

Queensland Health's Directions for Aged Care

2004 – 2011

Forward

Contents

Background



Queensland Government
Queensland Health

Foreword

Our seniors hold a wealth of knowledge and insight which contributes towards making Queensland a wonderful state.

And in an ever-developing state with people living longer and longer, the influence and effect of our older population is becoming even greater.

Over the next 20 years the population aged over 65 years will grow at three times the rate of the population between 15 and 64 years and in some rural and remote areas this growth rate is expected to be four to five times that of the younger age group.

Older people are already the greatest users of health services and Queensland is committed to a health system that will cater for increased demand.

To ensure this there are many issues to consider.

We know that many people wish to stay in their homes as they age so that they need community services to make this possible. Older people also often have different care needs in hospital compared to younger patients and may also need more time to recover.

Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse backgrounds must receive care appropriate to their needs.

Older people living in rural and remote areas must have good access to services.

Our workforce is committed to providing quality health care to older people. They have to be supported with opportunities for ongoing education and training on health care to older persons. The contribution by this workforce, carers and volunteers must be recognised and supported.

Queensland Health's *Directions for Aged Care 2004-2011* provides a clear guide for delivering even better health services to older people. It reflects the *Queensland Health Strategic Plan 2004-2010* intent to promote a healthier Queensland and will ensure the consumer is the focal point of the health care system.

The development of this document would not have been possible without the input of past and present health professionals, carers and volunteers. I would like to thank those who contribute to the continued delivery of quality health care services to all Queenslanders.

The Hon. Gordon Nuttall MP
Minister for Health
Member for Sandgate

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Background

Queensland and more broadly, Australia's aged care system is structured around two main forms of care: residential and community. These may operate separately or be amalgamated.

The Australian Government's Department of Health and Ageing finances and regulates residential aged care, Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages which provide high care services to older people in the community in place of residential aged care.

To ensure that only those who are highly dependent are placed in residential aged care or receive high care community packages, Aged Care Assessment Teams (ACATs) have been established nationally to determine a client's need for these services.

State and Territory governments retain the major responsibility for the public provision of health services, including public and psychiatric hospital systems, rehabilitation, public health, and the Home and Community Care (HACC) program which is joint Australian Government and State Government funded.

Although the aged care system has many positive features it has become incredibly complex for consumers, carers and service providers to negotiate through the mix of services provided by the various levels of government.

In addition older people have special care needs that must be recognised by the system. Older people:

- often have a slower recovery rate than younger people after an acute episode and therefore require increased support services while recovering
- may undergo unnecessary and multiple assessments to receive support services
- may have a carer that is a similar age and who therefore must be considered in the planning and delivery of services to the client
- often require more than one support service and coordinating these across government jurisdictions can at times be challenging
- generally would prefer to stay in their homes rather than go to a residential aged care facility
- are at greater risk of developing dementia and therefore require specialised diagnosis, treatment, management and support services
- with a pre-existing mental illnesses will require both mental health and aged care services
- living in rural and remote areas of Queensland do not have the same access to services as those living in regional and metropolitan areas. Older Aboriginal and Torres Strait Islander peoples particularly experience problems since many live in isolated communities in rural and remote areas of Queensland

Like many other developed countries, Australia's population profile is changing with proportionally more older people in the population than before. At a more local level the proportion of people in Queensland aged 65 and over in 2003 was 11.7 per cent. By the year 2051, this is expected to rise to almost 28%. The proportion of Queenslanders aged 85 years and over is expected to increase by more than eight times, from just over 1 per cent in 2002 to around 8 per cent in 2051¹.

These trends are significant for the Queensland public health system because older people are the greatest consumers of health services due to age-associated illnesses and disabilities. Service usage increases significantly in the last year of life. The ageing of the population also means that there will be more people with pre-existing serious mental illnesses living beyond the age of 65, and older persons who require assessment and treatment for depression, psychosis and anxiety related disorders, and dementia sufferers with associated psychological problems.

Queensland Health must be ready to meet this increased demand and ensure that high quality care is offered in a dignified and appropriate manner. This can only be achieved through effective planning and use of existing resources as well as continued negotiations with the Australian Government for funding that recognises the growing care needs of an ageing population.

1 ABS Population Projections Australia 2002-2101. Cat no. 3222.0.

Queensland Health's Directions for Aged Care 2004-2011

The purpose of *Queensland Health's Directions for Aged Care 2004-2011* is to provide direction to health service providers on meeting older people's health and aged care needs while respecting their (and their carers') choices about that care. It will inform future health service planning decisions.

The document is primarily targeted to those 65 years and over and those 45 years and over who are from Aboriginal and Torres Strait Islander backgrounds. It is recognised however, that persons younger than this may require interventions and support that are characteristic of older persons.

The document focuses on areas that require attention now, to ensure Queensland Health continues to deliver quality services to our ageing population. It recognises the need to both support continuing good health and provide services for those whose health status has been compromised.

Directions for Aged Care addresses seven policy areas:

Acute hospital services

Care for older Aboriginal and Torres Strait Islander peoples

Community care

Dementia care

Mental health care

Residential aged care

Workforce

These policy areas were chosen as they reflect the main care areas and conditions relevant to older people. A separate workforce component has been included to address the issue of a declining aged care workforce.

The outcomes sought for older people and their carers by 2011 are as follows:

- Older people will receive patient-centred care in hospitals from staff equipped with enhanced knowledge and skills to deal with their complex needs
- There will be an integrated assessment system across the full care continuum with a comprehensive referral system to ensure people are directed to the most appropriate care service in their setting of choice
- People living in Queensland Health Residential Aged Care Facilities will receive quality care in line with the *Aged Care Act 1997 and Principles*
- People living with dementia will have access to a greater range of services to improve their quality of life
- Carers will have better respite options, education and training, and ongoing support to help them continue to take on the role of carer

- Integrated Community Care services will meet older people's changing needs as their condition deteriorates
- Partnerships with the non-government sector will be strengthened
- All services, both mainstream and specific, will provide care in a culturally respectful way for Aboriginal and Torres Strait Islander peoples and for those from culturally and linguistically diverse backgrounds
- Older people with mental health problems will have better access to mainstream aged care services
- Older people from rural and remote regions will have access to generalist and specialist services to meet their health and aged care needs

The policy context

The *Smart State: Health 2020 Directions Statement* (Queensland Health 2002) provides a general description of key directions for the Queensland Health system and is the visionary document by which Queensland Health operates. *Smart State: Health 2020* states that strategies for the delivery of health services to older Queenslanders must address integrated and accessible health care, strengthening primary and community care, effective rehabilitation services and, providing access to residential aged care. In addition there is acknowledgment that an ageing population will increase demand for health services over the coming two decades.

Queensland Health's Directions for Aged Care 2004-2011 endeavours to build upon the vision provided in *Smart State: Health 2020* to provide a more detailed vision for the delivery of aged care services in Queensland.

Queensland Health's Directions for Aged Care 2004-2011 does not specifically target health promotion or disease prevention strategies, as these are addressed in other Queensland Health documents such as *the Queensland Health Outcome Plans* and the *Statewide Action Plan: Falls Prevention in Older People 2001-2006*. The Mental Health and Aboriginal and Torres Strait Islander components do, however, incorporate health promotion initiatives as these are not well represented in other aged care initiatives for these target groups.

Appendix A (page 71) refers to a number of relevant policy documents/statements used to guide the development of *Queensland Health's Directions for Aged Care 2004-2011*.

Principles

The principles underpinning the *Directions for Aged Care 2004-2011* are:

Dignity

- Valuing and supporting the dignity and diversity of older people
- Respecting, protecting and promoting the rights of clients of health services, and their respective carers

Independence

- Maintaining and where possible returning the client to previous levels of independence

Client focus

- Organising services around meeting the needs of clients
- Providing culturally respectful care

Access

- Providing access to health services regardless of social, cultural or religious background, mental health status or location

Coordination

- Linking clinical treatment and care that spans community, hospital and residential aged care settings

Quality

- Providing services according to the *Aged Care Act and Principles 1997*
- Providing treatment and care that meets industry best practice

Carer recognition

- Recognising and supporting the valuable contribution of carers

Collaboration

- Developing and strengthening partnerships with government and non-government providers

Implementation and evaluation

Implementation of strategies identified in *Directions for Aged Care* will be aligned with the *Integrating Strategy and Performance (ISAP)* initiative, which is Queensland Health's vehicle for achieving the Queensland Government's *Smart State: Health 2020* vision and the *Queensland Health Strategic Plan 2004-2010*.

Implementation will be guided by an implementation plan that allows for strategies to be rolled out in two phases.

Phase I (2004 to 2005/6) will focus on:

- development and enhancement of interdisciplinary partnerships
- evaluation of trials and pilot projects
- identification of best practice models to be rolled out across the State
- promotion of cultural change by District "champions" who are willing to use new approaches
- following different patterns and timeframes in different Health Service Districts and Zones depending upon the state of existing services and infrastructure.

Phase II will be developed at a later stage of implementation.

An evaluation of Phase I of implementation will occur in late 2005. The evaluation will be based on key outcomes identified in the document and performance indicators that are relevant to Phase 1.

Acute hospital services

Older people are high users of treatment services, particularly hospitals, with almost half (46 per cent) of the total bed-days in all Queensland state hospitals being used by people aged 65 and over². A significant proportion of this use is for non-acute services, such as rehabilitation, long term care, palliative care and assessment. For example, during 2002/2003, 67 per cent of the non-acute bed days in Queensland hospitals were occupied by people aged 70 and over³.

The trend for shorter lengths of stay in acute hospitals may not always be appropriate for older people. Many older people have complex health care needs, often involving more than one condition, and involving both chronic and acute conditions.

Older people may have ongoing support needs related to chronic conditions. They may also require support services following acute episodes because they have a slower recovery rate than younger people.

In future, hospital services must expand their focus beyond delivering acute care, to allow for longer hospital stays. They will have to deliver acute and non-acute care and also improve the coordination of their services with community health and social care services.

