALTH
CANCER

WE ENCOURAGE A YEARLY ABORIGINAL & TORRES STRAIT ISLANDER HEALTH CHECK.

An Aboriginal health check is an overall view of your health and wellbeing. There are different health checks for certain ages.
Having a health check helps Aboriginal and Torres Strait Islander people receive Primary Health Care that is catered too your needs.

It involves a holistic approach on your health including your physical, social and emotional wellbeing.
These checks assist in early detection, diagnosis, and early intervention for common and treatable conditions that may lead to a chronic disease and/or early death.

The earlier a condition is discovered the more likely your Health Care Providers can help you reduce those risks.

ITC ENROLMENT PROCESS

Your doctor will fill out a referral form. You will be asked to sign a consent form to confirm that you wish to enrol in the program.

To help organise your care, the Care Coordinator will need to share your information with your doctor and sometimes with other services, and may also need to send information to you. The personal information gathered, used and shared by CKAHSAC ITC Program involved in your care will be maintained in way that values your privacy and you have the right to withdraw from the program at any time

- ☐ ***I am Aboriginal and/or Torres Strait Islander.***
- ☐ ***I Have a current Chronic Disease Care Plan.***
- ☐ ***I have 1 or more of the 6 chronic conditions.***

HOW DO I REGISTER?

See your Doctor, Health worker or ITC Team at CKAHSAC for more information on registration, Or call 86262500 and ask to speak to Jodie Milne ITC Coordinator

PLEASE NOTE, IF YOU DON'T TICK ALL THESE BOXES YOU MAY NOT BE ELIGIBLE FOR THIS PROGRAM

CCSS PROGRAM

The Care Coordination Supplementary Service (CCSS) program is an Australian government initiative to assist Aboriginal and Torres Strait Islander people who have chronic disease and are enrolled in the ITC Program.
These Services align with the patients care plan.
Patients registered under the ITC Activity may be referred by their GP to services that are not accessible through the public health system in a clinically acceptable timeframe, or where transport is inaccessible or unaffordable.
When barriers such as these exist, the Care Coordinator may use the Supplementary Services Funding Pool to expedite the patients access to these services in the private sector.