IMPACCT Services

A transdisciplinary approach to care

Gold Coast Health
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Queensland Government

Jingeri.
We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples, of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people present today.

Overview

- Making an IMPACCT
- IMPACCT Services
- Client Cohort
- Eligibility criteria
- How to access IMPACCT
- A Patient's Journey

IMPACCT Services

Vision:

A community strengthened through care & connection

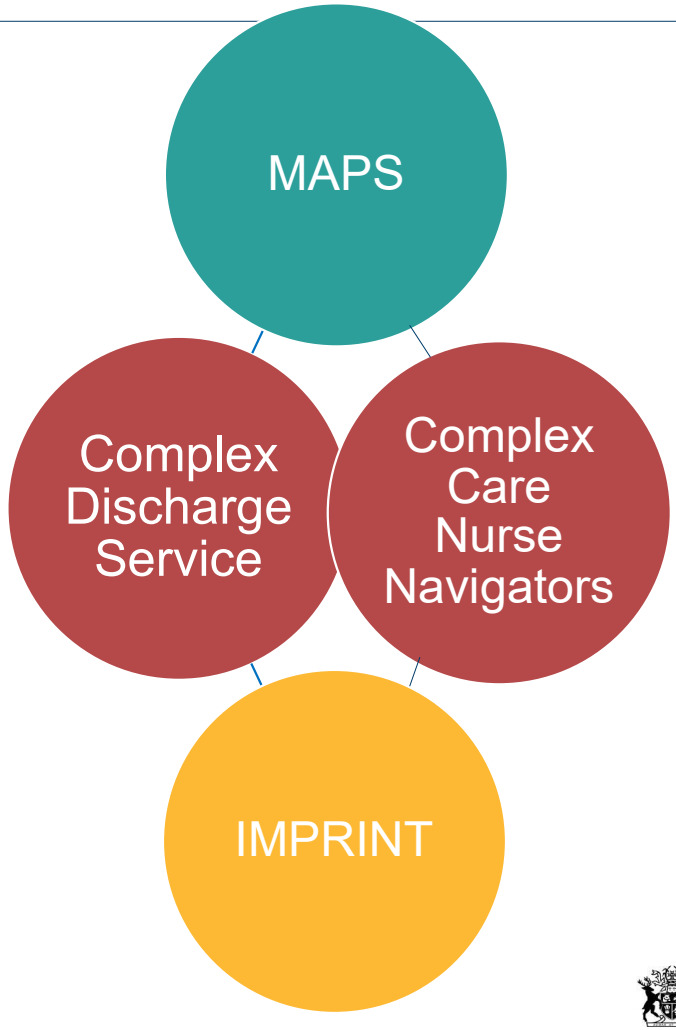
Mission:

To promote health, equity and access to Gold Coast community members with complex needs through support, empowerment, interagency collaboration and advocacy.

IMPACCT Services

Four specialised services:

- Transdisciplinary model
- Outward facing
- Interservice integration
- Holistic view of health
- In-home safety optimisation
- Future focused planning



Multidisciplinary Avoidance and Post-Acute Service

- Allied Health & Nursing model
  - MAPS Coordinator, OT, PT, SW, Nursing, CA, Service Navigator, AOs
- Promotes hospital avoidance & reduced length of stay (LOS)
  - Rapid clinical response within 24hrs
  - Promotes in-home care & safety
  - Alternative pathway
    - Referrals from GPs, QAS, ED, OPD, GCHHS community services
- Seven-day service 8.00am to 6.30pm Mon to Fri, 8.00 am to 4.30 pm on the weekends
- Time limited - up to 2 weeks LOS

MAPS - What do we do??

Provide bridging assistance to at risk / vulnerable patients:

- Home safety assessments (OT, PT, SW)
- Equipment prescription +/- short term loan
- Medication management (excl. administration)
- Wound management
- Personal hygiene assistance
- Emergency food support /shopping
- Transport home (where no other alternatives)
- Facilitated transport to medical appointments

Complex Discharge Service

- Allied Health model
  - SW (1.0 FTE), OT (1.0FTE), Service Navigator (0.5FTE), AO (0.5FTE)
- Aim to support safe & sustained discharge
- Address psychosocial & environmental complexities
- Implement established discharge plans in the community
- Shared management of vulnerable clients
- Time limited

CDS – What do we do??

