



Rural Allied & Community Health Service

Outpatient Referral Guideline

Aboriginal & Torres Strait Islander Health Worker: Balance and Mobility Clinic: Cardiac & Pulmonary Rehabilitation: Community Health Nurse: Dietitian: Exercise Physiology: Healthy Eating Group: Occupational Therapy: Physiotherapy: Podiatry High Risk Foot: Psychology: Social Work: Speech Pathology

Servicing Biggenden, Childers, Eidsvold, Gayndah, Gin Gin, Monto, Mount Perry, Mundubbera. Agnes Waters - Physiotherapy and chronic condition psychology services.

Services are offered via hospital clinics, telehealth, groups and individual sessions. Please use this guide so patients can be accurately triaged.

Minimum information for referrals (include to avoid returned referrals):

- Identifying details (full name, address, home and mobile number), date of birth
- Referrer's contact details
- Relevant information about the patient's presentation and **reason for referral**
- **Date of onset (referrals will not be accepted without this information)**
- Any particular risks, test or diagnostic results or care requirements to be alert to

Out of core business scope:

- a private provider services the town and the referral is under a GP Team Care Arrangement or My Aged Care referral, or is eligible for DVA, MVA insurance or Workcover service.
- the client, or substitute decision maker, has not consented to, or has declined the service
- the request is related to the client's disability and the service is more appropriately delivered through an NDIS package or an ECEI short term intervention service. NDIS Advocacy services are available to assist.
- a service is funded under a child's education provider (e.g. speech pathology)

Notes:

- Team Care Arrangement referrals only accepted in towns not serviced by a private provider.
- Where clients do not meet criteria for services as listed below the referral will be returned
- Referrals more appropriate for specialist clinics such as persistent pain management or other Specialist Out Patient Department clinics will be returned as a GP referral is required.
- Paediatric referrals for developmental concerns should be concurrently directed to the local Child Health Nurse (if they have not seen the nurse in the previous 6 months).
- Direct referrals for children with multiple developmental concerns to the Child Development Service (noting telehealth is supported in the home town) or NDIS ECEI (Bush Kids).
- Referrals may be directed to group programs, multidisciplinary clinics or other members of the service based on intake questionnaires, clinical indicators and local service skill set.

Service specific criteria and exclusions is outlined in subsequent pages of this guideline.

Referral forms are available from the Rural Allied & Community Health Service (07 41613571), and the PHN Wide Bay Health Pathways website.



<p>Service Program - Aboriginal and Torres Strait Islander Health Worker Service</p>	<p>Category 1 <i>(within 30 days)</i></p>	<p>Category 2 <i>(within 90 days)</i></p>	<p>Category 3 <i>(within 365 days)</i></p>
<p>Services are provided for people who identify themselves as from Aboriginal, Torres Strait or Australian South Sea Islander origin.</p> <p>This Service is available, upon request, for any patient who wishes to utilise this service.</p> <p>The Indigenous Health Worker may support people by:</p> <ul style="list-style-type: none"> • Providing advice and advocacy on culturally appropriate practice and protocols • Screening clinics and health promotion • Encouraging clinical health checks to facilitate holistic assessments of health and well-being. • Working with Aboriginal and Torres Strait Islander communities, individuals and the wider health services to improve health outcomes. • Assisting clients with navigating the health journey and accessing services (eg: care coordination, specialist appointments, telehealth, transport, case conferences, providing joint appointments) 	<p>Indigenous inpatients (same day contact from inpatient list)</p> <p>Follow up clients who have Discharged Against Medical Advice (next working day)</p> <p>Assist with discharge planning and return to home</p> <p>Phone calls to clients with booked appointments (from weekly booked SOPD & rural AH clinic list) – preplanning to support travel and associated attendance support needs.</p> <p>Link with IHLO/IHW at hub and metro sites re access, patient transport and telehealth access.</p> <p>Connect with Centrelink about payments and other issues that arise while in hospital (non-medical related Centrelink requests will be redirected to Centrelink)</p> <p>Support for pregnant women to access antenatal appointments and smoking cessation support.</p> <p>Work with health services to ensure the patient journey is culturally safe and Closing the Gap targets are met.</p>	<p>Assist patients to access services (general)</p> <p>Assist patients to understand and comply with health conditions, medications and health plans.</p> <p>Prevention and early intervention programs – including programs focusing on chronic conditions, diabetes, cancer, heart health, oral, ear and eye health.</p> <p>Coordinate targeted ear health screenings in rural communities</p> <p>Provide information about breastfeeding, ear health, nutrition, maternal health, and immunisation</p> <p>Support immunisation clinics</p>	<ul style="list-style-type: none"> • Complete a general health assessment • Non acute wellbeing checks <p>Work with health services to ensure the patient journey is culturally safe/general cultural safety education.</p> <p>General community education/health promotion</p>



