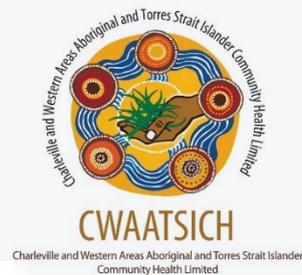
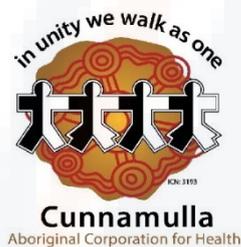




NUKAL MURRA

SYSTEM, PROCESS & PORTAL PROCEDURES MANUAL

SEPTEMBER 2025





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Nukal Murra acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters, and community. We pay our respects to them, their cultures, and to Elder’s past, present and future.



NUKAL MURRA ALLIANCE OVERVIEW

Background

In late 2016, Western Qld PHN commissioned Nous Group, an independent consultancy firm to review the effectiveness and efficiency of the Integrated Team Care (ITC) Program in each site across the region and identified that best practice was often delivered through and provided by Aboriginal & Islander Community Controlled Health Services. Charleville and Western Areas Aboriginal and Torres Strait Islander Community Controlled Health Services (CWAATSICH) was identified as the preferred brokerage service to deliver the ITC program across Western Qld from 01st July 2017-30th Jun 2018.

The naming of the Nukal Murra Health Support Services combines two traditional languages from the Western Queensland catchment: Nukal meaning 'plenty or many' in the language of the lower gulf and Murra meaning 'hand or hands' in the language of Central West and Southwest.

Integrated Team Care Program Guidelines (ITC Program Implementation Guidelines – Updated July 2024)

- The Integrated Team Care (ITC) Program is to improve the way chronic diseases are managed for Aboriginal & Torres Strait Islander people in the Western Queensland region, comprising of Care Linkage and Supplementary Services program strands. Contributing to greater clinical and cultural leadership by the Western Queensland Aboriginal Community Controlled Health Organisation (ACCHO) sector to enable greater quality and capability in services for Aboriginal and Torres Strait Islander people of the catchment.
- Maximising the pool of funds available to support Supplementary services for Aboriginal and Torres Strait Islander people with complex chronic conditions.

Integrated Team Care Program Implementation Guidelines – Updated July 2024

<https://www.health.gov.au/sites/default/files/2024-07/integrated-team-care-program-implementation-guidelines.pdf>

Funding components include:

Care Coordinators support client's compliance with their care plan needs and to provide support where required.

Supplementary services: are used to support expenses clients may incur to access allied health or specialist services (including medical aids), transport in the way of fuel cards & cab vouchers.

Please note: supplementary services will only be funded where every other source of assistance has been exhausted.

Nukal Murra Health Support Service (NMHSS) is an alliance of Six bodies:

- Western Queensland Primary Health Network (WQPHN),
- Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health (CWAATSICH),
- Cunnamulla Aboriginal Corporation for Health (CACH),
- Goondir Health Services (Goondir) and
- Gidgee Healing Aboriginal Medical Services (Gidgee)
- Ngarnal Aboriginal Community Controlled Health Service (Mornington Island)

Nukal Murra Health Support Service (NMHSS) is responsible for:

- Delivering Integrated Team Care (ITC) services throughout Western Queensland.
- When a GP makes a referral for a patient to receive supplementary services, the referral is uploaded to the Portals Central Point of intake referral.
- Referrals are then allocated to relevant Care Coordinators
- Patient is deemed eligible once all Intake Flow Chart Steps have been completed (as per the Intake Flowchart).
- All steps must be completed by the Care Coordinator and a recommendation to be forwarded to the Practice Manager / Clinic Manager for final approval.
- Once Final approval has been granted Care Coordinator employed by the respective ACCHO will coordinate the Supplementary Service and makes the upfront payment.
- The Care Coordinator responsible for receiving the client referral, must communicate the outcome back to the referring GP / client within a timely manner.
- At the end of each month, ACCHO's will be responsible for each of their respective financial accountability including approval of invoices, quotes and distribution of resources.

Responsibilities

(Please note: GP will represent General Practitioner in an ACCHO, Private Practice; an Aboriginal Medical Centre; a Hospital and Health Service Practice (Claiming under 19.2B and the Royal Flying Doctor Services across the WQPHN Region)