- Comprehensive biopsychosocial / functional assessments
- Collaboration & advocacy with external agencies
  - DoH, QCAT, DOCS, NDIA, Centrelink
- Guardianship & Administration support
- Equipment prescription and trials
- Service linkage & navigation
- ACP support

Complex Care Nurse Navigators

- Non-clinical Nursing model
  - Generalist Nurses (8 FTE), Service Navigator (1FTE), AO (0.5FTE)
- Aim to support continuity of care
- Aim to support safe & sustained discharge (OOHC)
- Care Coordination - NOT Case Management
- Goal oriented
- Time limited

CCNNs – what do we do??

- Partner with patients & the broader health team to facilitate a comprehensive and appropriate care response
  - Service linkage
  - Cross sector information sharing
  - Stakeholder meetings
  - Advocacy
  - Care planning
- Holistic & culturally sensitive assessments
- Health coaching & education
- Health literacy enhancement
- ACP support
- Expedition of care / treatment response
- ED AMP – support patient flow & an appropriate treatment response
- PACH NN – partner with QAS to support OOHC for low acuity patients

Complex Care Team Client Cohort

Eligibility for MAPS + Complex Care Team

Inclusion Criteria

- Medically stable
- Lives in GC Catchment OR be known to GCHHS Service
- Medicare Entitlement
- Has a nominated GP (*not a requirement for NN*)

Exclusion Criteria

- Maternity & paediatric patients
- Inpatients under care of MDT
- RACF residents
- Patients with high risk HVRA
- Patients with high care needs (MAPS)
- Patients who DAMA (*MAPS only*)

Integrated Multidisciplinary Proactive Risk Identification & Navigation Team (IMPRINT)

Multidisciplinary doctor led service

- Geriatrician, GPwSI, Neuropsychologist, CNC, OT, SW, CA, SN (AO)
- Proactive service – NOT Reactive
- Initial contact completed within 7 days
- Referrals: ACAT, GP, Inpatient teams, outpatient clinics

IMPRINT Services

- Provide multidisciplinary in-home reviews
- Comprehensive health / psychosocial assessment
- Medical optimisation
- Capacity assessment
- ACP support
- Service linkage
- Functional / Cognitive assessment
- Equipment prescription
- Guardianship & Administration support
- Provide education
- Discuss prognosis
- Refer on to community services

IMPRINT Client Cohort

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Eligibility for IMPRINT

Inclusion Criteria

- Live in GC Catchment
- Medicare entitlement
- Aged 65+
- Approved for high level HCP (3,4)
- Requiring support to navigate health & community sectors
- Have a nominated GP
- Are willing to engage with IMPRINT

Exclusion Criteria

- RACF residents
- Nil ACAT assessment
- Patients with high risk HVRA

A Patient's Journey

- 76YOM
- Rapid decline in function. Recurrent presentations /admissions with cystitis, haematuria, anaemia, hyperglycaemia & falls
- Medical History: MDS, PD, T2DM, IHD, CKD, HTN, IDA.
- ACP: Nil EPoA, AHD, SoC
- Social History: Lived in private rental with flatmate, supportive sons, retired realtor, ACP recipient, minimal formal supports, smoker, nil ETOH

A Patient's Journey

Identified Issues:

- Over / underutilisation healthcare services (YTD): x16 ED presentations, 15x admissions = 106 bed days. Multiple OPD FTAs
- Polypharmacy
- ? medication non-adherence, initial difficulty managing newly prescribed insulin.
- ? cognitive impairment
- Social isolation
- Functional incontinence
- Decrease in LOF (new baseline – mobile with w/c)
- Inadequate equipment to support in-home safety /independence.
- In-home services inadequate to meet care need
- Financial constraints

A Patient's Journey

Referred to MAPS Jan 2024:

- MAPS OT – equipment prescription + loan
- MAPS SW – ACP support, service linkage, fee waiver for services
- MAPS EN – Medication review, pain review, BGL monitoring, wound care, hygiene set-up
- MAPS CA – shopping, hygiene set-up, delivery of loan/ rental equipment
- MAPS Clinician – Hospital discharge support (transport home) + welfare calls
- CCNN (MAPS support) – medication reconciliation, supervised medication administration, pain management education, insulin management education (preparation administration, storage), health coaching, risk escalation, interservice information sharing.