Service Program - Balance and Mobility Clinic	Category 1 <i>(within 30 days)</i>	Category 2 <i>(within 90 days)</i>	Category 3 <i>(within 365 days)</i>
<p>The focus of this program is to improve participant's lower limb strength and balance ability and to equip them with skills, knowledge and confidence to reduce the likelihood of future falls.</p> <p>Eligibility:</p> <ul style="list-style-type: none"> • identified problems with balance or mobility • history of a fall in the last year (2 to 4) • all patients will be assessed to confirm appropriateness for individual versus group treatment 	<p>Recent presentation to DEM</p> <p>High risk of hospital readmission.</p> <p>Referrals may be directed to specific professionals in the first instance (e.g. Occupational therapy, podiatrist or Physiotherapist).</p>	<ul style="list-style-type: none"> • Long stay resident in hospital or MPHS • Person in the community identified as high risk for balance or mobility difficulties, who has not previously completed the program • Diagnosed condition with known balance and mobility impacts (e.g. Parkinson's Disease) and has not previously completed the program 	<p>Clients who have previously completed the Falls and Balance program, with a change in medical status not categorised as category 1 or 2.</p>
<p>Exclusion/Out of Scope:</p> <ul style="list-style-type: none"> ▪ Clients with a chronic condition, but without a history of falls (i.e. falls risk only) should be referred to the Chronic Condition Self- Management Program. ▪ Clients who are high frequency fallers with limited to no improvement possible due to their condition, medication or substance abuse. ▪ Clients unwilling to complete an exercise program, including home exercise tasks should be referred to the Chronic Disease Self-management Program in the first instance. ▪ Clients who have previously completed the Falls and Balance program without a change in medical status. ▪ Clients who are currently accessing services from another services provider to assist their balance and mobility e.g. private physiotherapy, occupational therapist or podiatrist. Please postpone referral until the episode of care with that provider is complete. 			



Service Program - Cardiac and Pulmonary Rehabilitation * Post Acute Phase	Category 1 <i>(within 30 days)</i>	Category 2 <i>(within 90 days)</i>	Category <i>(within 365 days)</i>
<ul style="list-style-type: none"> • Cardiac event recovery - post cardiac surgery, including stents, PAM's, ICD's, CABA's, and valves • People with asymptomatic ACS • Well controlled stable Heart Failure clients with approval by GP or cardiologist • People with risk factors of Heart Disease • People with COPD or Chronic Bronchitis • People with Chronic Asthma, ILD, Bronchiectasis, CF • Other: Pre and Post Lung Transplant, Lung Cancer, slow to recover pneumonia 	<p>New event –seen within 28 days post discharge</p> <p>Cardiac Rehabilitation Discharge from hospital with a diagnosed acute heart condition Referral from a tertiary hospital into Cardiac Rehabilitation GP referral for recent cardiac changes</p> <p>Respiratory: newly diagnosed or conditions with a recent (past 60 days) exacerbation of symptoms and/or hospital admission -Significant ongoing physical deconditioning following hospital admission -Does not understand/ unable to manage their COPD symptoms (consider impact of diagnosis) -Risk of readmission or hospital avoidance related to respiratory condition, oxygen support</p>	<p>Cardiac condition: Chronic / stable conditions requiring further cardiac risk factor reduction and management including: -Past heart event- has not attended Cardiac Rehabilitation in the past -Readmission / presentation with chest pain</p> <p>High risk for CVD as indicated by 3 or more risk factors requiring further management if optimal control not achieved with medical management</p> <p>Respiratory Condition: Chronic stable long-term condition requiring pulmonary rehabilitation -Unintentional weight loss -malnutrition screen <2 More than 2 disease related admission / presentations in the previous 6 months</p>	<p>People who have completed the program previously.</p> <p>Recommend redirect referral to the Chronic Disease Self-Management Program</p>
<p>Exclusions/Out of Scope: Patients without medical clearance. Patients with comorbidities are recommended for the Rural Allied & Community Health Chronic Disease self-management Program. Patients at risk of heart disease should be directed to “Get Healthy” coaching program via 1300HEALTH or MyHealth for Life 13RISK. Patients seeking support for smoking cessation should be directed to 13QUIT (137848).</p>			