NUKAL MURRA

SYSTEMS AND PROCESSES

SERVICE MAP AREA

CACH

Thargomindah
Eulo
Cunnamulla

Gidgee Healing

Mount Isa
Cloncurry
Urandangi
Commonweal
Normanton
Dajarra
Doomadge

Ngarnal

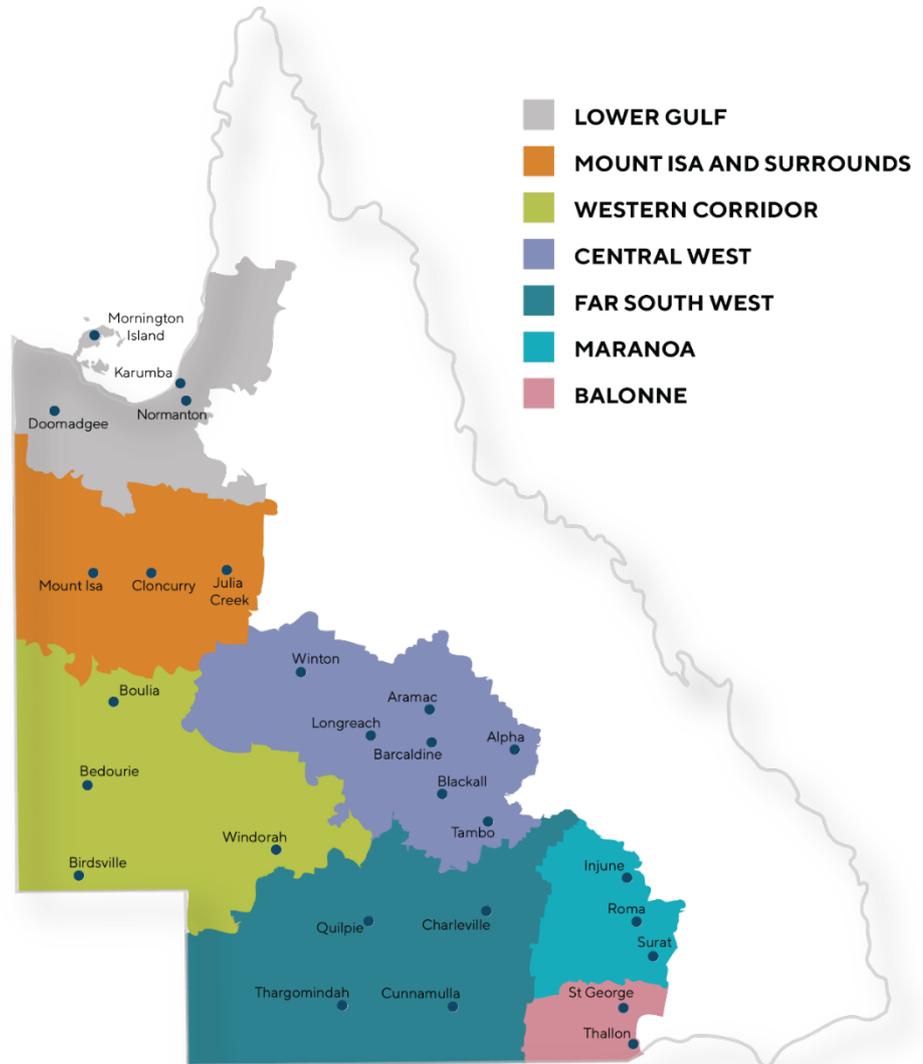
Mornington Island

Goondir

St George
Dirranbandi
Bollon
Mungindi
Thallon

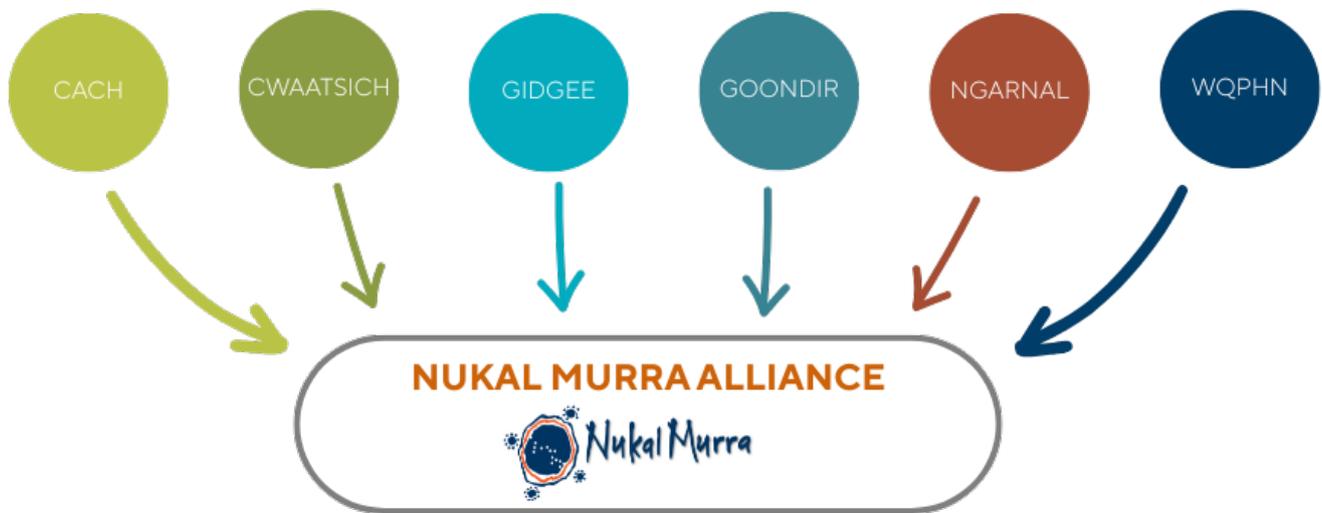
CWAATSICH

Charleville
Quilpie
Roma
Surat
Mitchell
Wallumbilla
Longreach
Barcaldine
Birdsville
Blackall-Tambo
Jericho
Aramac
Muttaborra
Ilfracombe
Winton
Boulia
Bedourie
Jundah
Isisford
Alpha
Windorah

