

How to access the program

Nhulundu Integrated Team Care

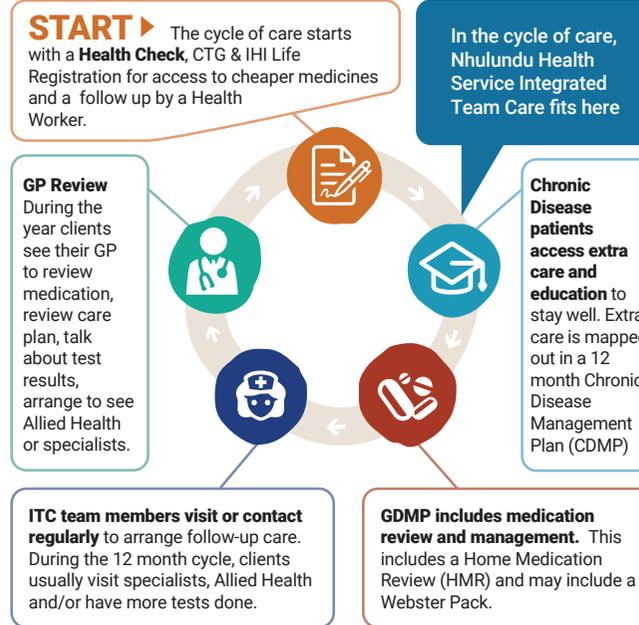
- 1 GP Completes an Aboriginal and Torres Strait Islander Health Check MBS 715
- 2 GP completes a Chronic Disease Management Plan with Nhulundu Integrated Team Care (ITC) as a provider
- 3 GP assesses the clients needs for extra services and refers eligible client to Nhulundu Integrated Team Care to arrange/purchase extra services.
- 4 Nhulundu Integrated Team Care review the referral. If accepted, one of our ITC team will follow up with the client and referring doctor.

For GP referral forms, go to **CQ Health Pathways**. Email completed form to itc@nhulundu.com.au For program enquiries contact the Integrated Team Care staff on 4979 0992



A Continuum of Care

Case management coordination and health education for eligible clients



Your feedback matters to make our services even better. For compliments, suggestions or complaints scan this QR code to complete our online form or talk to our friendly staff on 4979 0992.



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Gladstone Region Aboriginal and Islander
Community Controlled Health Service Ltd

ACN. 610 044 641



Assisting First Nations people
with Chronic Disease

Integrated Team Care



Providing assistance for Aboriginal & Torres Strait
Islander people with chronic disease to access
specialist and Allied Health services



Gladstone Region Aboriginal and Islander Community Controlled Health Service Ltd

What is Nhulundu

Integrated Team Care

Nhulundu Integrated Team Care is funded under the Commonwealth's Integrated Team Care (ITC) program by Country to Coast QLD Primary Health Network (PHN). The ITC program aims to improve outcomes for Aboriginal and Torres Strait Islander people through better access to multi-disciplinary care and improved access to culturally appropriate services in mainstream primary care services.



Eligibility Criteria

Aboriginal & Torres Strait Islander people who:

- Live in the Central Queensland PHN region
- Have a diagnosed chronic disease & chronic needs that require multidisciplinary coordinated care

Nhulundu Integrated Team Care focuses on the key lifestyle diseases causing excess mortality & morbidity

- Cardiovascular disease
- Diabetes
- Chronic respiratory disease
- Chronic kidney disease
- Mental Health
- Cancer



Additional Services

- Gap fees associated with health appointments eg. allied health and specialist appointments
- Travel and accommodation to attend health appointments above the Patient Travel Subsidy Scheme (PTSS) payments
- Webster packs for people with polypharmacy not under any other program
- Spacers, Nebulisers, CPAP & CPAP Accessories,
- Blood Sugar/Glucose Monitoring Equipment
- Medical footwear prescribed and fitted by a Podiatrist, relevant to the chronic condition
- Help to access additional Allied Health services- Physiotherapist, Exercise Physiologist, Diabetes Educator, Podiatrist etc
- Mobility aids
- Spectacles

Nhulundu Integrated Team Care will provide these services, if documented as a need in clients GDMP and where they are not available under other programs. Subject to funding availability and approval.



As a person accessing Nhulundu Integrated Team Care services you have the right to:

- Access culturally appropriate services that meet your health care needs
- Receive safe and high quality health services, provided with professional care, skill and competence
- Receive open, timely and appropriate communication about your health care in a manner you can understand
- Join in making decisions and choices about your care
- Assume that the care provided will be respectful of you and your culture, beliefs and personal needs and requirements
- Assume that your personal privacy is maintained and proper handling of your personal health and other information is assured
- Provide feedback about your care and have your concerns investigated and responded to.