Service Program - Community Health Nurse (Eidsvold, Mundubbera, Gaydah)	Category 1 <i>(within 30 days)</i>	Category 2 <i>(within 90 days)</i>	Category 3 <i>(within 365 days)</i>
<p>Services are provided to adults to promote health and independence with a key goal to delay and prevent hospital admission by assisting clients to manage their conditions in the community.</p> <p>The Community Health Nurse may support people with:</p> <ul style="list-style-type: none"> • Individual health assessment and coordination plans including physical, social and emotional wellbeing • Referrals to services within the service and the broader community • Assistance to navigate and access relevant services • Encourage medication compliance by providing practical education on prescribed and over the counter medication • Education on health conditions to encourage self-management • Health coaching for clients with complex needs. 	<p>Clients at risk of hospital admission/re-admission</p> <p>Service coordination of an urgent nature</p> <p>Clients at risk of Medication misuse (including oxygen)</p> <p>Nursing assessment- for at risk clients with complex health issues or as required for Cardiac and Pulmonary Rehabilitation program initial assessment</p> <p>Home oxygen set up</p> <p>Inpatients for discharge support with complex issues (more than one chronic condition for example)</p> <p>Examples include complex co-morbidities such as COPD Diabetes with complications Post cancer treatment Post cardiac events Medication issues Post stroke</p>	<p>School vaccination programs</p> <p>Clients with chronic conditions as per category 1 that require non urgent support</p> <p>Health coaching for clients with chronic conditions who are not appropriate for group programs</p>	<p>Health screening programs</p> <p>Community education and health promotion</p> <p>*Consider referral to the Chronic Condition self-management group</p>
<p>Exclusion/Out of scope:</p> <ul style="list-style-type: none"> • Wound dressings (direct to local hospital, GP practice or care provider) • Continence care (direct to My Aged Care Continence Advisor or NDIS service provider) 			



Service Program Dietetics	Category 1 (within 30 days)	Category 2 (within 90 days)	Category 3 (within 365 days)
<p>Individual client services are prioritised according to their nutritional risk and utilise the Queensland Department of Health Framework for Efficient Dietetic Services (FEEDS), 2017.</p> <p>Some priority area services will be provided through group education to maximise nutritional services for the health service and to assist clients in developing self-management skills and support networks.</p> <p>The following (but not limited to) clinical areas will be referred to specialist dietetics services:</p> <ul style="list-style-type: none"> • Complex paediatric conditions • Oncology • Eating disorders <p>All referrals for chronic conditions with stable co-morbidities will be seen in a group education setting.</p>	<p>Nutrition Support – Malnutrition</p> <ul style="list-style-type: none"> • BMI < 16kg/m² • > 10% unintentional weight loss in 6 months • Or 5-10% weight loss BMI < 18.5kg/m² <p>Malnutrition Screening Tool (MST) score > 2 Pressure injuries Enteral nutrition – commencement, complications Requiring Home Enteral Nutrition Service (HENS) script</p> <p>Type 1 Diabetes – newly diagnosed or HbA1c > 10%</p> <p>Gestational Diabetes – newly diagnosed</p> <p>Failure To Thrive (FTT)</p> <p>Food Allergies – newly diagnosed</p>	<p>Nutrition Support – At risk of malnutrition Poor wound healing Type 2 Diabetes - newly diagnosed, HbA1c > 10% or commencing insulin therapy. Chronic Kidney Disease – newly diagnosed or symptomatic</p> <p>Inflammatory Bowel Disease – newly diagnosed or symptomatic</p> <p>Irritable Bowel Syndrome - newly diagnosed or symptomatic</p> <p>Paediatric feeding issues (other than FFT) Childhood obesity Childhood constipation Post surgery nutritional support Newly diagnosed gastrointestinal disease or surgery Oncology review (via cancer care) Chronic Condition with unstable co-morbidities Food Intolerances Pregnancy</p>	<p>Chronic gastrointestinal conditions – (Diverticular Disease, Hiatus Hernia, GORD, Constipation, Diarrhoea)</p> <p>Gout</p> <p>General dietary advice (vegetarian, anaemia & other nutrient deficiencies e.g. calcium)</p> <p>Chronic conditions – (including risk of) Hypertension Dyslipidaemia Type 2 diabetes Impaired Glucose Tolerance</p> <p>Healthy Eating Group – group program will be considered category 3 for prioritisation. Eligibility is BMI>30 with co-morbidity.</p>
<p>Exclusion/Out of Scope: Referrals will not be accepted for weight management unless unstable co-morbidities are present. Referrals should otherwise be directed to targeted coaching programs such as “Get Healthy” via 1300HEALTH or My Health for Life via 13 RISK (137475).</p> <p>A private provider services the town and the patient has been referred under a GP Team Care Arrangement referral, or is eligible for DVA or Workcover funded services.</p>			