A Patient's Journey

Onward referred by MAPS to CDS Feb 2024:

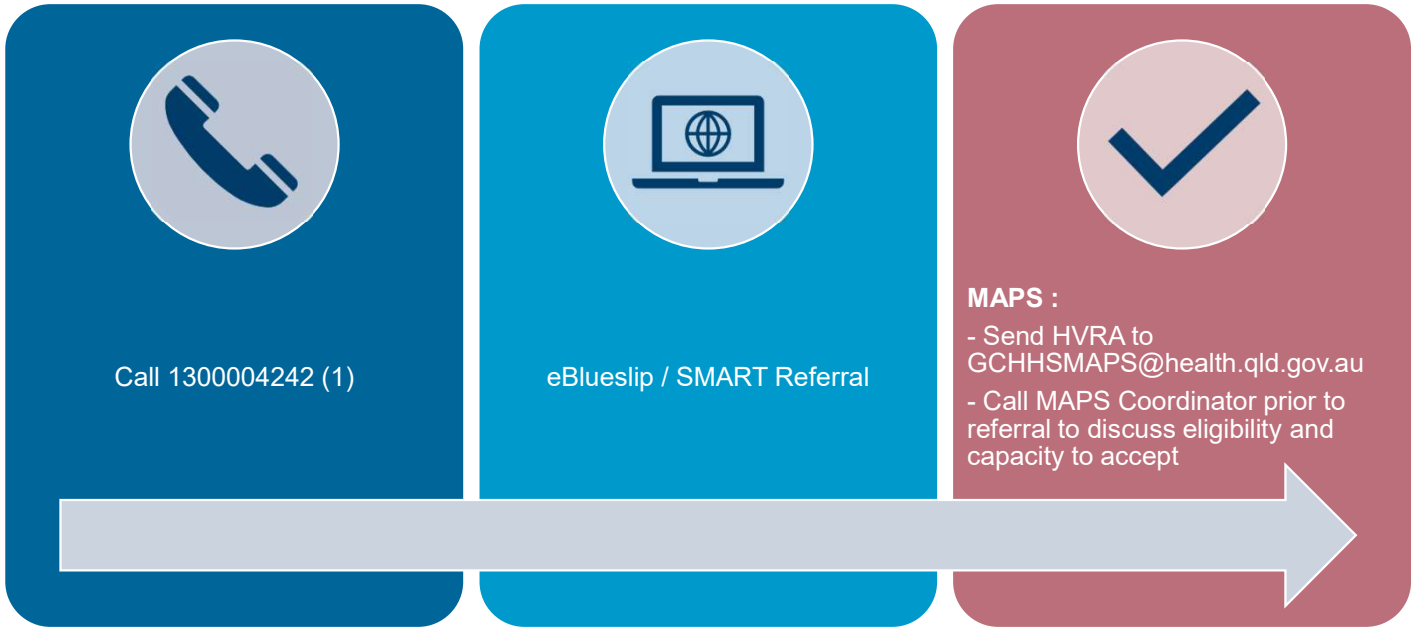
- CDS SW – f/up ACAT SPR, service commencement + fee waivers. Review accommodation options
- CDS OT – to follow up MASS application for equipment
- MAPS CA delegation – shopping for continence aids, facilitated transport to medical appts, med prompts. Applications for fee waivers completed.
- Webster pack arranged in liaison with GP, Pharmacist & client
- MAPS EEN – collection & delivery of medications from pharmacy to client.

A Patient's Journey

Onward referred to IMPRINT for complex medical concerns Mar 2024:

- OT: functional and cognitive assessments, MASS application for electric w/c
- Welfare checks & facilitated readmissions
- Geriatrician: comprehensive geriatric assessment, stakeholder discussions, liaison with GP. Referred to community palliative care
- Family meeting to discuss recommendations
- SW: advanced care planning, RACF education
- CNC: Comprehensive assessment, insulin education, medication error identification & escalation, health coaching, health literacy, continence assessment + MASS application, primary care service integration, interservice information sharing.

Referral Pathways



Thank you