

# Decision tool for referral to Silverchain - Care Coordination

## INFORMATION:

Silverchain has been funded to provide services that ensure patients have better care coordination & help them reach their chronic health goals. They will create a directory of health services that may facilitate the needs of patients & also identify gaps in services.

It is not a substitute for other services eg: DVA CVC or NDIS.

ITC also supports Aboriginal or Torres Strait Island people. (Review information in healthpathways)

*“Aboriginal and Torres Strait Islander patients with chronic disease can receive help to manage their medical care through the Integrated Team Care Program (Coordinated Care and Supplementary Services).*

*The ITC (CCSS) program provides the patient with a dedicated care coordinator to work closely with them, their general practitioner, the practice nurse, allied health practitioners, and specialists that they need to access as part of their ongoing care.”*

It is important to identify those patients needing social connections as there is a different referral pathway for this (currently). [https://www.pccs.org.au/wp-content/uploads/2021/10/Social-Rx-Flyer-PCCSrev5\\_GP-Version.pdf](https://www.pccs.org.au/wp-content/uploads/2021/10/Social-Rx-Flyer-PCCSrev5_GP-Version.pdf)

**REFERRAL FOR SOCIAL PRESCRIBING:** Simply download and fill out the referral form from [pccs.org.au/social-rx](https://www.pccs.org.au/social-rx) and fax it to 1300 067 747 or secure message it to HealthLink ED: **gpsocial**

I would suggest that future planning for CC services should be “no wrong coordination care referral”.

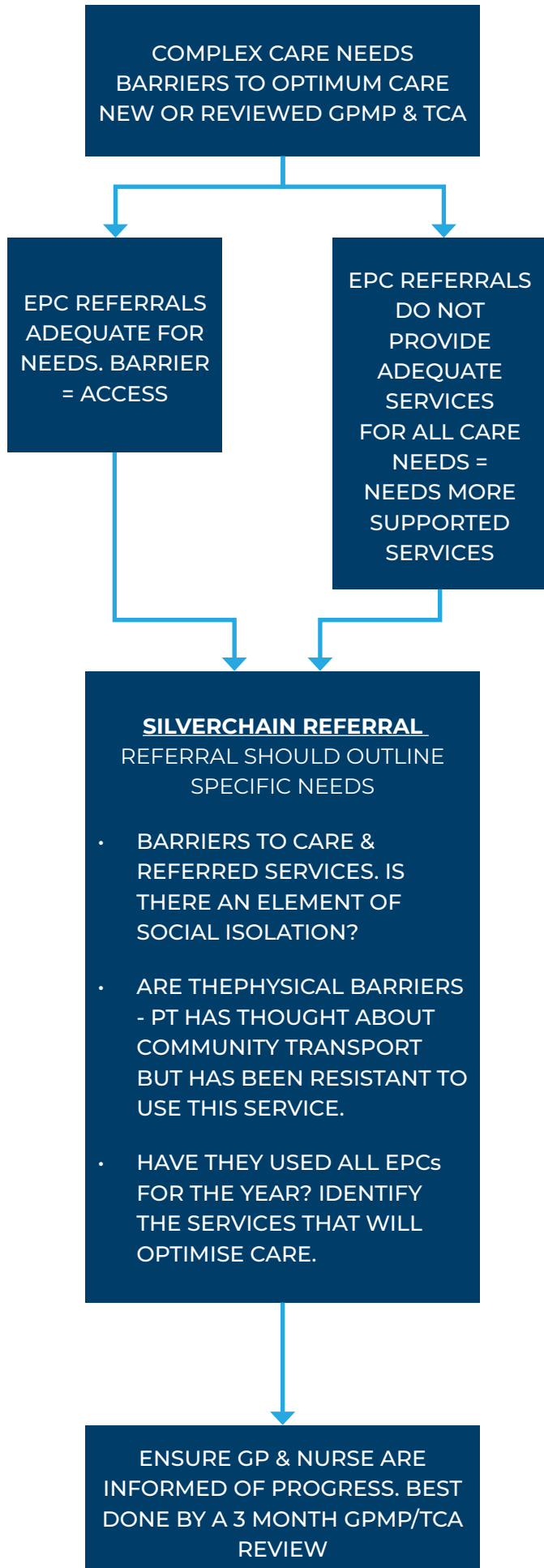
## PATIENT SELECTION:

- › Chronic & complex care needs
- › Unable to manage care through usual referral pathways for allied or community-based care or
- › Up to date GPMP & optimising TCA fully but requiring further support for clinical care.

Examples:

- › Limited or no carer support. EPC referral done but there are barriers to achieving their goals & accessing these services. (Can use Silverchain to find local services that will help them achieve these visits.)
- › Patient has diabetes, OA & chronic pain, so requires the EPC referral for their feet x 5 so there is no further EPC's available to have a “knee program” to improve mobility & pain management (which will help their diabetes).

*\*\*Please do check with patients whether they have PHI with extras cover that may also be a way of increasing services.*



## IDENTIFICATION OF PATIENTS FOR CONSIDERATION OF CC REFERRAL

1. TRAINED PENCAT CHAMPION : to identify those patients with complex health needs. The first tranche will be active patients with more than 2 diagnoses including:
  - › Diabetes + CVD or CKD
  - › MSK conditions + diabetes or CVD
  - › CVD + AF or CKD
  - › Heart Failure (stand-alone diagnosis)
2. These identified patients will be reviewed by the lead nurses in each practice & divided into 2 groups:
  - a. Up to date with their GPMP & from clinical file can be identified as benefiting from CC due to complexity of health care conditions. These patients will be contacted by the practice nurse (PN) allocated to check on their progress & explain the opportunity of extra support with the referral to Silver Chain.  
  
If they agree to proceed – PN will commence the referral process with approval by the treating GP.
  - b. Due for GPMP or review - will be recalled for FTF or Video review & the same assessment will occur to determine if they will benefit from CC referral. If so, above referral process will proceed.
3. All referred patients will have clinical information uploaded to INCA (to be further defined once training has occurred). This will be done by the PN with GP approval.
4. NOTE: Discussions with Silver Chain to be finalised. Feedback would be expected after receipt of the referral & then at a planned follow-up. The follow-up communication would be directed to the responsible PN for entry into the clinical file (may be direct through INCA – TBC)
5. A video case conference between Silver Chain & PN/GP would be planned to assess progress at 6-8 weeks after the referral. At this case conference a decision will be made & documented whether further coordination required or if patient can now be discharged from the program.
6. A clinical patient review would be planned at 3 months.