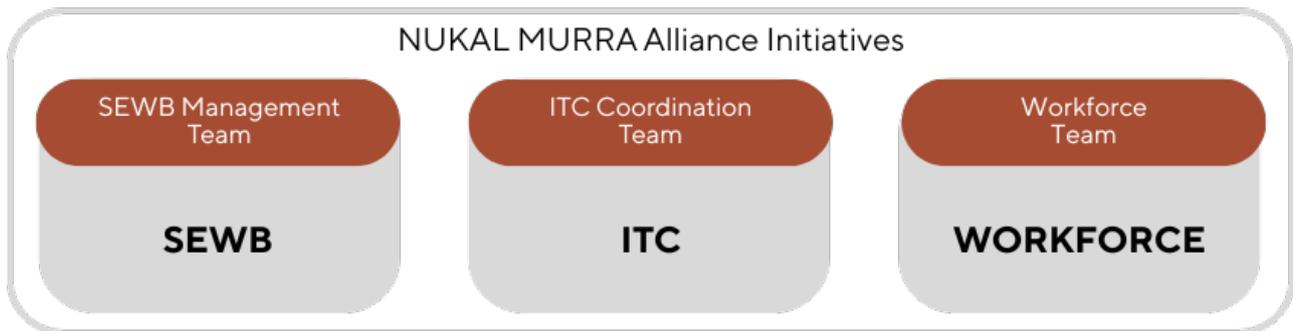


NUKAL MURRA ALLIANCE STRUCTURE AND EXECUTIVE COMMITTEE

NUKAL MURRA ALLIANCE STRUCTURE

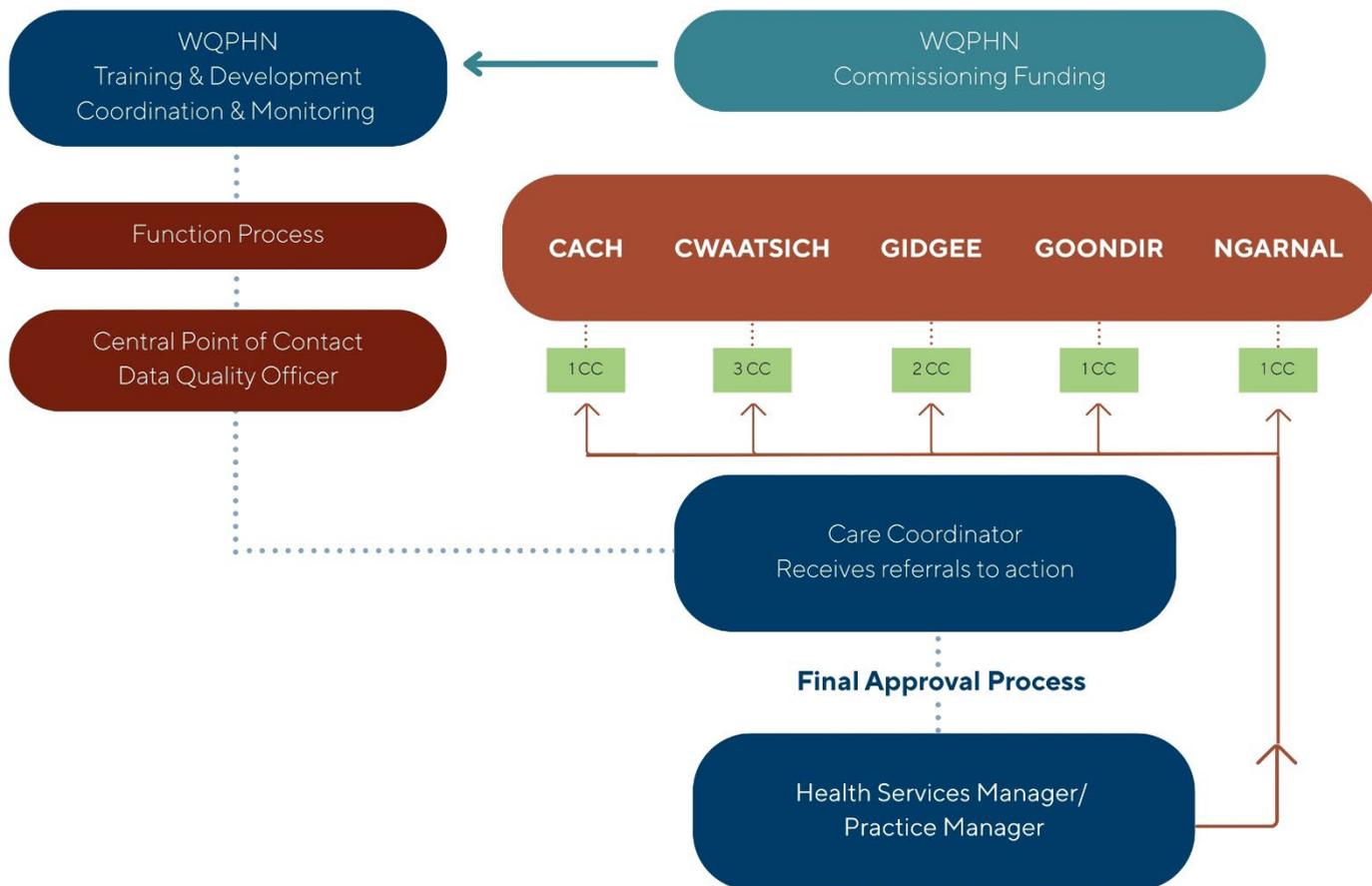


NUKAL MURRA EXECUTIVE COMMITTEE



BROKERAGE APPROACH

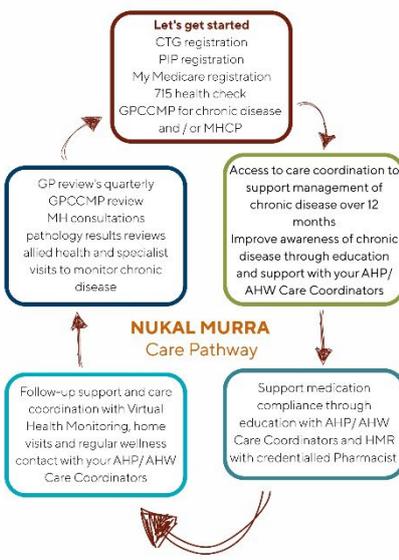
Figure 1 - The Health Support Service Structure



HEALTH SUPPORT SERVICE BROCHURE

How is the program accessed?

- ✓ **STEP ONE**
GP completes Aboriginal & Torres Strait Islander health check.
- ✓ **STEP TWO**
GP completes GP Chronic Condition Management Plan and or Mental Health Care Plan.
- ✓ **STEP THREE**
GP assesses the patient's needs for extra services after all alternatives, program services, have been exhausted.
- ✓ **STEP FOUR**
GP refers eligible patient to Nukal Murra for further assessment and approval.
- ✓ **STEP FIVE**
Nukal Murra review the referral. If accepted, a Local Care Coordinator is assigned to follow-up with the patient and referring GP, and if rejected or approved, GP and patient to be advised in a timely manner.



Let's get started
CTG registration
PIP registration
My Medicare registration
715 health check
GPCCMP for chronic disease and /or MHCP

GP review's quarterly GPCCMP review
MH consultations
pathology results reviews
allied health and specialist visits to monitor chronic disease

Access to care coordination to support management of chronic disease over 12 months
Improve awareness of chronic disease through education and support with your AHP/AHW Care Coordinators

NUKAL MURRA
Care Pathway

Follow-up support and care coordination with Virtual Health Monitoring, home visits and regular wellness contact with your AHP/AHW Care Coordinators

Support medication compliance through education with AHP/ AHW Care Coordinators and HMR with credentialled Pharmacist



Nukal Murra

HEALTH SUPPORT SERVICES

ABORIGINAL AND TORRES STRAIT ISLANDER



Providing support to General Practice to improve access to specialist services for Aboriginal and Torres Strait Islander patients with chronic disease




Phone: 1800 653 339
Fax: 07 4409 4510
Email: nukalmurra@nukalmurra.com

Nukal Murra supported by funding from the Australian Government under the PHN Program



phn
WESTERN QUEENSLAND
An Australian Government Initiative

WOPHN and Alliance for Nukal Murra acknowledge Marrabinya Indigenous Health Support Service for use of their material and overall support.

