Frailty in the Community Program Office
Corporate House155
Varsity Parade
Varsity Lakes
QLD 4227

GP INFORMATION SHEET

Frailty Care in the Community Program

Gold Coast Primary Health Network (GCPHN) presents **Frailty Care in the Community** Program, consisting of individual assessment, care navigation and a 6-session group-based exercise program and therapeutics Program.

Program Goal:

- Support senior Australians to live in the community for longer through commissioning early intervention initiatives that promote healthy ageing, slow decline, and support the ongoing management of chronic conditions.
- Increase awareness in the primary health care workforce of the needs of the population and the availability of these initiatives.

Objective:

The key components of a frailty management and prevention program/service are:

- 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 the validated Frail Scale for Risk Assessment) 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.).

Program duration: The program supports the patient for a total of 4 to 6 months of care navigation and assessment. The group-based exercise program runs for two hours each week for six weeks. This program requires in person attendance; however home visits may be arranged.

Cost: There is no cost to the patient. This program is fully funded by the Department of Health.

Location: Our initial and ongoing service assessments are held at our Varsity Lakes office. In person group-based exercise programs are held in Robina. The venue will be provided to the patient directly.

Extra Allied Health services offered:

Patients actively engaging in the program can also access an additional **five extra Chronic Disease Management (CDM) Services (previously known as EPCs)**. This is in addition to the Medicare allocated five CDM services.

Eligibility for access to these extra services includes:

- Active engagement in the Frailty Care in the Community Program
- Completed use of the allocated five Chronic Disease Management Services accessed via GP Management Plan.

The "Turning Pain into Gain" Persistent Pain Program gratefully acknowledges the financial and other support from the Gold Coast Primary Health Network Australian Government Department of Health

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Allied Health providers who have a contract agreement with GCPHN are approved service providers who can deliver the extra GCPHN approved CDM services. All allied health providers involved in the Frailty Care in the Community program are upskilled on the current evidence-based knowledge of healthy aging.

The purpose of these extra services is to:

- Provide service access for the patient towards comprehensive modalities which they otherwise may be unable to explore due to limited-service access or financial constraints and/or
- To optimise their current treatment modality.

Where required home visitations are available for vulnerable or high-risk patients unable to attend to travel to their appointments.

Patient participation

Patients participating in this program must meet the program eligibility criteria as set out in the referral form. Patients participating in this program should be able to attend ongoing individual service assessment at our Varsity Lakes consulting room.

GPs and Specialists can refer to the program by completing the referral form. Further enquiries please call Joyce on 0412327795 or email: frailtyprogram@painwise.com.au

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