Queensland Health's Directions for Aged Care 2004-2011 focuses on care services provided to admitted patients and emergency services to non-admitted patients in both large and small hospitals. Large hospitals face challenges in coordinating patient care from a variety of disciplines. Smaller rural hospitals are challenged with access to specialist geriatric care. In many cases, due to the absence of residential aged care beds in the area, smaller rural hospitals take on the long term care of many older persons.

Implementation of the *Directions for Aged Care* will lead to:

- improved access to appropriate hospital services
- an improved care continuum and a more effective hospital interface with other services
- improved access to geriatric care in rural and remote hospitals

2 Australian Hospital Statistics 1999-00. Health Services Series No. 17. Australian Institute of Health and Welfare.

3 Queensland Hospital Admitted Patient Data Collection (QHAPDC) – Queensland Health (extracted 7 October 2003).

Action area 1: Assessment

Key outcome:

- Older patients presenting to Queensland public hospitals will receive appropriate, comprehensive and efficient assessments of need

Performance indicators:

- Increased number of patients receiving risk screening
- Increased number of patients identified as ‘at risk’ undergoing comprehensive assessment
- Client/carer satisfaction

Outcomes	Strategies
Older persons presenting to emergency departments will undergo appropriate screening to identify risk of adverse health outcomes.	Review existing emergency department screening procedures for older persons to be accurately screened for risk factors related to adverse health outcomes (e.g. including physical, psychological, cultural, social factors).
Older people with a positive risk screen have a comprehensive interdisciplinary assessment.	Review existing comprehensive assessment procedures to determine their capacity to accurately identify care needs and incorporate the input of interdisciplinary health professionals, including community service providers.
Older people at risk of adverse health outcomes have a care plan developed early in their admission that reflects their immediate and post discharge needs.	Provide education and training to hospital staff on Continuity of Care Planning including the development of interdisciplinary care plans.
Geriatric assessments within the hospital setting will not be unnecessarily repeated.	<p>Arrange for full comprehensive gerontological assessments and treatment options before Aged Care Assessment Teams (ACATs) conduct their assessments.</p> <p>ACATs and other hospital assessment teams to determine ways to appropriately share patient information.</p>
Assessment outcomes will be clearly communicated to both patients and carers in a culturally appropriate manner.	Educate hospital staff on how to access services (including interpreter services) for those from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander backgrounds, to enable older persons and carers to make informed decisions.

Outcomes	Strategies
Hospital emergency departments will offer appropriate environments for older patients.	Develop guidelines for existing emergency departments to facilitate screening and assessment activities and minimise patient discomfort (e.g. quiet areas for assessment, observation beds).

Action area 2: Access

Key outcome:

— *Older people will have access to aged care specific health services according to need*

Performance indicators:

— *Patient/carer satisfaction*

— *Timely access to services as identified in care plan*

Outcomes	Strategies
Patients will be treated appropriately based on their condition irrespective of other considerations.	Develop hospital policies that clearly state that acute hospital care is provided to patients regardless of age, mental, physical, financial and social status.
Patients will be able to access sub-acute and transition care in a timely and appropriate manner.	<p>Develop flexible models (acute or community settings) for sub-acute and transition care to minimise premature residential/continuing nursing care.</p> <p>Develop admission and intra-hospital referral protocols that facilitate a smooth transition for the patient when accessing acute, transitional, step down and community care services.</p>
Patients in rural and remote hospitals will receive specialist geriatric input into their assessment and care.	<p>Increase the use of communication technologies, including TeleHealth, to enable health professionals from rural and remote areas to access specialist geriatric services when diagnosing and treating patients in acute care settings.</p> <p>Network rural and remote facilities to specialist geriatric care services to enable communication and, where possible, organise visits to these facilities.</p>

Outcomes	Strategies
A continuity of care planning (CCP) framework, considerate of the unique needs of older people, will be distributed to all hospitals.	Provide Queensland Hospitals with the General Practice Advisory Council (GPAC) Continuity of Care Framework to be incorporated into hospital in-training sessions and discharge planning procedures.
Patients will experience uninterrupted access to community services after discharge.	Hospitals develop and maintain partnerships/ collaboration with local community service providers (including residential aged care facilities) to facilitate a smooth transition for the patient from the acute to the community setting.

Action area 3: Service delivery

Key outcomes:

- Care will be delivered that addresses the unique needs of older persons including broader social and psychological needs
- Avoidable admissions of older persons will be reduced and unnecessary re-admissions minimised

Performance indicators:

- Care plans reflect sound application of geriatric care principles
- Reduction in patient admission and re-admission rates
- Patient/carer satisfaction

Outcomes	Strategies
Planning for patients’ post discharge needs is coordinated and where possible services are secured before discharge.	Arrange that, where possible, CCP is undertaken by a single staff member – or coordinated by a team - knowledgeable on the interface between the hospital and community and able to secure services for the patient prior to discharge.
Patient Continuity of Care Planning issues will be clearly communicated to community service providers.	Educate staff on the need to forward discharge summaries in a timely manner to the patient’s principal community practitioner(s) (e.g. GP, case manager).

Outcomes	Strategies
Care needs of older people will be addressed through evidence-based, standardised care.	<p>Develop evidence-based standards for delivering care to older persons, including on the appropriate length of stay (LOS) for older patients occupying acute beds.</p> <p>Encourage the use of case management models for older patients with complex care needs.</p> <p>Investigate the feasibility of linking hospital accreditation with providing agreed minimum standards of care for older patients.</p>
<p>Avoidable admissions will be reduced.</p> <p>Unnecessary re-admissions will be reduced.</p>	<p>Adopt appropriate models of acute and sub acute care delivery in non-hospital settings (e.g. “hospital in the nursing home” and “hospital in the home”).</p> <p>Develop guidelines, procedures and educational strategies for hospitals and residential aged care facilities to prevent unnecessary re-admissions after discharge back to the community.</p>
Client’s medication will be administered and monitored according to APAC guidelines.	All Queensland Health hospitals, through the Queensland Health Quality Use of Medicines Program, will be provided with resources/education/training to adhere to the Australian Pharmaceutical Advisory Council “National guidelines to achieve the continuum of quality use of medicines between hospital and community” (1998).
A service planning model will be developed to determine future demands on hospital services.	Arrange for health service districts and appropriate policy and business units to work together to develop a comprehensive service planning model.

Action area 4: Carers

Key outcome:

- *The needs and contribution of carers will be considered when an elderly person is in a hospital setting*

Performance indicators:

- *Evidence of carer input into patient assessment and care plans*
- *Patient/carers satisfaction*

Outcomes	Strategies
<p>Carers will be provided with the opportunity to provide input into patient assessment and care.</p>	<p>Develop guidelines that encourage the incorporation of carer input into the patient assessment process and the development of care plans.</p> <p>Educate hospital staff on methods of determining if carers can deliver all or some post-acute care, and educate them on how to do this.</p>
<p>Hospital staff will be aware of the carer’s role and the pressures that may be experienced by carers.</p> <p>Carer needs will be routinely identified and addressed.</p>	<p>Educate hospital staff on the pivotal role carers play in delivering care to older persons and the personal stress that may be experienced by the carer.</p> <p>Identify carer’s needs and take them into consideration when determining the care requirements of older patients.</p> <p>Incorporate carer needs into Continuity of Care Planning.</p>
<p>Staff will be able to advise on and assist with acquiring appropriate emergency respite services.</p>	<p>Determine emergency respite services available in various locations across the State.</p> <p>Educate staff on assisting carers to locate and secure appropriate respite services.</p>

Action area 5: Partnerships

Key outcomes:

- *Strengthened partnerships in delivering acute care services and their integration with the community*
- *Integrated support for research and development into best practice service delivery*

Performance indicators:

- *Improved partnership initiatives/activities in patient care, referral and research*
- *Research on best practice service delivery coordinated and/or funded by Queensland Health*
- *Service provider satisfaction*

Outcomes	Strategies
Patient care will flow smoothly from the hospital to the community setting.	In partnership with community based service providers develop referral procedures, guided by the Continuity of Care Planning framework, that facilitate patient transfer from the hospital to the community (e.g. streamlined assessment, referral pathways, discharge summaries).
Service providers will receive information within appropriate timeframes.	<p>Establish consensus on service providers' information needs (both patient and general service-related) within and beyond the hospital setting, and facilitate the exchange of this information.</p> <p>Determine the most appropriate methods for information transfer between settings and service providers, and if these should be standardised or adapted to local situations.</p> <p>Develop and use protocols for information exchange including options for client-held records and/or web-based applications.</p>
General practitioners and other service providers will provide relevant input into patient care plans.	Arrange dialogue between Divisions of General Practice, representative organisations for domiciliary nurses and key hospital staff to determine viable methods of incorporating input into patient care plans.

Outcomes	Strategies
There will be research and development of care models for older people in acute settings.	Develop partnerships with universities and research bodies to encourage research into best practice for delivering care to older patients in acute settings.
Established role and functions of the private health sector in delivering aged care.	Queensland Health, the Australian Government and private insurers investigate the feasibility of transferring patients with private health insurance, occupying public beds, to post discharge care coordinated and funded by private health service providers/insurers.

Care for older Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander Australians have a much younger profile than the population generally. Their life expectancy at birth is up to 20 years shorter than that for other Australians. Therefore, Aboriginal and Torres Strait Islander peoples can be expected to access aged care services from the age of 45 years onwards.

Many older Aboriginal and Torres Strait Islander peoples experience problems accessing appropriate levels of service, because they live in isolated communities in rural and remote areas of Queensland.

However, health and aged care services are only part of the equation. Older Aboriginal and Torres Strait Islander peoples prefer to remain in their community for as long as practicable. The capacity of families and communities to provide care is crucial for this to occur. If communities cannot cope, frail aged people are at greater risk of premature or inappropriate admission to residential aged care or hospital.