HEALTH SUPPORT SERVICE BROCHURE



What is Nukal Murra?

Nukal Murra is funded under the Commonwealth's Integrated Team Care (ITC) program by Western Queensland Primary Health Network (WQPHN). The ITC program aims to improve outcomes for Aboriginal and Torres Strait Islander people through better access to multidisciplinary care and improved access to culturally appropriate services in mainstream primary care services.

Eligibility Criteria:

Aboriginal & Torres Strait Islander patients who:

- Live in the Western Queensland PHN region
- Have a diagnosed chronic disease.

Nukal Murra focuses on the key lifestyle diseases causing excess mortality & morbidity

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

Exceptional circumstances will be considered on a case-by-case basis.

Patients are referred by their usual treating doctor and need to have a current GP Chronic Condition Management Plan (GPCCMP).

Brokerage Services Include:

- Gap fees associated with health appointments e.g. allied health, specialist appointments
- Travel and accommodation to attend health appointments utilising PTSS initially
- Webster packs for patients with poly pharmacy (if applicable)
- Assisted breathing equipment – Asthma Spacers, Nebulisers, CPAP & CPAP Accessories,
- Blood Sugar/Glucose Monitoring Equipment
- Blood Pressure Monitoring Machine
- Medical footwear prescribed and fitted by a Podiatrist
- Mobility aids
- Spectacles

Nukal Murra will only approve and provide if the item is identified on the client's GP Chronic Condition Management Plan (GPCCMP), considered clinically necessary and funding is available.

Referring doctors need to be aware:

- Nukal Murra focuses on organising scheduled planned care in advance
- We require a minimum of 48 hours' notice to review, assess, respond to your referrals and arrange / purchase agreed services
- Nukal Murra is not set up to address crisis/acute issues
- Doctors will in the first instance refer patients for allied health services and refer to Nukal Murra after patient uses their allied health services for the calendar year
- Patients referred for assistance with CPAP equipment may be assisted only after prerequisite sleep study and diagnosis are completed
- Nukal Murra should be seen as a program after all alternative programs have been exhausted.