Service Program Exercise Physiology	Category 1 <i>(within 30 days)</i>	Category 2 <i>(within 90 days)</i>	Category 3 <i>(within 365 days)</i>
<p>Services are provided as individual or group programs for clients with chronic and/or complex health conditions and injuries at risk of hospital admission.</p> <p>The aim of the intervention is to facilitate long-term behaviour change by encouraging the self-management of health through exercise / physical activity with a view to preventing and treating disease.</p> <p>The Exercise Physiologist may:</p> <ul style="list-style-type: none"> • Screen and assess for appropriate exercise and physical activity interventions • Assess movement capacity • Develop and prescribe safe, effective clinical exercise interventions for those with existing and complex medical conditions and injuries • Provide exercise-based rehabilitation and advice for patients following acute stage of injury, surgical intervention or during recovery to restore functional capacity and well-being 	<p>At risk of hospital readmission requiring early exercise intervention (clinical conditions as for category 2 & 3)</p> <p>Recent hospital admission due to exacerbation or condition complication requiring reconditioning</p> <p>Clients requiring individual consult/initial assessment for cardiac or pulmonary rehabilitation (includes group program assessments and phone/telehealth consults).</p>	<p>Chronic disease / health conditions usually considered category 3, but risk assessed higher due to comorbidities, readmission risk, disease progression and functional decline including:</p> <ul style="list-style-type: none"> • Complex co-morbidities • Type 1 diabetes • Type 2 diabetes - newly diagnosed, HbA1c > 10% or commencing insulin therapy or referred for group program • Moderate – severe depression / anxiety or mental health condition • Chronic kidney disease • Cancer patients • Class 3 Morbid Obesity • Increased falls risk <p>Medium – long term individual rehabilitation for sub-acute musculoskeletal, neuromuscular disease / injury / chronic pain conditions with MODERATE to SEVERE symptoms and /or functional and structural impairment, as assessed by exercise physiologist or redirected from physiotherapy or from the multidisciplinary team clinics</p>	<p>Exercise prescription for Class 1-2 obesity, mild-moderate type 2 diabetes (HbA1C 7-8% or greater), mild depression / anxiety, hypertension, dyslipidaemia, impaired glucose tolerance, age related de-conditioning and other chronic conditions that will not deteriorate quickly or require increased complex care if delayed</p> <p>Medium - long term individual rehabilitation for sub-acute musculoskeletal, neuromuscular disease / injury / chronic pain conditions with MILD to MODERATE symptoms and / or functional and structural impairment, as assessed by exercise physiologist or redirected from physiotherapy or from the multidisciplinary team clinics</p>
<p>Exclusion: referrals for exercise training or coaching not related to a medical condition or for general lifestyle risk factor advice.</p> <p>For support for people to get more active refer to the free information and coaching service 13HEALTH (13432584).</p> <p>People at risk of diabetes and chronic conditions should be directed to the My Health for Life coaching program via 13RISK (137475).</p>			



Service Program Healthy Eating Program (dietetics led)	Category 1 <i>(within 30 days)</i>	Category 2 <i>(within 90 days)</i>	Category 3 <i>(within 365 days)</i>
<p>Eligibility: BMI>30kg/m² + co-morbidity</p> <p>Individual consultation will be offered only if meet exclusion criteria for group Education (e.g. hearing loss)</p> <p>Note consent must be confirmed prior to referral.</p>	<p>Hospital presentation or admission relating to Diabetes or co-morbidities</p> <p>Patients with pressure area or malnutrition screening risk factors (post discharge from hospital)</p>	<p>Identified as at-risk for hospital admission:</p> <p>3. Previous non-compliance – readiness for change status has changed.</p> <p>4. First presentation</p> <p>5. Lives alone</p> <p>6. Depression/anxiety or medication abuse</p>	<p>Client previously declined service or has indicated they do not wish to set or work towards health goals.</p> <p>Note: if BMI > 30 without co-morbidity:</p> <p>Redirect to 13HEALTH Get Healthy Coaching program or My Health For Life chronic disease and diabetes prevention program 13RISK (137475)</p>
<p>Exclusion/Out of Scope: Referrals for general weight loss or healthy eating advice without co-morbidities.</p> <p>As an alternative to this program, referrers may direct clients to free phone-based health coaching services. My Health for Life – for people identified as at risk of chronic conditions (type 2 diabetes, heart disease, stroke). Call 13RISK (137475).</p> <p>Get Healthy is a free information and coaching service that can help people to address lifestyle risk factors, get more active, help achieve a healthy weight and help with healthy eating. Call 13HEALTH (13432584). Clients may call direct or referrals from a health professional are also appreciated. More information and referral templates are available from www.gethealthyqld.com.au</p>			