Queensland Health's *Directions for Aged Care* is consistent with:

- *Queensland Health's Aboriginal and Torres Strait Islander Health Strategy 1994* (under review)
- *Queensland Mental Health Policy Statement for Aboriginal and Torres Strait Islander People 1996*
- *Agreement on Aboriginal and Torres Strait Islander Health 2002*
- *Torres Strait Islander Health Framework Agreement 1999*

At a national level, *Directions for Aged Care* is aligned with each of the key principles of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments July 2003* and the national *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2003-2008*.

Directions for Aged Care recognises that Aboriginal and Torres Strait Islander peoples are two distinct cultural groups and that the circumstances of each individual community are different; therefore a flexible approach to service delivery is required.

Directions for Aged Care supports the principles of community participation and ownership, at all levels. It aims to ensure cultural respect in assessment and service delivery for all older Aboriginal and Torres Strait Islander peoples and their carers across Queensland.

This document outlines initiatives to improve access to assessment and service delivery and describes measures to increase support services for carers and communities.

Implementation of the *Directions for Aged Care* will:

- support a continuum of care that allows older Aboriginal and Torres Strait Islander peoples to remain in their community for as long as practicable, but also provide access to residential aged care if necessary
- provide ease of access to a full range of services, including more intensive community services that directly substitute for both low and high level residential aged care
- enhance support services to Aboriginal and Torres Strait Islander communities to assist them to fulfil their role as carers
- ensure Aboriginal and Torres Strait Islander peoples have direct input into government decision making in the planning, design and delivery of health and aged care services through statewide, regional and local partnerships

Action area 1: *Assessment*

Key outcome:

– *Improved cultural appropriateness and effectiveness of assessment services*

Performance indicators:

- *Increased use of culturally respectful tools and practices when assessing Aboriginal or Torres Strait Islander peoples*
- *Client/carer satisfaction*

Outcomes	Strategies
Assessment tools and processes will be culturally respectful.	Develop assessment tools and processes which respect cultural differences. Train assessment staff in the use of culturally respectful tools. Include the District Coordinators – Indigenous Health Services in all health and aged care assessment processes for Aboriginal and Torres Strait Islander clients e.g. those conducted by ACATs and hospital discharge planners. Streamline assessment processes and share information to minimise alienation of clients e.g. examine ways to implement a system of client held records.

Action area 2: Access

Key outcome:

– *Improved access to services across the care continuum for clients and carers*

Performance indicators:

- *Increased use of services by communities and/or individual Aboriginal or Torres Strait Islander peoples*
- *Client/carer satisfaction*

Outcomes

Strategies

Aboriginal and Torres Strait Islander clients and carers – including those from rural and remote areas – will have increased choices when accessing residential and/or community services.

More services for Aboriginal and Torres Strait Islander peoples will be available.

Aboriginal and Torres Strait Islander clients and carers will have improved access to the full range of services.

Build capacity for Aboriginal and Torres Strait Islander HACC organisations to deliver the services required to keep HACC eligible people at home in their communities, by:

- Providing training and support for culturally specific service providers.
- Implementing the *Home and Community Care Aboriginal and Torres Strait Islander Service Development Plan*.

Negotiate with the Australian Government for:

- greater numbers of CACPs.
- the full rollout of EACH packages.
- increased funding for Aboriginal and Torres Strait Islander Flexible Services.
- continued prioritisation of the expansion of HACC services specifically for Aboriginal and Torres Strait Islander communities.

Examine ways to secure more respite services (residential, palliative, emergency, overnight and in-home) without the need for an ACAT assessment, e.g. enable day respite centres to provide overnight care.

Consider providing additional Multipurpose Health Services in rural and remote Aboriginal and Torres Strait Islander communities.

Accelerate HACC service reforms and improve service availability for HACC eligible Aboriginal and Torres Strait Islander clients and their carers.

Outcomes	Strategies
	<p>Review funding methodology in consultation with the Australian Government to ensure equitable distribution of resources to older Aboriginal and Torres Strait Islander peoples and their carers in rural, remote and urban centres.</p> <p>Investigate the feasibility of removing access barriers to services such as client financial contributions and the need to provide own transport.</p>
<p>Older Aboriginal and Torres Strait Islander clients and carers will have access to culturally respectful services.</p>	<p>Employ Aboriginal or Torres Strait Islander clinical staff or an appropriate liaison officer who is familiar with inter-agency links and cultural issues.</p> <p>Encourage cultural awareness training across all government departments.</p>
<p>Aboriginal and Torres Strait Islander clients and carers will be able to make informed choices along the care continuum.</p>	<p>Provide culturally respectful education and information to raise awareness about the ageing process and the services available.</p> <p>Use appropriate visual design (language, art and symbols) in information and health promotion material.</p>
<p>Clients and carers will be comfortable in accessing mental health services that are appropriate to their needs.</p>	<p>Raise awareness about mental health problems for older Aboriginal and Torres Strait Islander peoples and the need to incorporate mental health as part of the continuum of care.</p> <p>Increase awareness of the role of Aboriginal and Torres Strait Islander Health Workers and Indigenous Mental Health Workers in the community.</p> <p>Advance an Aboriginal and Torres Strait Islander-specific health promotion, illness prevention and early intervention approach to mental health care that includes education for the broader community, consumers and carers.</p>

Action area 3: Service delivery

Key outcome:

– Improved service delivery which is culturally respectful

Performance indicators:

- Increased services offered to Aboriginal or Torres Strait Islander peoples that are culturally appropriate/respectful
- Client/carer satisfaction

Outcomes	Strategies
Older Aboriginal and Torres Strait Islander clients and carers will be comfortable in using all Queensland Health services.	<p>Implement culturally respectful service delivery protocols and care procedures e.g. accommodating gender issues, in all settings.</p> <p>Develop Continuity of Care Planning procedures that respond to the broader health and cultural needs of Aboriginal and Torres Strait Islander peoples.</p> <p>Investigate the capacity for services to implement physical design that is culturally respectful.</p>
Aboriginal and Torres Strait Islander clients and their carers will be able to use flexible services which are appropriate to their needs, across the range of settings.	<p>Include identification of the Aboriginal and Torres Strait Islander status of older people in all data collection activities, in line with established protocols.</p> <p>Identify gaps in service provision.</p> <p>Collaborate with other service providers for better integration of acute care services, culturally specific primary health services, GP services and community clinics.</p> <p>Provide follow-up home visits after discharge from hospital, where possible.</p> <p>Ensure appropriate complaints mechanisms operate across all sectors and in all settings.</p> <p>Examine ways to combine HACC, CACPs and residential aged care in one location, to avoid unnecessary uncertainty and confusion for clients and carers.</p>

Outcomes	Strategies
	Develop flexible and culturally respectful models of care, in collaboration with service providers and other State Government departments, Aboriginal Community Controlled Health Services (ACCHSs), Aboriginal Medical Services (AMSs) and Australian Government agencies.
	Examine ways to deliver more flexibility and cultural respect within existing service models and funding guidelines, e.g. allowing more time for service provision to accommodate a holistic approach.
	Examine ways to improve the portability of CACPs and HACC services when clients relocate.

Action area 4: Carers

Key outcome:

- Increased capacity within Aboriginal and Torres Strait Islander communities to fulfil their role as carers

Performance indicators:

- Increased access/use of carer support services
- Client/carers satisfaction

Outcomes	Strategies
Aboriginal and Torres Strait Islander communities will be able to access increased levels of carer support and education.	<p>Empower carers to participate across the full range of health and aged care settings.</p> <p>Examine ways to assist in developing carer support groups in local areas to enable the sharing of information and strengthen support networks.</p> <p>Examine ways to secure a range of culturally respectful and flexible respite services.</p>

Outcomes	Strategies
	Use Indigenous Mental Health Workers to disseminate information to family and carers about the type of mental health problems faced by older Aboriginal and Torres Strait Islander peoples.
	Provide specific education resources to support carers of older Aboriginal and Torres Strait Islander peoples with dementia.
	Investigate the feasibility of providing appropriate accommodation and transport for carers.

Action area 5: Partnerships

Key outcome:

- *Strengthened partnerships in planning, designing and delivering health and aged care services to Aboriginal and Torres Strait Islander peoples*

Performance indicators:

- *Improved partnership initiatives/activities with services delivered to older Aboriginal and Torres Strait Islander peoples*
- *Client/carer satisfaction*
- *Service provider satisfaction*

Outcomes	Strategies
Formal and informal partnerships will be established/strengthened at the statewide, regional and local levels to collaborate in planning, designing and delivering health and aged care services for older Aboriginal and Torres Strait Islander peoples.	Engage with, and empower the Queensland Aboriginal and Torres Strait Islander Health forums, Health Reference/Health Action Groups and local community members to participate in the decision making process.
Aboriginal and Torres Strait Islander peoples will have direct input into government planning and decision making.	Encourage mental health professionals to collaborate with Aboriginal and Torres Strait Islander Health Workers, Indigenous Mental Health Workers and/or key people within the local Aboriginal or Torres Strait Islander community, across the health spectrum.

Outcomes	Strategies
	<p>Include aged care as a standing item on the agenda for Aboriginal and Torres Strait Islander Zonal Health Coordinators' Forums.</p>
	<p>Develop Memoranda of Understanding (MOUs) between Health Service Districts, the Queensland Divisions of General Practice, AMSs, ACCHSs, ACATs, Australian Government agencies, HACC, DSQ to ensure integrated service provision.</p>
	<p>Promote local networks between agencies to facilitate the coordination and cooperation of services.</p>
	<p>Promote partnerships between mainstream and culturally specific service providers.</p>
	<p>Promote MOUs between Queensland Health and other agencies (e.g. Education Queensland and the Department of Housing) where appropriate for specific initiatives.</p>
	<p>Use existing partnerships to progress initiatives e.g. the Queensland Aboriginal and Islander Health Forum and the Primary Health Care Access Program.</p>

Community care

The clear preference of older people and their carers is to remain at home for as long as practicable. Assisting people to act on that preference is a key objective of Queensland Health.

