



About PainWISE

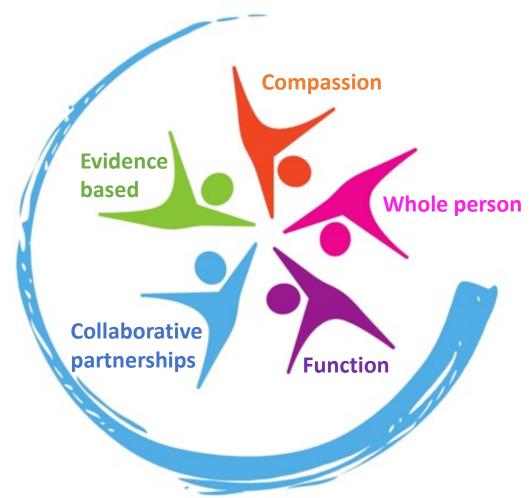


- Last 10 years working with the GCPHN as a provider for the Turning Pain into Gain Program (1st Community Based Persistent Pain Program in primary healthcare in Australia)
- Innovate models of care for pharmacy industry, private hospitals and corporate health
- Utilising mixed funding models
- Focused on whole person-centred care and collaborative partnerships with key primary healthcare allied health and medical stakeholders

The Values of Frailty Care in the Community

FRAILTY CARE
IN THE COMMUNITY

- Compassion based approach
- Whole person-centred care
- Function rather than disease based
- Collaborative partnerships for better access
- Evidence based to support primary care health practitioners and grow work force knowledge



Program Pathway

Low, Moderate & High Risk Patients

Referral to the Healthy Aging Frailty Prevention

program

Our team will assess

cateogorisation

Registration in the Healthy Aging Frailty Prevention Program

Treatment commencment

Discharge and post

program evaluation

Peer to Peer Support

GP Referral

Refer

F.R.A.I.L Scale

Assessment

Treatment

Completion

Support

Minimum duration of program is approximately 4-6 months Medication review
 Progressive
 resistance training

Nutrition review

Group based participation in selfmanagement frailty program Referral to multidisciplinary team prioritized by goals and needs

Peer to peer support group

Home based services

- Physio/Ex Phys
- Med Reviews
- · Check in service

Key objectives



- Literacy and awareness of healthy ageing, frailty management and prevention, including:
 - Skill building in progressive resistance training
 - Nutrition
 - Medication management
 - Mental health awareness and support tools and services to help manage anxiety, depression and loneliness.
- Risk categorisation (using validated scales that are simple to use for referral purpose) so that patients are accessed into the right program at the right time, including ruling out red flags.
- Clinical and psychosocial needs assessment with focus on frailty prevention.
- Navigation of health services to multidisciplinary services depending on the patient's prioritised needs (e.g., psychologist, dietitian, exercise physiologist, physio, occupational therapist, etc.).
- Feedback to GP during the program and at discharge of participation.

Referral process

REFERRAL FORM Frailty Care in the Community Program Healthy Ageing Program





Phone Joyce McSwan for further information on 0412 327 795
Forward completed Referral via Medical Objects (preferred) to:
Name: Joyce McSwan
Provider Number: JM4226000Q0
or Fax: 07 3539 9801

DATE:

IENT		

Patient Name:		DOB:	Gender: M / F
Address:		Email:	
Daytime contact number: Home:	Work:	Mobile:	

PATIENT PRESENTATION

-	

PAST HISTORY

Has the patient previously attended a falls prevention or frailty program/clinic? YES/NO

If yes, specify where and wher

The patient has met ALL the following criteria to be eligible for the program (please tick):

- ☐ The patient is > 65 years old (Older Persons) or > 55 years old (Aboriginal & Torres Strait Islander)
- The patient has scored >1 in the FRAIL scale risk assessment (please see the FRAIL scale risk assessment on page 2 of this referral)
- The patient is not a palliative care patient
- The patient does not currently reside in a Residential Aged Care Facility
- ☐ The patient requires improved self-management strategies and skills to optimise ongoing <u>cace</u>
- The patient is able to give voluntary, informed consent for the ongoing collection of audit data.

ı	REFERRING GP/ORGANISATION DETAILS
ı	Please stamp/insert details:
ı	·
ı	
ı	
ı	GP Signature
ı	Date
	REFERRING ALLIED HEALTH PROFESSIONAL DETAILS (if this applies **A GP Sign off is mandatory for this referral to be accepted**
ı	Please stamp/insert details:
ı	
ı	
ı	
ı	AHP Signature:
ı	

On the receipt of this referral, the patient will be contacted with details of the Gold Goast Primary Health Methods will be held in Community, Healthy Appling Program to be reviewed with an initial service assessment. Our Bervice Assessment will be held at our office at Corporate House, Varriely Lakes. The group-based Fraility Care in the Community Program will be held at various. North and South community centres on the Gold Coast. Patients will be allocated accordingly to cut their individues. Please provide for your patient the "Patient information Sheet" for their further information. Patients can also call us directly to enquire further one Gold 282 27786

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FRAIL SCALE RISK ASSESSMENT

	Questions	Scoring	Results
Fatigue	How much of the time during the past 4 weeks did you feel tired? A = All or most of the time B = Some, a little or none of the	A = 1 B = 0	
Resistance	time In the last 4 weeks, by yourself and not using <u>aids</u> , <u>do</u> you have any difficulty walking up 10 steps without resting?	Yes = 1 No = 0	
Ambulation	In the last 4 weeks, by yourself and not using <u>aids</u> , <u>do</u> you have any difficulty walking 300 metres OR one block?	Yes = 1 No = 0	
Illness	Does the patient have the following conditions? Hypertension Diabetes Cancer (not a minor skin cancer) Chronic lung disease Heart attack Congestive heart failure Angina	0-4 answers = 0 5-11 answers = 1	
	Arthritis Kidney disease		
Loss of	a Arthritis	Yes = 1	

You can also use the Frail Scale Risk Assessment calculator: www.painwise.com.au/frail-scale



Frail Scale Risk Assessment Calculator:

www.painwise.com.au/frail-scale

Referral Form Available:

https://gcphn.org.au/pat ient-care/olderpersons/healthy-ageingresources/

Eligibility criteria



- Residents living at home within the Gold Coast Community, who could be at risk of early entry into aged care
- Those who are at risk of frailty who are unable to access mainstream services (available privately, through private insurance and/or the medical benefits scheme) this may include but not limited to;
 - Aboriginal and Torres Strait Islanders
 - Culturally Diverse Communities (CALD)
 - LBGTIQAP+
 - Those on a Commonwealth Pension
- Ages
 - _o 65 plus (Older Persons)
 - 55 plus (Aboriginal & Torres Strait Islander)

Exclusions

- · If the patient is under palliative care services, they will not be eligible for the service.
- If the patient is already in a Residential Aged Care Facility the patient will not be eligible for the service.

Our service offering

Location

- Varsity Lakes Frailty Care in Community Program Main Office
- Robina Community Centre Group based program (indoor and outdoor)
- Northern Community Centres e.g. Southport, if required depending on demand of referrals
- Home based mobile service (as required based on needs and risk categorisation)

In person and telehealth available