Service Program Occupational Therapy	Category 1 (within 30 days)	Category 2 (within 90 days)	Category 3 (within 365 days)
<p>Services are provided for adult and paediatric clients.</p> <p>Eligibility for conducting home visits will be determined on a case by case basis.</p>	<p>Inpatients Burns Acute Hand injuries Pressure area management Hospital discharge planning (home assessment/equipment prescription) Newly diagnosed condition requiring compression therapy Newly diagnosed neurological condition Pre-op management - PACS</p>	<p>-Chronic neurological condition -Cognitive Assessments -Upper limb conditions eg: post acute neurological event, sub-acute hand injuries -Home and activities of daily living assessment -Equipment prescription – including wheelchairs (non NDIS clients) -Oedema / compression therapy review -Scars not at imminent risk of contracture.</p>	<p>Chronic Pain (consider referral to the Persistent Pain service) Chronic hand conditions e.g. arthritis</p>
<p>Paediatric Referrals for developmental concerns are accepted via the Child Health Nurse (following screening assessment) or Child Development Service (CDS). The rural allied and community health service will assist families to attend the CDS access appointment from their local community.</p>	<p>As per above</p>	<p>As per above -Paediatric chronic pain -Paediatric Assessments requiring information to assist with diagnosis (joint with CDS) -Paediatric assessments for developmental and learning skills (joint with CDS) -School Aged Paediatrics – treatment for occupational performance problems <i>outside</i> the school environment e.g.: feeding</p>	<p>Paediatric block therapy program or advice for developmental and learning skills (where the child is not eligible for NDIS/ECEI or school - based services)</p>
<p>The following (but not limited to) clinical areas will be referred to specialist occupational therapy services for intervention, support and or joint management will be provided via mentoring program and telehealth: Cancer care/lymphoedema, Burns, Hands rehabilitation e.g. tendon repair, complex splinting e.g. fibre glass splinting.</p> <p>Exclusions/Out of Scope:</p> <ul style="list-style-type: none"> - Paediatric referrals that have not been seen by the Child Health Nurse, CDS or tertiary paediatric service (Children’s Health Qld) <ul style="list-style-type: none"> - School aged child requiring assistance to support learning in the school environment/access the curriculum (e.g. eligible for education funded support services) - A child or adult who is eligible for service through an NDIS package or an ECEI short term intervention service. - Referrals for Encopresis/eneurisis should be directed to the Continence Advisory Service - a private provider services the town and the patient has been referred under a GP Team Care Arrangement referral, Home Care Package, or is eligible for DVA or Workcover funded services. 			