Queensland Health provides or funds programs and services for older people who are frail or suffer from one or more chronic conditions. These include health promotion initiatives, health maintenance and support programs such as the Home and Community Care Program (HACC), assistance with aids and appliances, spectacles and dental schemes and various ambulatory care services. Some, notably HACC, also target younger people with a disability. While *Directions for Aged Care* is directed at older people, younger people with disabling conditions will also benefit.

The Australian Government is also a major funder of community services through programs such as the National Respite for Carers Program, Community Aged Care Packages (CACPs) and Veterans Home Care (VHC). It is also a substantial contributor to HACC.

Unfortunately, community care has become unnecessarily complex. Finding the right organisation to provide the right service is not always an easy task. Currently, older people and their carers face a confusing mix of assessment services that often results in frustration at being over-assessed when only a simple service is required. A more integrated approach to assessment is needed to improve the level of services and response times.

There is support across consumer and provider organisations for a clear continuum of community care that enables older people to age in place with support increasing in direct proportion to need. HACC support is at the beginning of the continuum, usually when people are still in their own homes. Once clients are assessed as meeting the criteria for admission to residential aged care, alternative Australian Government funded services are required to maintain them at home.

The community care system has many strengths including dedicated and skilled staff and a long tradition of volunteers supporting older people. Formal community care and health services are only part of the equation. Partners, families and friends, as live-in carers or supporting carers, play vital roles in maintaining frail older people living in their own homes with a degree of independence.

Implementation of the *Directions for Aged Care* will:

- facilitate an effective continuum of care for older people and their carers
- build a strong client-oriented system that features simple access, consistency in assessment and quality service responses
- build upon existing arrangements between Queensland Health, the Australian Government, non-government organisations and general practitioners, to provide better access to inter-disciplinary care for older people
- better meet the needs of the culturally and linguistically diverse, and Aboriginal and Torres Strait Islander peoples

Action area 1: Assessment

Key outcome:

- *Reduced duplication and unnecessary assessment of older people accessing community services*

Performance indicators:

- *Reduction in assessments (screening and comprehensive) for clients accessing community services*
- *Client/carer satisfaction*
- *GP/health professional and; other community service provider satisfaction*

Outcomes	Strategies
<p>Simplified screening and assessment arrangements for access to community services across the continuum of care.</p> <p>Screening processes will accurately identify the need for comprehensive assessment.</p> <p>Providers will have a clear understanding of the roles and responsibilities for screening and assessment at various levels.</p>	<p>Establish three different levels of assessment activity:</p> <ol style="list-style-type: none"> 1. service eligibility 2. functional screening 3. comprehensive assessment. <p>Implement the Ongoing Needs Identification (ONI) screening and assessment tools and protocols.</p> <p>Provide training and assistance to HACC services and other primary care providers in using the screening tools.</p> <p>Investigate methods for conducting assessments in rural and remote areas where staff numbers are limited and travel required is extensive (e.g. Internet and web based technology, videoconferencing etc).</p>
<p>Clients will be assessed less frequently and more appropriately, including by GPs.</p> <p>Surplus resources currently used for multiple assessments will be used for direct service delivery.</p> <p>Assessment outcomes and service levels will be better tracked.</p> <p>Clients will have access to a client held record.</p>	<p>Negotiate with the Australian Government on a strategy to facilitate comprehensive assessments of people seeking high levels of support through HACC or Australian Government funded community or residential aged care.</p> <p>Develop clear principles and guidelines for comprehensive assessment and conduct demonstration projects to trial various models in both rural and metropolitan centres.</p> <p>Assign responsibility, training and resources to integrated Aged and Community Care Assessment Teams or other services to accept a greater assessment role.</p> <p>Educate key organisations on assessment services and implementation arrangements.</p>

Action area 2: Access

Key outcome:

– Improved access to community care services

Performance indicators:

- Proportion of HACC services accessed by older people as indicated in assessment outcomes
- Client/carer satisfaction

Outcomes	Strategies
<p>Clients and their carers will be able to access services that are flexible and responsive to their immediate needs, and in a variety of settings.</p> <p>Community aged care programs will allow ageing in place in the community.</p> <p>There will be simpler systems for consumer access.</p>	<p>Negotiate with the Australian Government to place HACC, CACP and EACH along a continuum of care with agreed service parameters that enable ageing in place.</p> <p>Fund specialist HACC comprehensive services to redirect recurrent funding for assessment activity to direct service delivery.</p> <p>Review HACC funding methodology in consultation with the Australian Government to ensure equitable distribution of resources to older people and their carers in remote, rural and major population centres.</p> <p>Investigate the feasibility of a single/central point of entry into the HACC Program e.g. Customer Call Centre.</p> <p>Investigate barriers to clients accessing HACC services due to transport limitations.</p>
<p>Older people will have better access to integrated medical, nursing and allied health care.</p>	<p>Assess outcomes of the coordinated care trials and other HACC funded models.</p> <p>Apply outcomes to establish integrated partnership arrangements between general practitioners and Queensland Health.</p>
<p>Older people will have better access to community based rehabilitation</p>	<p>Explore opportunities to fund and further expand community based rehabilitation that relies on a multi-disciplinary approach to achieve client outcomes.</p>

Outcomes	Strategies
Client information will be able to be accessed/held in a variety of formats by authorised service providers.	Determine the capacity for secure electronic transfer of client information.

Action area 3: Service delivery

Key outcome:

– *Community care services will be delivered in an efficient and client focused manner*

Performance indicators:

- *Positive service performance reviews*
- *Client/carer satisfaction*
- *GP/health professional; and other community service provider satisfaction*

Outcomes	Strategies
Australian Government /State government responsibilities in service provision will be more clearly aligned.	Negotiate with the Australian Government on separating funding for basic services and high needs services, ensuring links with Australian Government Own Purpose Funded Packages (e.g. CACPS).
Funding and feasibility of high usage HACC services (which may be substituted for residential aged care) will be reviewed.	<p>Map and evaluate HACC funded models for high-needs pools.</p> <p>Determine most appropriate models for integrating HACC services with MPHS in rural and remote areas.</p> <p>Investigate the potential to pool these funds with Australian Government programs that substitute for residential aged care.</p>

Outcomes	Strategies
HACC organisations will have improved economies of scale and range of services.	Use HACC purchasing processes and incentives to encourage existing providers to take on additional service types.
Service delivery, particularly in domestic assistance and support, will be more efficient.	<p>Use contracting arrangements to encourage smaller providers of a single service type to integrate with other providers in the same geographic area.</p> <p>Encourage co-location of HACC services where practicable.</p> <p>Educate smaller organisations to share resources and business management tasks (e.g. payroll).</p> <p>Develop clear policies for use by HACC service providers when discharging clients are transferring to another service provider.</p>

Action area 4: Carers

Key outcome:

- Carers will have improved access to a greater range of support

Performance indicators:

- Increased range and use of carer support services
- Client/carer satisfaction

Outcomes	Strategies
Carers will play an increased role in the care of older people.	Develop resources and training for staff to effectively involve carers in decision making and care planning.
Improved access to carer education, training and support.	Provide opportunities for carers to participate in planning and developing policies and programs for older people.

Outcomes	Strategies
	<p>Establish a carer education and training model including topics on manual handling, reducing injury, care planning etc.</p> <p>Support carers to access appropriate counselling and support services.</p>
Increased use of flexible carer respite.	Extend the availability of respite (including in home respite, centre based day respite and short term residential respite) through HACC regional planning processes where funding allows.
Carers will have easier access to respite options.	<p>Standardise and align State and Australian Government respite programs.</p> <p>Establish a clear respite framework through collaboration with the Australian Government and consultation with providers and older persons' advocacy organisations.</p>

Action area 5: Partnerships

Key outcome:

- *Strengthened partnerships in delivering community care services*

Performance indicators:

- *Improved partnership initiatives/activities between local, state and national community care service providers*
- *Client/carer satisfaction*
- *Service provider satisfaction*

Outcomes	Strategies
Arrangements between general practitioners and Queensland Health will be more integrated.	<p>Promote stronger links between general practitioners, Queensland Health Community Health Services and community managed services to improve coordination of care and resources, through:</p> <ul style="list-style-type: none"> • information sharing among providers • collaborative funding arrangements

Outcomes	Strategies
Services will be more responsive to the community care needs of older people.	Consult with carer and advocacy organisations about local planning and priority setting to develop better models of care.
Older people will experience the benefits of a more integrated service system.	Develop partnerships with general practitioners and non-government providers to improve communication and cooperation between sectors.
Stronger relationships with other government and non-government organisations will exist.	Continue involvement in cross-departmental and inter-governmental initiatives that address social isolation, housing and support arrangements for both older people and younger people with disabilities.

Dementia care

Dementia is a syndrome that can result from a number of diseases that affect the brain. Its variable presentation makes it difficult to understand and there are still many gaps in our knowledge regarding this condition.

The incidence of dementia rises with age. As the population ages, particularly with the increase in those aged 85 and over, there will be a significant increased demand for dementia care.

Dementia is one of the main reasons for people needing residential aged care. A survey of State Government residential aged care facilities in 2000 showed that more than 70 per cent of residents had some degree of dementia.

People living with dementia and their carers should be able to access appropriate services across all settings – acute, community and residential. Staff need to be aware of their special needs and must be trained to work confidently and supportively with them.

Carers play a vital role in supporting older people living with dementia to remain in the familiar environment of their own homes.

Carers need appropriate support to sustain their caring role in the community. They need to be able to access respite care in times of crisis and to be an active partner in service planning processes. This is particularly important when people living with dementia exhibit behaviours that affect not only the person, but also their spouse, family and other carers.

Queensland Health has used feedback from a dementia care workshop and other consultations to develop strategic policy directions that will guide the future development of dementia services across the State.

Directions for Aged Care will deliver improved early assessment, diagnosis and early interventions for people living with dementia, and will reduce diagnostic confusion between delirium and dementia.

Although *Directions for Aged Care* is targeted towards services for older people, appropriate care will also be provided to younger people living with dementia. This will include Aboriginal and Torres Strait Islander peoples who, because of their lower life expectancy, may require these services at an earlier age.

