Chronic Care Coordination Service

A free service for people living in South Eastern NSW

Information for general practices

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

Our free Chronic 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.

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

Benefits for general practices

We know that general 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 your patients with the necessary, ongoing support to monitor and improve their health.

Your patients will also be provided with the support and education to understand the importance of following the health advice you and others provide to them.

Building partnerships to improve patient care

We 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.

How we support your patients

We work with your patients to navigate the health system by:

- explaining medical language and test results
- establishing goals and develop plans to help them maintain their best health
- providing advice and information on the 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 or Diabetes
- finding alternative solutions when a patient may face long wait times for community-based services
- helping plan and book transport to ensure patients can attend their appointments, where required

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- regularly contacting your patient via phone or videocall to check on their progress
- helping patients understand medication instructions and provide help to fill their prescriptions.

Patient eligibility

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

- residents of the South Eastern NSW region, who are living at home
- living with chronic conditions and complex care needs
- eligible for Medicare
- eligible for 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.

About Silverchain

Silverchain is Australia's leading in-home care specialist, providing complex health and aged care services to 115,000 clients a year. We have been trusted by Australians to deliver care that is differentiated by quality and safety for almost 130 years.

How the service works

GP identifies patient

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

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.

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 with them to assess their needs and to identify achievable health goals

Wrap-around support

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

Referral process

If you have patients who would benefit from this service, please refer them to us. Referral forms are available on your practice software, search for Silverchain care coordination referral from. Please submit the via HealthLink, EDI: virginia.

To use the PDF fillable referral form please go to our website silverchain.org.au/refer-to-us/new-south-wales

For further information or to check your patient's eligibility for this service, please contact us on **1300 300 122** or email screferrals@silverchain.org.au

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COORDINARE

phn SOUTH EASTERN NSW
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Contact us

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