Care Coordination Support Service

A free service for people in South Eastern Melbourne.

Information for referrers

At Silverchain we can help. We will work together with your practice and your patients to coordinate their clinical and non clinical support needs to maintain their health and wellbeing.

What we can do for your patients

We know that ongoing management is important for people who regularly present to emergency departments for low acuity conditions and for those living with chronic and complex disease, especially if they are not connected to a GP.

We will work with them and care service providers to effectively implement strategies to manage their conditions.

This service will be provided at no cost to your eligible patient and will include:

Assessment and planning

Once the referral has been approved, a Care Coordinator will undertake a Chronic Conditions Risk Assessment to determine the level of support needed, and depending upon their needs, develop a Chronic Condition Management Plan.

Care coordination

We make service provider appointments and arrange transportation when needed. This can include:

- finding alternative solutions when patients face long wait times for community-based services
- assisting with additional referrals
- liaising with and sharing relevant information (with consent) with care providers to ensure patients receive the right care
- assistance with identifying relevant social and funding support and to understand the importance of following the health advice they are provided with
- identifying a GP and connecting the patient to them if they do not have one.

Personal support

We maintain regular contact with patients via phone or videocall to check on their health and well-being and can speak to family members on their behalf if requested.

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

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.

How the service works

Referrer identifies patient
Referrers review their patients to see if they meet the service eligibility criteria.

Obtain patient consent and complete referral
Referrers speak to patients about the free service and obtain consent for referral.

Referrer submits referral form to Silverchain.

Introduction to Silverchain and assessment
One of our experienced care coordinators will contact your patient to introduce our service.

Working in partnership we will undertake an assessment of needs and determine achievable health goals.

Wrap-around support
Our care coordinators will provide patients with assistance to access services and supports to better manage their conditions.

Benefits for referrers

We know that 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 referred 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.

Patient eligibility

People are eligible for the service if they:

- are residents of the LGA regions of Frankston, Greater Dandenong, Casey, Cardinia, Kingston and Mornington Peninsula.
- are living with a chronic condition or complex needs
- have limited access to multidisciplinary care
- are over 18 years of age or Aboriginal and Torres Strait Islander people who are 15 years of age
- are eligible for a GPMP
- have consented to the referral.

Note: Current recipient of HARP (Hospital Admission Risk Program), DVA cardholders eligible for care coordination services through DVA, NDIS clients, people on Workcover or under Transport Accident Commission, permanent residents of residential aged care or recipient of palliative care services are not eligible.

Referral process

If you have patients who would benefit from this service, refer them to us.

Please go to our website silverchain.org.au/refer-to-us/victoria and fill out the PDF fillable referral form and submit via Efax **1300 601 788**.

For GPs please search for Silverchain care coordination referral form in your practice software and submit via HealthLink, EDI:virginia.

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

About Silverchain

Silverchain group is Australia's leading in-home care specialist, providing complex health and aged care services to more than 115,000 clients a year. Trusted by Australians to deliver care differentiated by quality and safety for almost 130 years.

This service is supported by the South Eastern Melbourne Primary Health Network.

Contact us

Silver Chain Group Ltd
National enquiries: 1300 650 803
info@silverchain.org.au
silverchain.org.au

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SG0044-VIC-23