Implementation of the *Directions for Aged Care* will:

- provide improved access to appropriate quality services, across a variety of settings, for people living with dementia and their carers
- enable better coordination at the interface of different services, such as acute/residential or community/mental health

- provide more appropriate access to care, at a time of crisis, for people living with dementia
- enhance support services for carers

Action area 1: Assessment

Key outcome:

- *Better targeted and more appropriate assessment of older people living with dementia*

Performance indicators:

- *Evidence that assessments incorporate processes for accurate dementia diagnosis*
- *Client/carer satisfaction*

Outcomes	Strategies
People with dementia will have improved access to assessment services.	Develop an independent approach to assessment of older people with dementia (through Integrated Aged and Community Care Assessment Teams) that comprehensively covers dementia care requirements, including community care, in addition to the need for residential aged care.
People with dementia will not face multiple assessments to receive a range of services.	Provide dementia-specific training for Aged Care Assessment Team staff.
	Develop appropriate referral and clinical pathways to enhance the sharing of assessment information between service providers, including GPs and pharmacists.
	Use interpreters, where required, to assist in the assessment process for peoples from culturally and linguistically diverse backgrounds and for Aboriginal and Torres Strait Islander peoples.

Outcomes	Strategies
Staff will be better able to distinguish delirium from dementia.	Establish assessment criteria to assist early identification and appropriate management of delirium, prior to any referral for an assessment/diagnosis of dementia or other cognitive impairment.
Early assessment, diagnosis and treatment of dementia, including behavioural management, will be standard practice.	Incorporate the need for early detection of cognitive impairment and early diagnosis of dementia into policies, procedures and training for a variety of disciplines.

Action area 2: Access

Key outcome:

- *Improved access to a range of services for people living with dementia*

Performance indicators:

- *Increased number and range of dementia care options available to clients and carers.*
- *Client/carer satisfaction*

Outcomes	Strategies
An increased range of dementia care services will be available in all health service districts.	Identify the health service districts in each zone that will provide dementia expertise.
People with dementia will have improved access to, and choices for respite care.	Provide training on cultural issues to service providers that care for clients from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds.
	Facilitate access across districts to a range of more flexible and holistic dementia care options, including those living at home without a carer.
	Develop appropriate service models that offer a range of respite options for people living with dementia and their carers.

Outcomes	Strategies
<p>People in rural and remote areas living with dementia will have improved access to and choice of services.</p> <p>Service providers have improved access to specialist support services.</p>	<p>Develop appropriate service models to respond to the challenges of settings where patients living with dementia are in close proximity to acute patients, such as rural hospitals and Multipurpose Health Services.</p> <p>Include relevant protocols and interventions in the Primary Clinical Care Manual.</p> <p>Adopt a zonal network approach to support health workers in rural and remote areas and promote tele/ videoconferencing to provide support.</p> <p>Explore opportunities to broaden the role of the Queensland Dementia Support Team and/or similar services to provide a statewide service.</p> <p>Provide education and training that maximises the use of TeleHealth to access geriatric/ psychogeriatric expertise and support.</p>
<p>Age appropriate services will be available to younger people living with dementia.</p>	<p>Identify appropriate levels and types of dementia care services for younger people that are offered by facilities in health service districts including rural support services.</p> <p>Facilitate the uptake of appropriate models.</p>

Action area 3: Service delivery

Key outcome:

– *Enhanced coordination and quality of care*

Performance indicators:

– *Evidence of use of referral pathways*

– *Client/carer satisfaction*

Outcomes	Strategies
<p>Reduced duplication of services.</p> <p>Services will be more integrated and coordinated.</p> <p>More appropriate referral pathways between services and sectors will exist.</p>	<p>Adopt an integrated approach to delivering dementia care services across community, acute, residential and specialist settings, through the development of:</p> <ul style="list-style-type: none"> • a team approach to service delivery that combines services that currently receive funding from different sources, into a consolidated dementia service. • service models for dementia care that clarify the roles and responsibilities of key service providers. • dedicated and specialised dementia care services operating within residential aged care settings, at a local/district level. <p>This will be achieved by combining expertise and resources (staff and funds) from aged care and mental health to enhance the provision of extended treatment and rehabilitative services.</p> <p>Establish referral pathways for dementia care that provide appropriate advice/support.</p> <p>Explore the capacity to establish additional memory clinics at a district level.</p>

Outcomes	Strategies
Innovative service models for dementia care will be operating.	<p>Develop a service delivery model for dementia clients that targets the special needs of those living in rural and remote communities, including Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Multipurpose Health Services.</p> <p>Develop more flexible service models for dementia care that are consumer orientated (and culturally appropriate).</p> <p>Develop service models that accommodate people with behaviours of concern across a variety of settings.</p> <p>Establish integrated case management models to support people living with dementia in community settings.</p>

Action area 4: Carers

Key outcome:

- Carers able to access appropriate information, advice and support, to enable them to sustain their caring role

Performance indicators:

- Increased range and use of carer support and training
- Carer/client satisfaction

Outcomes	Strategies
Carers will have access to specific training in caring for someone living with dementia.	Provide local and community-specific education programs for families caring for relatives with dementia – including dementia care, behaviour management and respite care through organisations such as the Alzheimer's Association and the Queensland Dementia Support Team.

Outcomes	Strategies
A greater number of people living with dementia who remain at home by choice.	Develop education and training resources for service providers to increase the involvement of carers in the active management of family members with dementia.
Appropriate and timely respite will be available.	<p>Negotiate with the Australian Government, private sector, residential aged care providers and community based organisations to develop more flexible approaches to respite service delivery, including emergency, overnight, short-term and weekend respite services across all settings.</p> <p>Develop outreach initiatives for respite and assistance within the family situation, including residential day care in the home and rural and remote areas.</p>

Action area 5: Partnerships

Key outcome:

- *Partnerships strengthened between services/organisations associated with improving care to those living with dementia*

Performance indicators:

- *Improved partnership initiatives/activities between services/organisations involved in dementia care*
- *Service provider satisfaction*
- *Client/carer satisfaction*

Outcomes	Strategies
Strengthened Australian Government /State Government partnerships regarding dementia care.	Liaise with the Australian Government on dementia care to form/strengthen partnership initiatives for dementia sufferers and their carers.

Outcomes	Strategies
Increased cooperation between services between sectors and service providers.	<p>Foster cooperation between agencies, by encouraging partnerships and using existing forums and links (existing committees, networks) at health service district level.</p> <p>Include activities that foster closer links between psychogeriatric units, residential aged care facilities and the acute sector in health service district plans (links with other health professionals, non-government organisations, GPs and pharmacists also to be considered).</p>
Service providers and the public will have improved knowledge of dementia care services.	<p>Develop forums, incentives and communication strategies that promote awareness of and coordination of services (both government and non-government organisations).</p> <p>Develop information/education networks on community awareness of dementia care.</p> <p>Provide local and community-specific education sessions about dementia for families caring for relatives living with dementia.</p> <p>Use Queensland Health websites to post public access information on dementia.</p>
Evidence-based practice in dementia care will be supported by quality research and development.	Take a leadership role in promoting research into dementia in partnership with universities, colleges and specialists.

Mental health services

Mental health services for older people were identified as a priority in the first *National Mental Health Plan*, endorsed by all States and Territories in 1992. The *Second National Mental Health Plan*, 1998, identifies additional areas of necessary reform as promotion and prevention, partnerships and quality and effectiveness.

The *Ten-Year Mental Health Strategy for Queensland* (1996) also identifies older people as a priority group in the reform of mental health services in Queensland. It defined older persons' mental health services as a 'component of the mental health service which targets older people with mental illness who require both specialised mental health and aged care expertise.'

With the ageing of the population there will be more people with pre-existing mental illnesses living well beyond the age of 65, who will require both mental health and aged care services.

Psychogeriatric services are primarily aimed at people aged over 65 who either suffer from:

- a mental disorder complicating an underlying disorder related to ageing such as dementia with psychotic features, or a mental disorder that has arisen for the first time
- a disorder related to ageing complicating a pre-existing mental disorder (e.g. a person with chronic depression who becomes frail or has multiple medical pathology)

Psychogeriatric services can also support health service providers caring for people with severe behavioural difficulties associated with organic brain disorders such as dementia.

Directions for Aged Care recognises that consumers and carers need to be more involved in all aspects of their care including service planning, delivering and evaluating new models of care. *Directions for Aged Care* also focuses on mental health promotion and prevention of mental health problems for older people and the issue of suicide.

Implementation of the *Directions for Aged Care* will:

- facilitate health promotion, prevention and early intervention initiatives for older people with a mental illness
- enhance service provision for older people requiring both mental health and aged care services
- encourage carer involvement in care planning
- develop key partnerships in delivering clinical and support services to older people and their carers

Action area 1: Assessment

Key outcome:

- *Comprehensive multi-disciplinary assessment services throughout Queensland*

Performance indicators:

- *Increased number of multi-disciplinary assessment services*
- *Evidence of GPs and other health professional participation in assessment activities/services/training*

Outcomes	Strategies
Specialised older people's mental health assessment services will be available when required.	Develop comprehensive assessment protocols and processes, in collaboration with relevant stakeholders, which are transferable across health care agencies.
Streamlined admission processes that reduce duplication of assessment	Support existing consultation liaison teams in developing expertise and providing specialist comprehensive older people's mental health assessments, particularly regarding depression, delirium and dementia.
Promotion of mental health and wellbeing in older people.	
Early identification and intervention of mental disorders.	Develop local networks to ensure links between older people's mental health services and specialised consultation liaison services, for special populations such as the Queensland Transcultural Mental Health Centre Services and Aboriginal and Torres Strait Islander Services.
	Include older people's mental health within broader promotion, prevention and early intervention initiatives.
	Provide specialist input into developing the Queensland Health Suicide Risk Management Framework.