Service Program: Physiotherapy

Category 1 <i>(within 30 days) Acute: Within 2 weeks of onset</i>	Category 2 <i>(within 90 days) Subacute</i>	Category 3 <i>(seen within 12 months) Chronic</i>
<p>Acute injury within 2 weeks of onset affecting ability to mobilise, work or participate in ADL's</p> <p>Acute back pain with referred leg pain.</p> <p>Recent surgery- TKR, THR, ACL reconstruction, rotator cuff repair, shoulder surgeries, ankle surgeries, post abdominal/gynaecological/obstetric.</p> <p>Pre-op management- Preadmission clinic</p> <p>Cardiopulmonary presentations with evidence of significant reversible deterioration in function.</p> <p>Early identification of incontinence or rapid decline in continence.</p> <p>Mobility assessment post fall with injury not seen in ED or as an inpatient.</p>	<p>Sub acute presentation of soft tissue injury that is more > 2 wks but < 3 months since onset- e.g. shoulder impingement, back pain.</p> <p>Sub acute surgical/orthopaedic/neurological conditions - e.g.CVA, PD, MND, MS reconditioning in the aged</p> <p>Interventions aimed at preventing surgery e.g. trial of conservative treatment for orthopaedic presentations</p> <p>Conditions which are worsening and/or limiting functional activities of daily living</p> <p>Long term back pain with acute flare up in the last 3 months.</p> <p>Subacute burns/scars not at imminent risk of contracture.</p> <p>Mobility assessment post fall with no injury and/or screening for falls and balance class (FAB).</p> <p>Postnatal presentation within 3 months of delivery.</p> <p>Pelvic health conditions 3-6 months onset (Incontinence, prolapse and pelvic pain)</p> <p>Paediatric motor delay (non complex cases)</p>	<p>Episodic exacerbations of long term chronic conditions which respond to treatment, mobility and ADL's are unaffected. E.g. OA, OP, rheumatoid arthritis</p> <p>Limited risk factors (Chronic disease calculator)</p> <p>Presentations aimed at restoring non-essential activity</p> <p>Pelvic health outpatients: > 6 mths</p> <p>Chronic Pain</p> <p>Maintenance neurological and physical condition programs e.g. CVA, Parkinson's, MND, MS.</p>
<p>Referral Guidelines:</p> <ul style="list-style-type: none"> • Reversible pathology conditions are given precedent over all others as the chance for a favourable outcome is greater. • Greatest physiological impact to healing tissues is within 6 weeks post injury -early treatment of acute injuries supports prevention of chronic pain • First time injuries/occurrences should be treated before re-occurrences, exacerbations and decompensations. • Severe pain if present is primarily a medical management and pharmacological concern. While pain relief is an important function of physiotherapy, prioritisation will take account of various clinical factors. <p>Exclusions/Out Of Scope:</p> <ul style="list-style-type: none"> - The following (but not limited to) clinical areas will be referred to specialist physiotherapy services: Paediatric conditions impacting development e.g. congenital foot deformities, Botox serial casting, Complex orthopaedic bracing, Complex pelvic floor conditions - Complex Chronic Pain presentations/those more appropriate for Pain 101 should be directed to the Persistent Pain service. - <i>School aged child requiring assistance to support learning in the school environment/access the curriculum</i> - A child or adult who is eligible for service through an NDIS package or an ECEI short term intervention service. - a private provider services the town and the patient has been referred under a GP Team Care Arrangement referral, My Aged Care Package, or is eligible for DVA or Workcover funded services. 		



Service Program Podiatry- High Risk Foot Service	Category 1 (within 30 days)	Category 2 (within 90 days)	Category 3 (within 365 days)
<p>Assessment includes vascular, neurological, dermatological, orthopaedic and biomechanical assessments of foot health and functioning.</p> <p>Evidenced based, best practice clinical services will be provided in alignment with <i>Queensland's HHS – Podiatry Statement of Core Business</i>, Qld Health, March 2015</p>	<p>Current foot ulcer+/- infection (to be seen within 2 days)</p> <p>Active Charcot Neuroarthropathy (to be seen within 2 days)</p> <p>Acute ischemia of the lower limbs</p>	<p>Foot deformity with peripheral neuropathy and/or peripheral vascular disease</p> <p>Previous foot ulceration or amputation</p> <p>Infected onychocryptosis indicated for nail surgery</p> <p>Post-Operative consultations following nail surgery</p>	<p>Peripheral neuropathy</p> <p>Peripheral vascular disease</p> <p>Surgical Waitlist Hospital Avoidance Review</p> <p>Paediatric Hospital Avoidance Review</p> <p>Community Education</p>
<p>Referral Guidelines:</p> <ul style="list-style-type: none"> • Individuals with chronic disease (including but not limited to Diabetes, Rheumatoid Arthritis, Gout) previously assessed by a Podiatrist as being “At Risk” or “High Risk” of foot complications, who need assessment and/or ongoing management of foot complications due to their chronic disease e.g. Peripheral Vascular Disease, Peripheral Neuropathy, severe foot deformity • Aboriginal and Torres Strait Islander people with diabetes are considered to be at high risk of developing foot complications until assessed otherwise • Individuals in the “At Risk” and “High Risk” categories, requiring surgical removal of pathological toenails • Category one conditions should be referred immediately to a specialist, wound care clinic, telehealth podiatry service or GP for interim intervention until the next podiatry visit. <p>Exclusions/Out of Scope:</p> <ul style="list-style-type: none"> • Referrals for bespoke orthotics/orthotics not related to eligible conditions above • Low Risk • The performing of routine nail care will only be undertaken if the patients meet the aforementioned criteria; this care is always at the discretion of the treating podiatrist. Referrals for toenail care should be directed to alternative options such as foot care clinics or aged care services. • a private provider services the town and the patient has been referred under a GP Team Care Arrangement referral, Home Care Package, or is eligible for DVA or Workcover funded services. 			



