Chronic care coordination

silverchain

For GP practices in South Eastern NSW

Do you have patients with a chronic health condition or complex care needs who require extra care?

At Silverchain we can help. We'll work together with your practice and your nominated patient to coordinate the health care support they need at home so they can maintain their best health and independence for longer.

Our free care coordination service

We know that ongoing management is important for people with chronic health conditions and complex care needs.

We will work with patients and care service providers to effectively implement chronic disease management strategies.

We have partnered with COORDINARE – South Eastern NSW Primary Health Network (PHN) to provide this service across the region, including – Wollongong; Shellharbour; Kiama; Shoalhaven; Jervis Bay; Eurobodalla; Bega Valley; Snowy Monaro; Queanbeyan Palerang; Goulburn Mulwaree; Yass Valley and Upper Lachlan Shire.

This service provides support to patients who need extra help to manage their chronic health condition. This includes assisting patients to make their health care appointments, arranging their transport, and liaising with their network of care providers.

Our role is coordinating the patient's care, and with their consent, we also share information with their network of health care providers, including you as the GP.

How will this service benefit GP practices?

We know that GP practices provide much more than medical care. A lot of time is also invested in supporting a patient's welfare.

With our assistance, your practice can free up time while we provide referred patients with the necessary, ongoing support to monitor and improve their health.

We help patients attend their appointments, access funding and work together with them to ensure they understand the importance of following the health advice they are provided.

Building partnerships to improve patient care

We work to support and enhance collaboration between health services, GPs, pharmacies, community health and social service providers to reduce reliance on traditional hospital services for patients with chronic health conditions.

Our partnership model enables patients to maintain better health, keep their independence and stay out of hospital for longer.

Some of the things we can do for your patients

We will work with your patients to decide what is most important and help them to navigate the health system by:

- Explaining medical language and test results
- Establishing the patient's goals and develop plans to maintain their best health
- Providing advice and information for the type of community-based services they need to improve their health condition
- Speaking with their family members on behalf of patients when needed
- Assisting in the coordination of additional referrals and appointments with other health providers for conditions like chronic obstructive pulmonary disease (COPD) or diabetes
- Finding alternative solutions when a patient may face long wait times for community-based services
- Helping plan and book transport for patients to ensure they can attend their appointments, where required
- Regularly contacting your patient via phone or videocall to check on their progress
- Helping patients understand their medication instructions and where required provide assistance with filling their prescriptions.

How does our service work?

1. GP identifies patient

GPs review their patients to see if they meet the service eligibility criteria.

2. Obtain patient consent and complete referral

GPs speak to patients about the free service and to obtain consent for referral. GPs then complete and submit a referral form to Silverchain.

3. Introduction to Silverchain and assessment

Our team of experienced care coordinators will contact your patient to introduce our service. Patients and our care coordinators will work in partnership to undertake an assessment of needs and determine achievable health goals.

4. Wrap-around support

Our care coordinators will provide patients with wrap-around assistance to access services and supports to better manage their conditions. We will provide feedback and updates to you as the GP to assist with patient welfare and records management.

Patient eligibility

Patients are eligible for referral to our care coordination service if they are:

- residents of the South Eastern region, who are living at home
- living with chronic conditions and complex care needs
- are eligible for Medicare
- have a GP management plan (GPMP) or Aboriginal and Torres Strait Islanders People Health Assessment
- eligible for a Team Care Arrangements (TCA)
- aged 18 and over, or 15 and over for Aboriginal and Torres Strait Islander
- have consented to a referral.

NOTE: Department of Veterans Affairs (DVA) cardholders eligible for care coordination through the DVA service, NDIS clients and permanent residents of residential aged care facilities are not eligible for this service.

Referral process

If you have patients who would benefit from this service, refer them to us.

Go to our website: silverchain.org.au/refer-to-us

The referral form is available to be uploaded to your practice software where the majority of fields are auto filled. You then submit via HealthLink, EDI: virginia

Or you can use the PDF fillable referral form and send via Efax: 1300 601 788

If you have any questions or need to check your patient's eligibility for this service, you can contact us on:

Silverchain referrals

Phone: 1300 300 122
Email: screferrals@silverchain.org.au

The experts in care

Silverchain is Australia's leading in-home care specialist, providing complex health and aged care services to 105,000 clients a year. We have been trusted by Australians to deliver care that is differentiated by quality and safety for almost 130 years.

We provide home-based health and aged care services in partnership with our clients, governments, hospitals, and health services, in Western Australia, South Australia, Victoria, Queensland, and New South Wales.

We tailor our services to each person's needs, preferences and cultural values. This includes providing nursing, care coordination, palliative care, home care and home support services, allied health services, virtual care and monitoring programs, and the provision of equipment and monitored personal alarms.

In addition, we also deliver customised home hospital programs and post-acute health care programs to help people transition out of hospital into the home, or to alternatively keep people out of hospital.

We believe that everyone deserves the right to choose where they receive their care, and that home care helps keep you connected to your community. If home is where you are most comfortable, then we'll meet you there with care you can trust.

Contact us

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COORDINARE

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