Outcomes	Strategies
Identification and referral of older people with mental illness will improve.	<p>Improve shared training for GPs (particularly bilingual GPs), community nurses and other care providers in contact with older people, to understand the benefits of identifying the early signs and symptoms of mental illness, particularly depression, dementia and delirium.</p> <p>Develop and implement a statewide risk assessment tool to identify older people's mental health issues early.</p>

Action area 2: Access

Key outcome:

- Improved access to specialised mental health care and increased access to aged care facilities for older people with a mental illness

Performance indicators:

- Increased range and use of specialised mental health services
- Increased number of older people with mental illness accessing aged care facilities

Outcomes	Strategies
Community awareness of older people's mental health issues will increase.	Establish regular district/local health forums on older people's mental health and early recognition of symptoms of mental illness.
Improved service provider awareness of service options.	Educate the community about services available to older people including specialised older people's mental health services, behavioural management support services, services for people from culturally and linguistically diverse backgrounds, services for Aboriginal and Torres Strait Islander peoples and adult mental health services.

Outcomes	Strategies
<p>Older people with mental health problems will receive appropriate care in the setting of their choice.</p> <p>Older people with mental illness will be able to access HACC services.</p>	<p>Develop integrated models of care between district mental health services, aged care services and primary health providers (including GPs), to address access to a range of flexible and holistic care and respite options.</p> <p>Review current HACC guidelines on access to services by older people with co-morbid health issues.</p> <p>Investigate and remove barriers to access services.</p>
<p>Improved quality and consistency of access to services.</p>	<p>Develop clinical care pathways, protocols and procedures to facilitate the process of transfer between health settings.</p>
<p>Consumers will have improved access to specialised assessment services in rural and remote areas.</p> <p>Older people with mental illness in rural and remote areas will have better access to specialised mental health services.</p> <p>Rural and remote district teams will have better access to specialised older people's mental health services.</p>	<p>Promote access to, and use of telepsychiatry services and e-mental health services in line with the Statewide TeleHealth Strategy.</p> <p>Establish networks between specialised older people's mental health and district mental health services, for consultation liaison advice, support and assessment services in all areas.</p> <p>Develop zonal pathways that establish clear linkages between specialised older people's mental health services and district mental health services.</p> <p>Develop specialised older people's mental health consultation and liaison services within each zone that deliver expert consultation and advice to regional, rural and remote area services including via the use of telepsychiatry where appropriate.</p> <p>Train relevant mental health professionals, service providers, consumers and carers in the use of videoconferencing technology.</p>

Action area 3: Service delivery

Key outcome:

- *Holistic models of service delivery that integrate in-patient care, community care, mental health promotion, illness prevention and early intervention for older people’s mental health*

Performance indicators:

- *Evidence of improved integration through application of models*
- *Client/carer satisfaction*

Outcomes	Strategies
Increased options and quality of service provision for older people with mental illness.	<p>Review older persons’ mental health service models, including national and international older people’s mental health models (including alternative models of care and population health approaches).</p> <p>Develop, pilot and evaluate evidence-based alternative models of care between mental health services and aged care services. Disseminate findings to health service districts.</p>
Health services across the state will have increased capacity to provide services for older people with mental health issues.	<p>Include consultation and liaison for older people’s mental health into a broader review of consultation and liaison with mental health services.</p> <p>Develop a holistic and integrated approach to service delivery that includes consultation, and liaison.</p> <p>Develop pathways and protocols for referral to and from mental health services for older people.</p>
Local district mental health services will work together in partnership in a fully integrated model.	<p>Review the existing models for extended inpatient mental health treatment services for older people.</p> <p>Document and implement best practice models (including an action plan to address specific issues for services identified) for the co-location and integration of mental health and aged care.</p>

Outcomes	Strategies
Service planning and delivery will be based on accurate data.	<p>Review current data collection systems to determine the need for separate data categories for older people with mental illness.</p> <p>Finalise and evaluate the statewide rollout of mental health outcome measures regarding older people's mental health service provision.</p>

Action area 4: Carers

Key outcomes:

- Increased client and carer involvement in individual care choices and broader policy and implementation issues
- Reduction in carer burden

Performance indicators:

- Evidence of client/carer involvement in care plans
- Evidence of client/carer involvement in policy and implementation issues
- Client/carer satisfaction

Outcomes	Strategies
Community stigma about mental illness will lessen.	Work with government and non-government, mental health, aged and community care to reduce the stigma of mental illness.
Increased choices for older people with mental health problems.	Support existing services that educate non-mental health service providers, carers and the public about older people with mental health problems.
More consumers will remain at home by choice.	<p>Identify how to maintain consumers in their own homes for as long as possible.</p> <p>Incorporate assessment of a carer's capacity to provide support in individual care plans.</p> <p>Assist carers to access support networks, services and educational opportunities.</p>

Outcomes	Strategies
Older people with mental illness and their carers will have more participation in care choices.	<p>Support older people, in either a voluntary or paid capacity, to participate in consumer and carer advisory processes and roles, through Queensland Carers Advisory Groups.</p> <p>Provide older people with the opportunity to participate in developing mental health services, including providing meaningful feedback on documents about mental health services, legislation and policy development.</p> <p>Encourage older people to actively participate, wherever possible, in individual care planning.</p> <p>Include carers in all aspects of planning of care while maintaining consumer rights.</p> <p>Train health care workers about their obligation to seek information from and disclose information to consumers, carers, guardians and other services, consistent with legal requirements.</p>

Action area 5: Partnerships

Key outcome:

- *Integrated approach to partnerships with key service providers in the government and non-government sectors*

Performance indicators:

- *Improved partnership initiatives/activities between government and non-government service providers*
- *Client/carer satisfaction*
- *Service provider satisfaction*

Outcomes	Strategies
Partnership arrangements with key stakeholders will exist.	Active participation in the Queensland Health Suicide Prevention Coordination Committee.
Key stakeholders will have greater input into policy and service provision.	<p>Develop formalised partnership agreements with key stakeholders.</p> <p>Include key stakeholders in developing legislation and other activities related to service provision for older people with mental illness and their carers.</p> <p>Support Australian Government initiatives to maximise Shared Care arrangements and assessment, between general practitioners and mental health services.</p>

Residential aged care

The Australian Government, with its legislative, policy development and funding responsibilities under the *Aged Care Act* and *Principles 1997*, will ultimately determine the future strategic direction of residential aged care.

However, Queensland Health, with 15 per cent of the high care places in Queensland, is a significant provider of residential aged care in this State and is committed to maximising choice, access and the quality of service provision within zonal and district networks.

Fourteen health service districts are responsible for operating 20 State Government residential aged care facilities across Queensland. Queensland Health also provides flexible residential aged care through Multipurpose Health Services (MPHS) in 13 small rural and remote communities across the State.

In many health service districts, particularly in rural areas, hospitals provide long term care to older people in the absence of alternative care settings.

Directions for Aged Care embodies Queensland Health's commitment to quality, resident-focused care in facilities that meets national standards.

This document provides policy direction for all health service districts – not only those responsible for a residential aged care facility.

Implementation of the *Directions for Aged Care* will:

- result in all State Government residential aged care facilities meeting the Australian Government's 2008 privacy and space standards
- ensure all residents receive quality care that respects their dignity, privacy and independence and meets the Accreditation Standards
- continue, where possible, to provide older people with access to long term care in Queensland Health's rural and remote hospitals and Multipurpose Health Services

Action area 1: Assessment

Key outcome:

– *Improved assessment processes for residential aged care services*

Performance indicators:

– *Reduction in assessments required for placement or change of level of care in a residential aged care facility*

– *Client/carer satisfaction*

– *GP/health professionals and service provider satisfaction*

Outcomes

Strategies

A reduction in unnecessary assessments of clients.

Services will share the results of assessments.

Promote a comprehensive, single point assessment model that facilitates access to all aged care services by:

- partnering with all stakeholders including the Australian Government, other providers and advocacy support groups.
 - negotiating with the Australian Government and other sectors of the residential aged care industry to abolish Aged Care Assessment Team (ACAT) re-assessment for the purpose of moving from low care to high care.
 - integrating components of ACAT and HACC assessment.
-

Action area 2: Access

Key outcome:

– Improved equity and access to Queensland Health’s residential aged care services

Performance indicators:

- Location and number of residential aged care places redistributed across the State
- Increased number of EACH packages provided by Queensland Health
- Increased number of aged care places in Multi Purpose Health Services (MPHS)

Outcomes	Strategies
Queensland Health’s residential aged care places will be more equitably distributed.	Negotiate with the Australian Government to redistribute residential aged care places allocated to Queensland Health from locations exceeding the Australian Government benchmark, to locations under the benchmark.
Residential aged care services will be as close as possible to where older people prefer to live.	Negotiate with the Australian Government to convert unused residential aged care places to Extended Aged Care At Home (EACH) Packages.
Residential aged care facility size will reflect local demand.	Access places in the Australian Government Innovative Care Pool.
Rural and remote communities will have more flexible, integrated and cost-effective care services.	<p>Optimise the benefits of the MPHS model by supporting continuous quality improvement approaches in line with the National Quality Improvement Framework.</p> <p>Negotiate with the Australian Government on an agreed approach to planning and targeting MPHS including establishing an agreed cross government work plan for the development of MPHS.</p>

Action area 3: Service delivery

Key outcomes:

- Residential aged care services consistent with the Aged Care Act and Principles 1997
- Residents will be provided with quality care in purpose built facilities
- Improved service to rural and remote communities

Performance indicators:

- All facilities meet accreditation
- Aged Care Capital Works Program completed

Outcomes	Strategies
Quality, resident focused care will be provided in Queensland Health facilities.	<p>Provide residential aged care services predominantly to:</p> <ul style="list-style-type: none"> • Frail aged people. • Older people with complex nursing needs. • Older people living with dementia and/or behaviours of concern. • Older people with psychogeriatric conditions. • Older people in rural and remote areas. <p>Provide palliative care consistent with the <i>Strategic Directions for Palliative Care Services 2000-2005</i>.</p> <p>Identify established and potential MPHS sites in Asset Strategic Plans.</p>
Accreditation will be maintained.	Implement continuous improvement plans in all facilities.
By 2008 privacy and space standards will be achieved.	Identify the scope of works at individual facilities and implement the Aged Care Capital Works Program.
New facilities will link the built environment to quality, resident focused care.	Use the modular design for construction of 'new build' residential aged care facilities.
The focus on resident care will be greater.	Negotiate with the Australian Government for a reduction in the documentation associated with care planning and accreditation.