HEALTH SUPPORT SERVICE FLYER



ABORIGINAL AND TORRES STRAIGHT ISLANDER SUPPORT



What is Nukal Murra Health Support Service?

Nukal Murra is an Aboriginal Alliance that helps **Aboriginal & Torres Strait Islander** people who have a chronic disease (like breathing & heart problems, sugar disease, cancer etc). They work with your doctor, as part of the Care Plan, to make sure you can get the appointments and services you need – if it is not available locally in a good timeframe.

How do I get the Support?

You must visit your doctor, who will make a Care Plan and send a request (referral) to the Nukal Murra team. They will contact you and help you organising what the doctor asks. Example:

- Health appointments – including in city areas
- Some travel - if Patient Travel from Hospital Service cannot help or taxi voucher when away from home
- Equipment e.g. for sugar measuring and breathing Machines
- Some Aids like walkers and shower chairs etc

Is there a Cost?

No – if your doctor sends us a request telling us what you need, and we have enough funds, we provide this at no cost to you (The Government through WQPHN are funding this as part of Closing the Gap).

How do I get in touch?

If you have a question, please call:

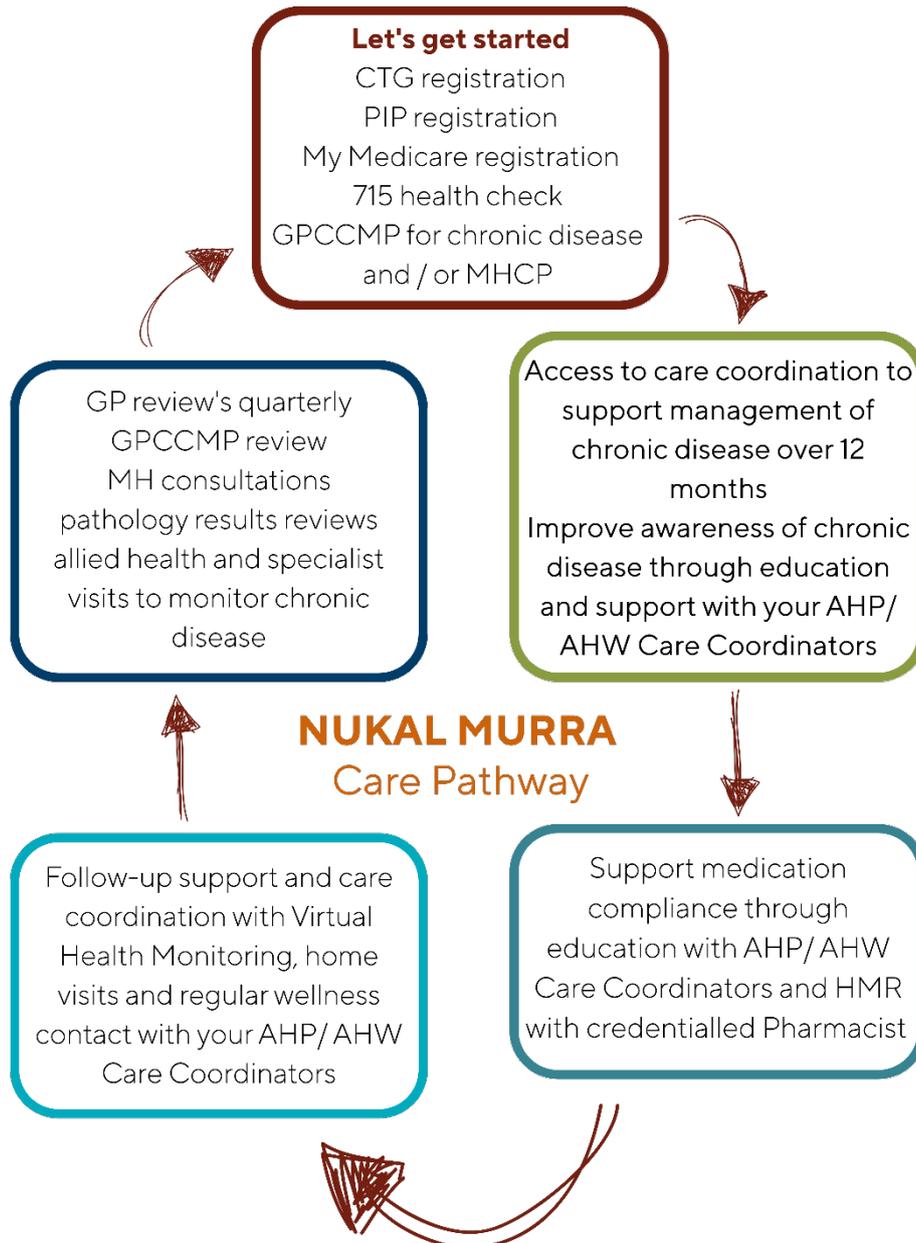


1800 653 339



Nukal Murra is supported by funding from the Australian Government under the PHN Integrated Team Care (ITC) Program.