Service Program Psychology (chronic conditions)	Category 1 (within 30 days)	Category 2 (within 90 days)	Category 3 (within 365 days)
<p>Health focused psychological assessment and management of patients with a focus on improving the health outcomes and preventing hospital admissions/readmissions for those with complex chronic conditions. Includes integrated care planning, assistance with patient's psychological factors that impact on their condition and to facilitate chronic condition self-management.</p> <p>May include: Cognitive Behavioural Therapy (e.g. psycho education re adjustment to illness/diagnosis/treatment, motivational interviewing; problem-solving), Acceptance and Commitment Therapy, health behaviour change, mindfulness and relaxation training, hypnosis.</p>	<p>Clients at risk of hospital admission/re-admission with complex/co-morbid chronic condition health needs:</p> <ul style="list-style-type: none"> -Significant health condition with repeated acute episodes in which lifestyle behaviours significantly contribute (e.g. patient with COPD admissions continues to smoke). -Lifestyle health behaviours prevent/preclude a patient from accessing a medical service/treatment that they need urgently. -Moderate/severe/rapid deterioration in mood contributing to significantly poor or worsening adjustment and coping related to chronic disease management, diet, pain tolerance, adherence etc. -Anxiety/mood – mod/severe impact on health and functioning where a delay > 30 days is likely to have a detrimental impact on patient well-being or medical care 	<ul style="list-style-type: none"> - Co-morbid depression, anxiety, adjustment or adherence difficulties that is caused by or interferes with the management of the patient's health condition(s) or presenting issue requiring medical intervention (e.g. anxiety resulting in poor adherence to blood sugar testing in a diabetic with an elevated Hba1c, CPAP non-adherence, anxiety related to exercise and COPD). -Presentations such as: adjustment difficulty, grief or significant distress that interferes with the ability of the patient to cope effectively with their health condition(s), its symptoms or treatment. - Poor adherence to directions for medications, medical advice or disease management plans. - Outpatients- psycho-education/adjustment to new diagnosis, illness and medical condition and treatment. - Stable chronic sleep difficulties →at risk of future medical complications. 	<p>Client who require support to make lifestyle changes and modify behaviour that significantly impacts on the disease.</p> <p>Clients may be directed to group programs, with individual appointments scheduled for those requiring higher level of support.</p> <p>Lifestyle health behaviours prevent/preclude a patient from accessing a medical service that they might be able to access in the future (e.g. gastric band surgery).</p>
<p>Exclusions/Out of Scope: those for which there exist other specialised public services. Appointments will usually not be made specifically for the following:</p> <ul style="list-style-type: none"> •Severe and enduring mental health issue (consider Mental Health Services) •Acute suicide risk (consider Mental Health Services) •Anxiety, depression, where that disorder is unrelated to & not affecting their physical health condition (consider primary care psychology services, e.g. the ATAPS "Better Access to Mental Health" scheme via their GP.) •Significant substance abuse or dependence (consider specialist drug and alcohol services) •Relationship issues that are unrelated to the patient's health condition (consider specialist therapy services e.g. Relationships Australia) •Patients seeking psychological assessments or reports for legal purposes (consider private psychology services.) •Patients seeking assessments not directly related to their physical health, for example the neuropsychological assessment of learning disorders •Referrals may be redirected to group self-management, dietary and/or exercise education prior to receiving individual interventions for diet or exercise •Patients should be requested to engage with Quitline prior to receiving individual interventions for smoking 			