Outcomes	Strategies
Accessible specialised residential dementia care units will exist.	Support cooperation between key stakeholders to plan and develop dementia units with the appropriate mix of staff.
Resource efficiency within health service districts will be better.	Develop and implement a funding model linking Queensland Health's supplementation to the care needs of residents.
More informed decision making will be possible.	Implement the Aged Care Information Management System (ACIMS), providing consistent sector specific data collection, management and analysis, in all facilities.
Facilities will be able to robustly assess against the Residential Classification Scale (RCS) and subsequently maximise revenue.	<p>Train facility staff in the use of the RCS instrument, ensuring there is skills transfer to existing staff.</p> <p>Provide an additional resource to manage RCS documentation and appeals, self-auditing, and training of nursing staff.</p>
Knowledge and skill levels in collocated services will be significantly improved.	<p>Develop guidelines and protocols in collocated residential aged care services such as MPHS to ensure appropriate integration and specialist intervention is provided as necessary.</p> <p>Provide education and training to staff on geriatric care and mental health.</p>

Action area 4: Carers

Key outcome:

- Carers will have improved access to a greater range of support

Performance indicators:

- Increased range and use of carer support services
- Client/carer satisfaction

Outcomes	Strategies
Carers will be better informed of support available.	Develop and/or link in with existing carer support groups/networks.
Carers will have improved access to residential respite and day care.	Provide/expand residential respite care within the constraints of Australian Government place day allocation. Negotiate with the Australian Government to redistribute the residential respite allocation across health service districts according to demand.

Action area 5: Partnerships

Key outcome:

- Partnerships strengthened with non-government providers of aged care services

Performance indicators:

- Improved partnership initiatives/activities with non-government providers of aged care services
- Client/carer satisfaction
- Service provider satisfaction

Outcomes	Strategies
Increased cooperation between government and non-government service providers.	Encourage partnerships between service providers using existing committees and networks.

Outcomes	Strategies
Established links between General Practitioners and residential aged care facilities	Link with/develop local General Practitioner networks to develop partnership arrangements for GP involvement in residential aged care facilities.
Advocacy organisations will have greater input into health service planning.	Consult with advocacy organisations in planning and priority setting.
Established roles and responsibility for the care of younger people with a disability requiring residential care.	Negotiate with other Queensland Government Departments i.e. Disability Services Queensland and Housing to develop whole-of-government policies for younger people with a disability requiring residential care.

Workforce

Queensland Health is committed to providing integrated, people-focused, quality services across the care continuum, which appear 'seamless' to the consumer.

To deliver best practice, Queensland Health needs a workforce culture that values its people and supports them to achieve.

The predicted rise in the proportion of older people in Queensland creates a challenge for all health services. Queensland Health must be well prepared to meet the associated increased demand for services, and ensure quality care is offered in a dignified, client focused and appropriate manner.

Older people and their carers currently have access to a broad range of health and aged care services. One of the strengths of our current system is that a dedicated and highly skilled workforce provides services across Queensland in the acute, residential and community sectors.

There is also a dedicated group of volunteers, who have a long tradition of providing invaluable support to older people.

Maintaining a highly skilled workforce is crucial to delivering quality health services. Australia is currently experiencing lower participation rates in aged care service delivery which is intensified by a workforce that as a whole is shown to be 'ageing' as the population ages.

One of the key areas identified for improvement in *Directions for Aged Care* is the provision of culturally respectful services to Aboriginal and Torres Strait Islander peoples. The related workforce objectives are ensuring that all aged care staff receive appropriate levels of cultural awareness training, and that more Aboriginal and Torres Strait Islander peoples are encouraged to work in all aspects of aged care service delivery.

Implementation of the *Directions for Aged Care* will guide Queensland Health towards:

- developing an appropriate skill mix which is sustainable and meets the needs of older people.
- recruiting and retaining appropriate numbers of skilled staff and ensuring their access to career development opportunities
- providing a supportive and attractive environment for the workforce
- recognising the valuable contribution of volunteers, especially in residential aged care facilities and in hospital settings.

Action area 1: Workforce development

Key outcome:

- Enhanced training and education of highly skilled health professionals who are able to deliver quality services across a variety of sectors

Performance indicators:

- Increased range and use of staff training and education programs
- Alignment of training with geriatric care principles

Outcomes	Strategies
Geriatric care will improve in all settings.	Develop geriatric care standards and principles and disseminate them widely across all sectors and service settings.
Competency based qualified staff are more available across a variety of sectors.	<p>Liaise with universities, colleges and accreditation bodies to incorporate geriatric care components (including dementia, delirium and mental health) and cultural awareness issues into the general and post graduate education curricula.</p> <p>Implement the recommendations of the Analysis of the Multidisciplinary Workforce for the 'Care of Older People' (2003).</p> <p>Explore the feasibility of providing more competency-based training opportunities for hospital staff and community health workers, e.g. dementia, mental health.</p>
Care provided to older patients in acute settings will be consistent with their unique requirements.	<p>Develop and implement an in-service training package for hospital staff on geriatric care issues that includes:</p> <ul style="list-style-type: none"> • identifying and managing patients with delirium. • considering the broader care needs of older patients (i.e. physical, social, cultural and psychological). • awareness of community and hospital services available to older persons. • consequences for older people's general health that may be experienced during long hospital stays (i.e. reduced mobility, increased dependency, depression).

Outcomes	Strategies
Medication management will be improved.	<ul style="list-style-type: none"> • management of patients with complex care needs (i.e. dementia, depression). • incorporation of client's input into care planning. <p>Provide training in the social determinants of health so that clinical staff across all care settings can better identify risk factors for health disadvantage, particularly regarding Aboriginal and Torres Strait Islander peoples.</p>
More appropriately skilled staff will be available in areas of need.	<p>Promote ongoing education and training in medication management for service providers in accordance with the Australian Pharmaceutical Advisory Council's "National guidelines to achieve continuum of quality use of medicines between hospital and community (1998) and Guidelines for Medication Management in Residential Aged Care Facilities (2002).</p> <p>Collaborate with the Australian Government, other providers, older persons' advocacy organisations and the tertiary and vocational education sectors to develop workforce plans and projections.</p> <p>Investigate and implement strategies to recruit and retain aged care workers in rural and remote areas.</p>
Appropriately skilled staff for the care of people living with dementia will be available.	<p>Develop targeted, specific dementia education packages, programs and ongoing in-service training regarding diagnosis and treatment, for all levels of staff across a variety of disciplines and settings (acute, community, residential).</p>

Outcomes	Strategies
Work environments will be more culturally respectful, effective, supportive and attractive.	Provide cultural awareness training to all staff who are providing health and aged care services to Aboriginal and Torres Strait Islander peoples, in all settings, across all sectors.
Services will be more responsive to Aboriginal and Torres Strait Islander clients and carers.	Negotiate with the Royal Australian College of General Practitioners for cultural awareness training to contribute towards continuing education points.
Service's capacity to respond to individual cultural and language needs will be better.	Mandate cultural awareness training as part of service agreements with non government providers who service Aboriginal and Torres Strait Islander clients.
	Incorporate aged care topics into the "Managing Cultural Diversity in Mental Health" training program.
	Increase the use of paid interpreters to assist in the assessment of culturally and linguistically diverse clients where required.
	Involve the Queensland Transcultural Mental Health Centre in improving access to specialised cultural consultation liaison services.
Appropriately skilled mental health trained staff providing care to older people will be available.	Support mental health workforce planning including: <ul style="list-style-type: none"> <li data-bbox="688 1453 1341 1526">• further development of appropriate models of flexible multi-disciplinary service provision. <li data-bbox="688 1549 1406 1623">• further development of training and education for staff on mental health issues specific to the aged.

Action area 2: Workforce retention

Key outcome:

- *Enhanced recruitment and retention of highly skilled health professionals who are able to deliver quality services, in a variety of sectors, across the State*

Performance indicators:

- *Improved recruitment and retention rates in the aged care workforce*

Outcomes	Strategies
The workforce will meet educational and vocational standards.	Implement the aged care recommendations of the 1998 Ministerial Taskforce on Nursing Recruitment and Retention.
The aged care workforce will be skilled, motivated and flexible and able to provide quality resident-focused care in all State Government residential aged care facilities.	Implement the recommendations from the Director General's Allied Health Recruitment and Retention Taskforce.
There will be enhanced career opportunities for aged care staff.	Develop and implement a change management strategy associated with the Aged Care Capital Works Program.
There will be an appropriate mix of staff in high stress areas.	Examine the options for increases in not only staffing levels but also skill mix in high stress areas, to manage people with unpredictable behavioural problems. This should apply to all settings where someone with dementia might require care (acute, especially in emergency departments, community and residential settings).

Action area 3: Aboriginal and Torres Strait Islander workforce development

Key outcome:

– Enhanced recruitment and retention of Aboriginal and Torres Strait Islander staff

Performance indicators:

– Improved recruitment and retention rates in the Aboriginal and Torres Strait Islander peoples aged care workforce

Outcomes	Strategies
There will be increased numbers of qualified Aboriginal and Torres Strait Islander staff across the aged care sector, e.g. in SGRACFs and ACATs.	Continue to implement the recommendations of the <i>Indigenous Workforce Management Strategy 1999-2002</i> .
Aboriginal and Torres Strait Islander expertise within the workforce will be increased.	Support the development of Queensland Health's implementation plan for the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.
The working environment will be flexible, supportive and offer greater career satisfaction.	Identify gaps in the Aboriginal and Torres Strait Islander aged care workforce and collaborate with relevant stakeholders on workforce projections and planning.
	Examine ways to attract and retain more Aboriginal and Torres Strait Islander staff, especially males.
	Provide education and training opportunities locally for Aboriginal and Torres Strait Islander peoples to encourage and support them to work in the aged care sector.
	Provide competency based training for Aboriginal and Torres Strait Islander health professionals to enable them to identify early signs of mental illness and associated mental health problems, including alcohol and drug related health problems.
	Develop appropriate resources and strategies to provide education and support to Indigenous Mental Health Workers caring for older people with mental illness.
	Negotiate with Education Queensland and the Australian Government for school-based traineeships and similar initiatives.