CARE PATHWAY



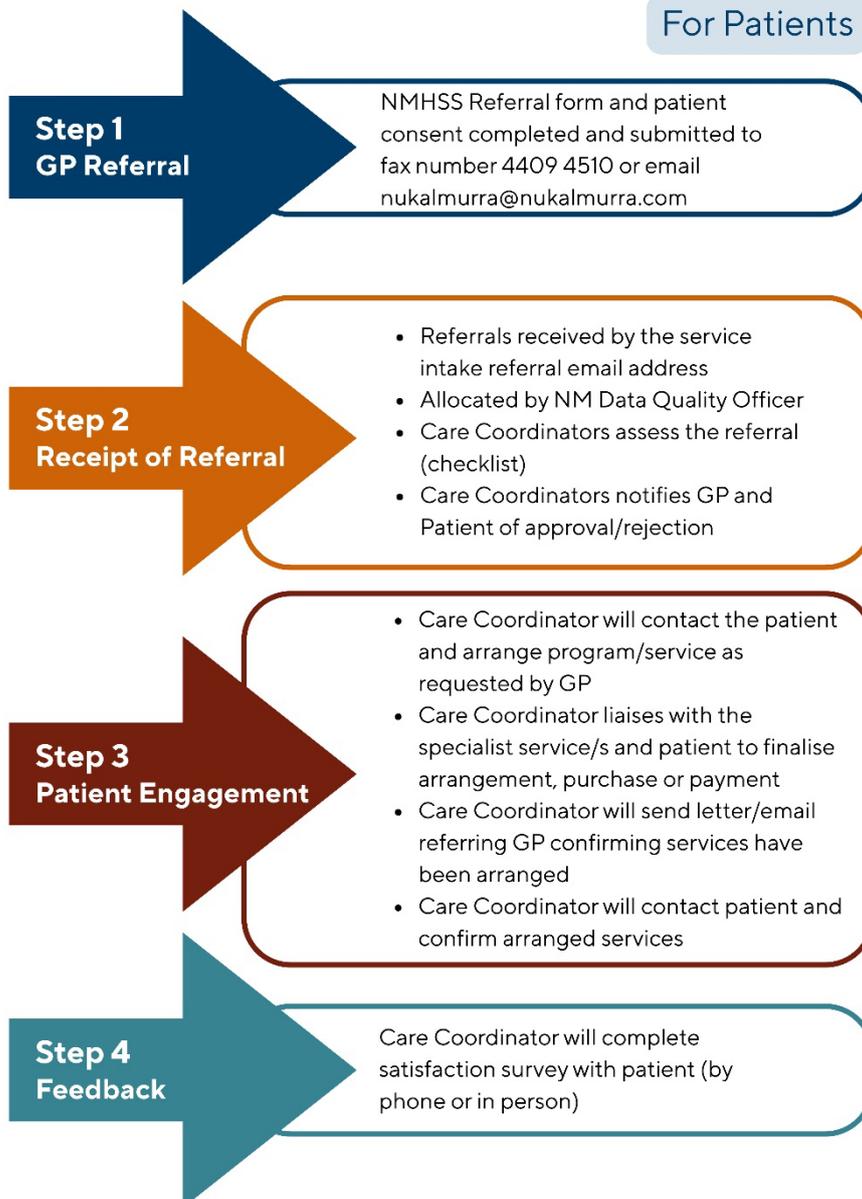
INTAKE FLOWCHART



1800 653 330

Intake Flowchart

For Patients



REFERRAL FORM

Nukal Murra Health Support Services Referral Form

Phone: 1800 653 339 Fax: (07) 4409 4510

To be eligible for the service, Aboriginal and Torres Strait Islander patients must be enrolled for chronic disease management in a general practice or an Aboriginal Community Controlled Health Organisation (ACCHO). **A new referral is required for each new service requested.** However, patients are only required to consent once, every 12 months.

PRACTICE DETAILS	
Practice/ACCHO Name:	<Practice>
Practice/ACCHO Address:	<UsrAddress>
Doctor's Email:	<DrEmail>
Phone Number:	<UsrPhone>
Fax Number:	<UsrFax>
Referring GP:	<DrName>

PATIENT DETAILS			
Name:	<PtFullName>		
Gender:	<PtSex>		
Residential Address:	<PtAddress>		
Postal Address:	<PtPOAddress>		
Next of Kin or Support Person:	<Next of Kin/Support Person (inc Phone number)>		
Date of Birth:	<PtDoB>	Medicare #:	<PtMCNo>/<PtMCLine> Exp: <PtMCEXpiry>
Phone Number:	Home: <PtPhoneH>		Mobile: <PtPhoneMob>
Health Care Card:	<Health Care Card>	Pension Card:	<PtPensionNo>
DVA:	<PtDVANo>	Health Insurance:	<Health Insurance Company (leave blank if not applicable)>
Willing to engage in Telehealth?		<Is the patient willing to engage in telehealth?>	

PROGRAM ELIGIBILITY	
Does the patient identify as Aboriginal and/or Torres Strait Islander?	<Indigenous Status>
Please list the patient's Chronic Condition/s (NB: Private dental services are not covered) <i>Patient must have a chronic condition to be eligible</i>	<What chronic conditions does the pt have?>
Does the patient have a current GP Chronic Condition Management Plan (GPCCMP) (<12months old) <i>(Patient must have a GPCCMP in place to be eligible)</i>	GPCCMP Billing Date: _____ Confirmation via PRODA and /or MBS billing data
SUPPORT SERVICES REQUESTED by GP as per GP Chronic Condition Management Plan (GPCCMP)	
<What Support Services are required? (1)> <What Support Services are required? (2)> <i>*Please note: Transport assistance will be determined by available funding</i>	
Reasons these Supplementary Services are required	
<Reason patient requires Supplementary Services>	



SUPPORT SERVICES REQUESTED by GP as per GP Chronic Condition Management Plan (GPCCMP)

If travel and accommodation support is required, have the PTSS Forms been completed and a copy attached to this referral form?