Service program: Social Work

Category 1 <i>(within 30 days)</i>	Category 2 <i>(within 90 days)</i>	Category 3 <i>(within 365 days)</i>
<ul style="list-style-type: none"> • Critical incident – psychological first aid if offered initially if involved in or witness to a critical event resulting in death or multiple injuries/suicide • Complex social situation requiring urgent resolution for hospital avoidance or discharge • Inpatient referral • Acute palliative care • Acute episode of domestic violence • Elder abuse • Include two or more of the risk factors listed below. 	<ul style="list-style-type: none"> -Post acute adjustment issues – new or changed diagnosis/prognosis -Recent trauma e.g. accident, suicide of loved one (non-immediate as per Cat 1) -Complicated grief/grief associated with changed health conditions -Bereavement following death of significant other/preparatory grief for life limiting illness -Psycho-social adjustment to chronic health condition -Mild depression -Mild anxiety -Complex stress - related to health condition impacting on daily living -Capacity issues – assessment for QCAT application where decision making effected by cognitive decline and/or memory deficits -Carer issues -Social isolation -Future care planning – future care needs e.g. EPOA and AHD Individual emotional support /counselling -Systems support - Involvement with support groups/programs as appropriate 	<p>Appointment provided to instruct in self-management activities and a date for review booked</p>
<p>Social Work Category 1 Risk Factors</p> <ul style="list-style-type: none"> • Lives alone and is socially and geographically isolated • Family conflict and/or estrangement • Unable to manage ADLs • History of declining services • Anxiety and/or depression • Self Neglecting/risk taking behaviours – poor hygiene/nutrition, over use of alcohol, driving when licence has been revoked, misuse of medications • Safety issues – aggressive or abusive behaviour, environmental risk factors. • High carer stress - carer's emotional and physical health, tension/conflict, decrease in engagement in usual activities. Precursor to elder abuse. • Cognitive impairment due to a number of factors including pre-existing condition, memory loss, stress. Impact on ability to make decisions re: care. <p>Referral Guidelines: Referrals are prioritised in accordance to needs and levels of impact on the individual's Psycho-Social Circumstance and health needs. Acceptance of referrals are classified within categories of distress, hardship, advocacy, support needs, counselling/support where there is a health-related issue e.g. Grief & Loss, Disability & Serious Illness, Emotional & Psychological issues adjustment.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • A child or adult who is eligible for service through an NDIS package or an ECEI short term intervention service. • Referrals for completion of documentation in relation to welfare are not eligible and should be redirected to Centrelink services • Wide Bay HHS employees or employees with access to work based services will be directed to the Employee Assistance Service (EAS). • Referrals for mental illness will be directed to the Mental Health Service 		



Service Program Speech Pathology	Category 1 (within 30 days)	Category 2 (within 90 days)	Category 3 (within 365 days)
<p>Prioritisation of paediatric clients will take into account the Leaders in Speech Pathology (LISP) <i>Prioritisation guidelines for speech pathology practice in child development services</i> (2010) and principles of early intervention.</p> <p>The following (but not limited to) clinical areas may be referred to specialist speech pathology services or joint management:</p> <ul style="list-style-type: none"> • Paediatric dysphagia • Cancer care/ laryngectomy • Tracheostomy management 	<p>-Severe dysphagia (risk of aspiration, dehydration or malnutrition is present)</p> <p>-Severe communication impairment (recent decline)</p> <p>-Infant failure to thrive/ feeding difficulties</p>	<p>-Outpatient chronic/longstanding dysphagia/feeding difficulties</p> <p>-Adult mild-moderate communication impairment (recent decline/ significant improvement)</p> <p>-Acute voice disorders with an Ear, Nose and Throat (ENT) referral</p> <p>-Tracheostomy/laryngectomy management support</p> <p>-Sub-acute Neurological /craniofacial conditions</p> <p>-Paediatric dysfluency (high priority)*</p> <p>-Paediatric speech/language disorder/delay (high priority)*</p> <p>-Paediatric sensorineural hearing loss</p>	<p>-Adult communication impairment (considered stable and without recent change)</p> <p>-Adult hearing and/or general communication support</p> <p>-Chronic voice disorder with an ENT referral</p> <p>-Adult dysfluency</p> <p>-Paediatric speech/language disorder/delay (medium/low priority)*</p> <p>-Paediatric dysfluency (medium/low priority)*</p>
<p>Exclusions:</p> <ul style="list-style-type: none"> • School aged (prep and above) referrals should be directed to the child's school (except for acute medical conditions/ post injury rehabilitation) • A child or adult who is eligible for service through ECDP, an NDIS package or an ECEI short term intervention service. • a private provider services the town and the patient has been referred under a GP Team Care Arrangement referral/ Chronic Disease Management Plan, Home Care Package, or is eligible for DVA or Workcover funded services. 			

* As categorised using the LISP *Prioritisation guidelines for speech pathology practice in child development services*, Qld Health, September 2010.