Care Plan Support and Coordination Service

A free service for adults living in the City of Wanneroo.

Information for referrers

At Silverchain we can help by coordinating clinical and non-clinical support for your patients to improve and maintain their health and wellbeing and keep them out of hospital.

Our Care Plan Support and Coordination Service is a free service, where Silverchain registered nurses provide additional support to patients living with mental health and/or drug and alcohol issues, who also have long term health conditions like diabetes, cardiovascular disease, cancer, respiratory disease, musculoskeletal conditions.

About our Care Plan Support and Coordination Service

We work with GP practices that are based within the City of Wanneroo to help identify eligible adults for referral to our Care Plan Support and Coordination Service.

Our service is designed to provide additional support in the community for this vulnerable cohort of adults to help them achieve better health outcomes and quality of life.

Our nurses work together with eligible patients, you as their GP, as well as community health and social services to provide varying levels of care coordination depending on the patient's health care and social needs.

There is no cost to you or your patient, as this service is funded by WA Primary Health Alliance through the Australian Government Primary Health Networks Program.

Patient eligibility

Patients are eligible for this service if they meet the following criteria:

- attends a GP practice in the City of Wanneroo.
- aged 18 years or over, and are
- experiencing mental health and/or alcohol and other drug related problems as well as long term health conditions such as asthma, diabetes, cancer, heart, or lung disease.

Referral process

Referral forms are available on your practice software, search for Silverchain Wanneroo Care Plan Support referral.

Or you can visit our website: silverchain.org.au/CPSCS to find the PDF fillable referral form and submit fax to **1300 601 788**.

More information

If you have any questions or would like to check patient eligibility, please email WACarePlanSupport@silverchain.org.au, or you may contact:

Jaclyn Geraghty, Program Manager Primary Care & Chronic Disease on **0477 353 720**.

Information about how this service works is on the following page.

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How our service works

Assessment and planning

Once your referral has been received, a Silverchain Registered Nurse will contact your patient and make a time to visit them at home or another safe place. We will:

- assess their needs and determine achievable health and social goals together
- work closely with your patient to understand their concerns and any barriers they face to receiving care and work with them to develop solutions
- provide feedback to you as the referrer at varying points.

If there is particular information you would like to receive, please let us know in your referral, and we will be happy to provide what you need.

Care coordination

We can make service provider appointments andproblem solve transport issues for patients when needed. This can include:

- helping them navigate mental health, alcohol or other substance support services
- finding alternative solutions when patients face long wait times for community-based services
- assistance with identifying social and funding support when eligible
- help to understand the importance of following the health advice received and how they can do this in their everday life
- liaising with and sharing relevant information (with consent) with other care providers to ensure patients receive the right care.

Personal support

We maintain regular contact with patients by phone or in person to check on their condition and can speak to family members on their behalf if requested.

We take the time to explain medical language, instructions, and test results, and can help with filling prescriptions, navigating the health care system as well as provide health coaching.

Guidance and support to meet the goals in their Chronic Disease Management Plan developed by their GP.

At each stage of your patients journey we will keep you informed of their progress. When your patient is discharged from our service we will provide you with copies of their care plan, other relevant documentation, and an outcome of care summary via email.

This service is funded by:

WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Acknowledgement of Country

Silverchain Group acknowledges the Traditional Owners of Country throughout Australia and recognise their continuing connection to land, waters, and culture. We pay our respects to their Elders past and present.

Silverchain Group also celebrates, values and includes people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

Contact us

Silverchain
Enquiries: 1300 650 803
info@silverchain.org.au
silverchain.org.au

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