Care@home

Department of Health

# Chronic Disease Management Program

## Helping to support adults with chronic medical conditions to reduce unplanned hospitalisation and improve patient health outcomes.

### Who we support

The Chronic Disease Management Program focuses on individuals who are at high risk of hospitalisation or readmission due to conditions such as Diabetes, Heart Failure, and COPD, as well as those living with long-term chronic conditions like Post-COVID-19 Syndrome.
Care is provided in collaboration with the individual's General Practitioner (GP), or in some cases, may be comprehensively managed by the Care@home team (including GPs) until the patient is transitioned back to the care of a primary care provider.

### Who we are

Care@home is a state-wide interdisciplinary service that remotely supports patients, to better self-manage their illnesses and chronic conditions in their own home using virtual care technologies.

### What we do

A member of the Care@home clinical team will contact the patient to do an initial Virtual Care Assessment.

This assessment will include evaluation of any risk factors and assessing the individual's suitability for the program and community-based care.

A personalised care plan will be developed to address each individual's specific needs.

Patients will be offered one or more of the following care interventions based on their needs:

- health coaching
- care coordination
- care navigation
- tailored remote monitoring program (if appropriate).

**Care@home is not an emergency or urgent care service, if your patient requires emergency care, please call 000.**

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## General Eligibility Criteria

- Care can be safely delivered in the community setting using Virtual Technology.
- The patient or medical decision maker consents to enrolment in the service.
- The patient has 24-hour access to a working telephone and be able to use it to escalate care if required.

## Patient Eligibility

- Have a diagnosis of one of the specified chronic diseases (Diabetes Mellitus, Heart Failure, Chronic Obstructive Pulmonary Disease)
- Patients who can be supported with care navigation and health coaching to manage their long-term chronic health condition, or
- Have a confirmed diagnosis of Post COVID-19 Syndrome (three months post onset of symptoms with symptoms for at least two months), or

**A person may not be suitable for the Care@home service if:**

- they are medically unstable i.e. complex or acute medical needs that exceed the capacity of a virtual service
- they have care needs that can be provided by Primary Care or THS Community based services
- their needs are better suited to hospital-based inpatient care, rehabilitation, or transition care
- the patient or medical treatment decision-maker does not consent to the service.

## Referring to Care@home

Care@home offers two referral pathways, Patient Self-Referral and Health Care Professional Referral:

- online Enrolment Form (Self Enrolment Only)
- callling the Care@home team on **1800 973 363**
- eReferral
  - referred to site: South – Community and Primary Care
  - referred to speciality – Care@home.

## Contact Care@home

**1800 973 363**
select option 2.

Open 8.00am – 4.30pm,
Monday to Friday.

## More information

More information at:
www.health.tas.gov.au/care-at-home



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