Please attach any arranged PTSS details re travel and accommodation.

Does the patient require financial assistance with costs associated with the specialist / further investigation fees to be supported by supplementary funding?

If so, please include details in each appointment box below. Leave blank if not applicable.

APPOINTMENT 1 DETAILS (IF APPLICABLE)

<i>Discipline (either medical specialist or allied health):</i>	
<i>Organisation Name:</i>	
<i>Phone number:</i>	
<i>Is the appointment booked?:</i>	
<i>Date/Time:</i>	
<i>Level of urgency (Urgent, High, Moderate, Low):</i>	

APPOINTMENT 2 DETAILS (IF APPLICABLE)

<i>Discipline (either medical specialist or allied health):</i>	
<i>Organisation Name:</i>	
<i>Phone number:</i>	
<i>Is the appointment booked?:</i>	
<i>Date/Time:</i>	
<i>Level of urgency (Urgent, High, Moderate, Low):</i>	

PATIENT CONSENT

My GP/Nurse/Health Worker has told me about Nukal Murra Health Support Services and I want to participate. I understand what I have been told and any questions I have had have been answered. I understand that services (Service providers including my GPs and/or Aboriginal Medical Service, Specialists, hospitals, allied health workers) might have to share my information for care planning and to assess my eligibility for chronic care services. I know that wherever possible you will ask for my verbal consent to share information with other services before doing so. I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to my Care Coordinator. The withdrawal will be valid as soon as the Worker gets my note, but will not apply to information that has been shared since my initial consent. I agree that some information about me (but not my name) will be kept and used so that you can improve the way care is provided to Aboriginal and Torres Strait Islander People.

Patient name: <PtFullName>

Signature: _____ **Date:** <TodaysDate>

AUTHORISATION

I have discussed the proposed referral to Nukal Murra Health Support Services with the patient and am satisfied that the patient understands and is able to provide informed consent to this.

Consent explained and referral authorised by: Dr Name: <DrName> **Provider Number:** <DrProviderNo>

Dr Signature: _____ **Date:** <TodaysDate>

DISCLAIMER: Approval of the Support Services requested will be on a priority basis and contingent on staff capacity and available funding.

NUKAL MURRA ACCHO/ GP CLINIC COMPLIANCE CHECKS

Completed by Data Quality Officer

Chronic Disease eligible	GPCCMP GPMHCP	
PIP Registration current	PRODA check	
CTG Registration	PRODA check	
My Medicare Registration current	PRODA check	
Current 715 health check	MBS billing date PRODA	
Current GPCCMP and/or GPMHCP	MBS billing date PRODA	

NUKAL MURRA COMPLIANCE PROCESS CHECKLIST

Completed by Care Coordinator

Care Coordinator Name:		
Clinic / Region:		
ELIGIBILITY CRITERIA	VERIFICATION METHOD	DATE COMPLETED
GP referral received via fax/email	<ul style="list-style-type: none"> Uploaded to Portals Central Point of Intake referral 	
Referral allocation by Data Quality Officer	<ul style="list-style-type: none"> Allocation to relevant Care Coordinator's clinic 	
CARE COORDINATOR COMPLIANCE CHECKS		
Eligible ITC request	<ul style="list-style-type: none"> Care Coordinator completes eligibility & compliance checks Care Coordinator identify costs & obtain quotes Request for support approved by Delegate Client and GP notified of outcome by Care Coordinator by phone, letter & email. 	
Non eligible ITC request	<ul style="list-style-type: none"> Client and GP notified by Care Coordinator by phone, letter & email of outcome. 	
Care Coordinator will contact client and arrange services / programs as requested by the GP: Liaise with specialist/s services and patient to: Finalise arrangement / booking Purchase and payment method	<ul style="list-style-type: none"> Data Quality Officer (DQO) will coordinate the Supplementary Service payment with finance team. Care Coordinator will notify client and GP by phone, letter and email To confirm services have been arranged To confirm payment 	
Care Coordinator will follow up post receipt of service / program	<ul style="list-style-type: none"> Complete NUKAL MURRA satisfaction survey in person or by phone 	



PATIENT CHARTER

Nukal Murra Health Support Services

As a patient accessing Nukal Murra Health Support Services you have the right to;

- access 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
- that the care provided to you will be respectful of you and your culture, beliefs and personal needs and requirements
- that your personal privacy is maintained and proper handling of your personal health and other information is assured
- comment on or complain about your care and have your concerns investigated and responded to.

IN RETURN YOU HAVE THE RESPONSIBILITY TO:

- advise us of any changes to your contact details
- keep your appointments, or notify us if you are unable to attend
- provide accurate information about your health and anything else that may have an impact on your care
- be as open and honest as you can, and ask for more information if you do not understand
- ask questions so you can learn about your condition and your care options before giving your consent to any treatment
- discuss your concerns and decisions with your health care provider
- treat all staff and others with respect and dignity
- accept that your health information may be shared with appropriate other health care providers and other agencies as authorised by law
- ask for your recorded health information to be corrected if it is inaccurate
- respect the privacy and confidentiality of others

Please contact Nukal Murra Health Support Services on

1800 653 339

if you have any questions or issues.



