

# Care Coordination Support Service



A free service for people in South Eastern Melbourne

## Information for referrers

Our Care Coordination team consists of registered nurses and allied health professionals trained in chronic disease management. We work with you and your team to help your patients get the health care support they need so they can maintain their health and wellbeing.

## About the service



Care coordination is important for people living with chronic and complex conditions.

Our assessment begins with the information and plan you provide to us. We then work with your patient to support the management of the impact of their chronic conditions.

We work in collaboration with health services, GPs, pharmacies, community health and social service providers to ensure that all services have the right information to work towards the patient's goals.

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

## Benefits for referrers

We understand the needs of people with chronic illness and complex conditions.

As we take on the role of coordinating care needs and supporting patients with their plans and goals, General Practice staff have more time to spend on providing medical care.

Together we work to empower people to self care, improve their quality of life, live better at home, and reduce their reliance on traditional hospital services.

We will communicate regularly to keep you updated with your patient's progress and any changes that occur over time.

## Patient eligibility

People are eligible for the service if they:

- Are residents of Glen Eira, Port Phillip, Mornington Peninsula, Casey, Stonnington, Greater Dandenong, Kingston, Bayside, Cardinia and Frankston.
- Are living with a chronic condition or complex needs.
- Are over 18 years of age or Aboriginal and Torres Strait Islander people who are 15 years of age.
- Have consented to the referral.

Note: Permanent residents of RACF, people eligible for care coordination services through DVA, and recipients of palliative care services are not eligible.

# Care Coordination Support Service

A free service for people in South Eastern Melbourne

## What we can do for your patients

We work with your patients to navigate the health system and support them by:

- Formulating personal goals that support them to maintain their best health.
- Maintaining regular contact via phone or online to check on their health and wellbeing.
- Helping them understand the importance of following the health advice provided by health professionals.
- Providing advice and information on the community based services available to support their health.
- Assisting with referrals for Allied Health, and other community based services.
- Looking for alternative solutions when there are long waiting times for services.
- Supporting their navigation of programs such as My Aged Care, Home and Community Care for Younger People and the National Disability Insurance Scheme (NDIS).
- Identifying social and government funding options that may be available to support their medical needs.
- Exploring options for transport to appointments.

## Client Story

Effie was referred to Silverchain to help navigate MyAgedCare for support at home. She had a history of Osteoarthritis and Chronic Respiratory Disease.

On assessment, our Care Coordinator found that she also had issues with mobility and getting to medical appointments. In collaboration with the GP, our coordinator arranged for Physiotherapy and Podiatry services through the GP management plan's Enhanced Primary Care Program. Effie also had help to get to appointments through the multi-purpose taxi program. Our Care Coordinator also helped Effie's daughter find providers for Personal Care and Domestic Assistance and arranged for a reassessment to enable her to access Respite care.

Through this support, Effie was able to continue to live safely at home.

## How to Refer

Search for Silverchain Care Coordination Referral Form in your practice software and submit via HealthLink, EDI:virginia.

OR

Visit our website [silverchain.org.au/refer-to-us/victoria](https://silverchain.org.au/refer-to-us/victoria), fill out the PDF fillable referral form and submit via Efax **1300 601 788**.

## For more information

For further information or to check your patient's eligibility for this service, please contact us.



- **1300 300 122**
- [screferrals@silverchain.org.au](mailto:screferrals@silverchain.org.au)
- [silverchain.org.au](https://silverchain.org.au)

## About Silverchain

Silverchain is one of Australia's leading in home care specialists, providing health and aged care services to more than 140,000 clients a year.

Trusted by Australians to deliver care that is differentiated by quality and safety for more than 130 years, we are proudly one of the only Australian home care providers accredited in both national health and aged care standards.

At Silverchain we celebrate, value and include people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

## Acknowledgement of Country

Silverchain respectfully acknowledges the Traditional Custodians of the lands on which we work and live. We acknowledge Elders both past and present, whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future leaders and reconciliation within Australia.

**Health. Human. Home.**