Keeping Well in Community
Care Navigation and Care Coordination

About the Program

The KWIC Care Navigation and Coordination Program is an integrated care initiative within South Western Sydney Local Health District (SWSLHD) empowering clients with the tools, support and motivation needed to independently manage complex chronic and psychosocial conditions in the community.

Our primary objective is to minimise avoidable hospital presentations and unplanned admissions, while expediting discharge from acute care settings. By facilitating and coordinating access to tailored care, non-clinical supports, and aiding informed/shared decision-making, we aim to comprehensively address a spectrum of health and psychosocial needs to ensure clients can 'keep well in the community' for longer.

Reduce hospitalisations, unplanned ED admissions and potentially preventable readmissions by establishing a network of support

Improve communication and seamless transfer of care between healthcare providers and different clinical settings

Enhance understanding of client care needs for improved targeting and prevention strategies as well as improved client, family and carer experiences

Support and capacitate KWIC clients in self-management and self-efficacy behaviours for improved patient activation

Advocate for the right to safe, quality care for clients and/or speak on their behalf to other healthcare providers

Link KWIC clients with local healthcare providers and services they need, to maintain their health (not limited to clinical services – includes psychosocial supports such as domestic, educational, and financial assistance, depending on eligibility)

Acknowledge and respond to cultural and linguistic diversity by assisting KWIC clients to locate culturally appropriate services and/or access NSW Health translators

Activities / How can we help?

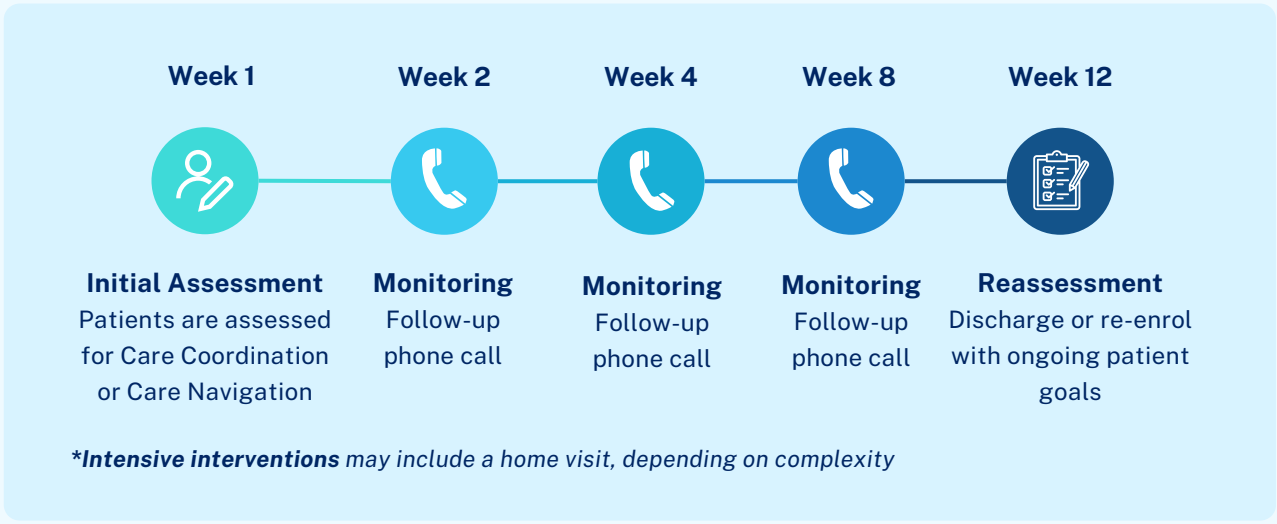
We work with clients, their families, carers and healthcare providers to set health goals and develop a care plan tailored to their physical, mental and psychosocial health needs. Care is provided primarily over the phone, with face-to-face consultations determined on a needs-basis.

For example, we can help with:

- A comprehensive health assessment over the phone (or in home, if necessary)
- Identifying and addressing barriers to improved health outcomes
- Setting healthcare goals in partnership with the client, their families, carers and healthcare providers
- Collaborating on the patient's healthcare plan and coordinating care
- Linking to a GP and other health and psychosocial support services
- Assistance with referrals to:
  - MAC, RAS, NDIS, Mental Health, Drug & Alcohol, and other relevant services
  - OT, social worker, health coaching program, falls prevention and other wellness programs
  - Smoking cessation program, dietitian, disease specific services and programs
  - Specialist services

Program Structure

The KWIC Care Navigation and Coordination Program is a comprehensive 12-week program aimed at reducing unplanned ED presentations and potentially preventable hospitalisations. We do this by identifying clients who are at risk of hospitalisation, frequent presenters and those suitable for earlier discharge.



****Intensive interventions** may include a home visit, depending on complexity*

How to Refer

There are three ways to access the KWIC program:
1. You can make a referral for your client and email to the KWIC team
2. We may call your client if they are identified as 'at risk' by RoH algorithm
3. Your client can make a self-referral by contacting the KWIC team for assessment

Phone: **0499 693 145**

Email: **SWSLHD-IntegratedCare@health.nsw.gov.au**