NUKAL MURRA

DATA AND PORTAL PROCEDURES

Data Quality Officer

Purpose of Position

The purpose of Data Quality Officer position is to work within the Nukal Murra Health Support Service- Integrated Team Care (ITC) Program. The Data Quality Officer is responsible for transferring data from paper formats into computer files or database systems, typing in data directly from clients, creating data spreadsheets, and ensuring the data is entered accurately, efficiently and in a timely manner. The Data Quality Officer works independently and cooperatively in a dynamic team.

Care Coordinator

Purpose of Position

The purpose of Care Coordinator position is the first point of contact for Aboriginal and Torres Strait Islander chronic disease clients. It is also responsible for quality administrative and office support services to enable the provision of high-level clinical care. Including the processing of appointments and administration of client's data is to work within the Nukal Murra Health Support Service- Integrated Team Care (ITC) Program. The Care Coordinator works independently and cooperatively in a dynamic team.

ACCHO's Health Service Manager | Clinic Manager

Purpose of Position

The purpose of the ACCHO roles will be to ensuring that referrals for Supplementary Services meet ITC guidelines, approving service referrals and expenditure prior to purchase, monitoring the finances of the Service brokerage fund and providing quarterly and EOY Reports to WQPHN.

Participate in monthly meetings with the WQPHN Coordinator to discuss to discuss financial expenditure, client engagements and service delivery outcomes. Individual ACCHO Health service manager / Practice manager may be required to meet outside of the monthly meetings as required to monitor progress and expenditure.

WQPHN Role

The purpose of the WQPHN role will be to promote the ITC Program to all GPs and allied stakeholders across the Western Queensland region, providing support and guidance on best practice models for Chronic Disease Management.

The role will also include implementing strategies to improve processes and provide training to Care Coordinators through quality assurance activities including introducing patient reported outcome measures (PROMS), mentoring and case reviews (patient journeys).



Monthly meetings to be organised with the ITC Care Coordination Approval Team to discuss financial expenditure, client engagements and service delivery outcomes. Individual ACCHO meetings may occur outside of the monthly meetings as required to monitor progress and expenditure.

Provide regular reports to NMHSS Alliance which include financial expenditure and service delivery activities for each individual Nukal Murra Alliance ACCHO.

Other Services Access Links

- [My Community Directory](#)
- Medical Aids Subsidy Scheme Guidelines (MASS) - <https://www.health.qld.gov.au/mass>
- Patient Travel Subsidy Scheme Guidelines (PTSS) - https://www.health.qld.gov.au/data/assets/pdf_file/0033/848706/qh-hsdgdl-050-2.pdf
- Heart of Australia (HOA) - <https://www.heartofaustralia.com/>
- ResMed - <https://shorturl.at/iVMXe>
- CPAP Direct Sleep Apnea Specialists - <https://cpap.com.au/>
- My Aged Care Guidelines - <https://www.health.gov.au/contacts/my-aged-care>
- CheckUp Australia Guidelines- <https://www.checkup.org.au/>
- The National Disability Insurance Scheme Guidelines (NDIS) - <https://www.ndis.gov.au/about-us/operational-guidelines>
- National Diabetes Services Scheme Guidelines (NDSS) - <https://www.health.gov.au/initiatives-and-programs/national-diabetes-services-scheme-ndss>
- Roma Community and Allied Health Service - <https://qfinder2.health.qld.gov.au/HealthServiceProvider/Index/10427ca5-7637-e611-80d2-00505601056f>
- Roma Hospital - South West Hospital and Health Service (Visiting Specialists)- <https://www.southwest.health.qld.gov.au/services>
- MBS Flow Chart for Chronic Disease Aboriginal and Torres Strait Islander- <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.mbsonline.gov.au%2Finternet%2Fmbsonline%2Fpublishing.nsf%2FContent%2FD240507EA219F004CA258AB9007F9CCF%2F%24File%2FWord%2520version%2520-%2520First%2520Nations%2520Australians%2520allied%2520health%2520services%2520flow%2520chart%2520%25E2%2580%2593%25201%2520March%25202024.docx&wdOrigin=BROWSELINK>
- Roma Pathology Services- <https://www.health.qld.gov.au/public-health/pathology-queensland/patients/collection-centres/a-z/roma>
- Roma Radiology Services- <https://www.healthdirect.gov.au/australian-health-services/healthcare-service/roma-4455-qld/roma-hospital-radiology-clinic/radiology-service/5584cfd8-75dc-b4fa-7023-07f87989a000>
- Vital Health- <https://vitalhealthqld.com.au/> <https://vitalhealthqld.com.au/services/>
- Indigenous Respiratory Outreach Care (IROC)- <https://metronorth.health.qld.gov.au/tpch/healthcare-services/connecting-care-to-country>
- Indigenous Cardiac Outreach Program (ICOP)- <https://metronorth.health.qld.gov.au/tpch/healthcare-services/cardiology/indigenous-cardiac-outreach-program-ico>