Action area 4: Volunteer workforce development

Key outcome:

– A workplace that values, attracts and retains a quality volunteer workforce

Performance indicator:

– Increased volunteer rates in the aged care sector

Outcomes	Strategies
More volunteers will be contributing to community care for older people.	Provide training for service providers to enable them to effectively attract and manage volunteers.
The volunteer workforce will be more productive.	Provide space, resources and training to enable volunteers in residential aged care facilities to deliver services to residents.
	Provide support and training opportunities for volunteers in community and other settings to deliver services to older persons.
Sustainable volunteer and community organisations will be more evident.	Support HACC funded volunteer organisations to develop and enhance their operational skills through quality management strategies.
More volunteers will be involved in service provision in Aboriginal and Torres Strait Islander communities.	Provide support to encourage more volunteers, especially males.
	Improve access to training and support for Aboriginal and Torres Strait Islander organisations that rely largely on volunteer support.

Glossary

Accreditation

The formal recognition provided to an aged care home by the Aged Care Standards and Accreditation Agency, where that home is considered to be operating in accordance with the legislative requirements of the Aged Care Act 1997. (*Residential Care Manual*, December 2001)

Acute care

Health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually provided in hospitals by specialised personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary for only a short time. (*Smart State: Health 2020 Directions Statement*, Queensland Health 2002)

Aged Care Assessment Program (ACAP)

The Aged Care Assessment Program (ACAP) is an initiative of the Australian Government. Under a cooperative working arrangement, the Australian Government provides funds to State and Territory Governments specifically to operate Aged Care Assessment Teams (ACATs). The core objective of the ACAP is to comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care needs. (*Aged Care Assessment Program Conditions of Grant*, 2002/03)

Aged Care Assessment Team (ACAT)

The persons engaged by the State, under the Aged Care Assessment Program, to conduct thorough assessments of the physical, medical, psychological, social and restorative care needs of frail older people, and provide a choice of appropriate services to meet those needs. (*Aged Care Assessment Program Conditions of Grant*, 2002/03)

An ACAT assessment comprises a multidisciplinary assessment of the medical, physical, psychological, social and restorative care needs of frail older people, to assist them in accessing the most appropriate service or combination of services, which best meet their needs and expressed wishes. Additionally, it has been assumed that this assessment would also prevent inappropriate and premature admission to residential aged care, and effectively provide a “gatekeeper” role for admission to Australian Government funded residential aged care facilities, Community Aged Care Packages (CACPs) and Extended Aged Care in the Home (EACH) services.

Aged Care Information Management System (ACIMS)

Queensland Health’s information management system that records and manages administrative and clinical (care plans) information in residential aged care facilities. This system has been integrated across all state residential aged care facilities.

Avoidable hospital admission

An admission that could have been avoided through interventions aimed at the primary care and ambulatory care level. Avoidable hospital admissions include unnecessary or inappropriate admissions (see glossary definition). (*Unnecessary and Avoidable Hospital Admissions for Older People (Draft)*, AHMAC, 2003)

Carer

A person whose life is affected by virtue of a close relationship and a caring role with a consumer. (Australian Health Ministers, 1998)

Case management

The mechanism for ensuring continuity of care across in-patient and community settings, for access to and coordination of the range of services necessary to meet the individual and identified needs of a person within and outside the mental health service.

Chronic conditions

Longstanding, persistent diseases or conditions that may be sequels to acute illnesses or injuries. Chronic disease management includes care specific to the problem and other measures to encourage self-care, to promote health, to prevent loss of function and to maintain quality of life. (*Smart State: Health 2020 Directions Statement*, Queensland Health 2002)

Collocation

Collocation means the housing together of services in the same building or on the same campus. It is a planning measure, which, if supported at the practice level, facilitates coordination of service provision without requiring amalgamation of service providers. In Queensland, it is supported by the concept of Operational Integration; this means that service components work in unison at service delivery level and retain sufficient integrity at management level to maintain and foster clinical expertise and to avoid program drift.

Community Aged Care Packages (CACPs)

Community Aged Care Packages enable frail older people to remain at home and receive care equivalent to low level residential aged care (hostel type care), through a coordinated package of appropriate community based services, based on the client's needs.

They are funded by the Australian Government to provide for the complex care needs of older people. To receive a package, older people must be assessed, by an Aged Care Assessment Team (ACAT), as needing the type of assistance provided by a package.

Co-morbidity

The occurrence of two or more disorders or conditions such as depressive disorder with anxiety disorder, or heart disease with diabetes.

Comprehensive assessment

Comprehensive assessment refers to a type or level of assessment which is consumer focused, independent of service provider perspectives and broader in scope and orientation than a general or service-specific HACC assessment. (*National Program Guidelines for the Home and Community Care Program*, 2002)

Consumer

A person using, or who has used goods or services (Australian Oxford Dictionary)

Continuity of care planning (also known as discharge planning)

The process through which people, hospital and community based services can work together to establish structures and networks which facilitate care across a range of services required. (Council on the Ageing, Victoria, *Removing Boundaries: Hospital Discharge Practices and Older People Returning to the Community*, Melbourne, 1994)

Delirium

A syndrome of disturbed consciousness, attention and cognition or perception which develops acutely, fluctuates during the course of the day and is attributable to a physical disorder. (*DSM IV*)

Dementia

Dementia is a syndrome due to disease in the brain, often of a chronic or progressive nature, in which there is an impairment of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not clouded. The cognitive impairments are commonly accompanied and occasionally preceded by deterioration in emotional control, social behaviour or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain. (*WHO ICD-10*, 1992)

Extended Aged Care at Home (EACH)

Extended Aged Care at Home (EACH) is a package of individually planned and coordinated services delivered to a frail older person, who is eligible for high level residential aged care (nursing home type care), to meet their daily care needs in the community, in their own home environment. EACH packages are funded by the Australian Government.

Health outcome

The change in health status of an individual or population attributable to an intervention or series of interventions. (*National Health Data Dictionary*)

Health system

All the services and initiatives of the health sector across the health continuum – health protection (including legislation), health promotion, prevention, screening, early inter-

vention, treatment, rehabilitation, palliative care and continuing care. (*Smart State: Health 2020 Directions Statement*, Queensland Health 2002)

Home and Community Care Program (HACC)

The HACC Program is a cost shared program between the Australian Government and State/Territory governments for services which support frail aged and younger disabled people to stay living at home. These services include Domiciliary Nursing (e.g. Blue Care, Qld), Meals on Wheels, Homecare and Respite Care.

Hospital in the home

A service that provides active treatment by health care professionals, in the home (including residential aged care), of a condition that would otherwise require acute hospital in-patient care, always for a limited period. (Sheppard S and Iliffe S. “*Hospital in the home versus in patient hospital care.*” *Cochrane Review*, 2002)

Inappropriate hospital admission

Admission made for inadequate or mistaken reasons (*Unnecessary and Avoidable Hospital Admissions for Older People (Draft)*, AHMAC, 2003)

Initial Needs Identification (INI)

INI is an initial screening process where both the underlying issues and presenting issues are identified.

Integrated Aged and Community Care Assessment Team/Integrated Assessment Team

A multidisciplinary team (collocated or ‘virtual’) operating within a District/area to undertake comprehensive HACC assessments, using the tiered approach with a common screening and assessment tool (ONI). The team is multidisciplinary and should encompass ACATs (if practical), and a mix of health professionals already competent to undertake comprehensive, holistic assessments (mental health staff, allied health staff, community health staff and non-government sector health professionals).

Interim care (see Transition care)

Mental health

A dynamic process in which a person’s physical, cognitive, affective, behavioural and social dimensions interact functionally with one another and with the environment.

Mental illness

A condition characterised by a clinically significant disturbance of thought, mood, perception or memory. (*Queensland Mental Health Act 2000*, page 5)

Multi-disciplinary teams

Teams that may contain general practitioners, nurses, assistants in nursing, geriatricians, psychogeriatricians, nurse practitioners, occupational therapists, speech pathologists, social

workers, physiotherapists, pharmacists, psychologists, mental health workers, and other practitioners working together to deliver assessment services and integrated health care.

Multipurpose Health Service (MPHS)

The MPHS is a concept involving the pooling of Australian, State, and local government funding to improve the provision of health services in small rural and remote communities by simplifying funding and accountability mechanisms and by providing a more flexible, coordinated and cost effective framework for service delivery. An MPHS may entail new service developments, redevelopment or refurbishment of existing services, or rearranging existing services. An MPHS may include acute hospital services and community based health services. Staff may also be shared between services.

Ongoing Needs Identification (ONI)

The ONI is a tool to assist service professionals to determine if a more detailed or comprehensive assessment is required. It facilitates appropriate referral to other service providers. The tool comprises consumer information, summary and referral information and supplementary (optional profiles). Information is inserted into the tool over time and it is therefore ongoing. The ONI is being trialed through various HACC teams in Queensland.

Palliative care

Care which does not attempt to cure a condition, but seeks to ease pain, discomfort and other complications while maintaining dignity and optimising independence and quality of life. (*Smart State: Health 2020 Directions Statement*, Queensland Health 2002)

Primary health care

A level of care, including services provided by general practitioners and other community-based service providers, and an approach to care, based on optimal access for communities to these local-level services. (*Smart State: Health 2020 Directions Statement*, Queensland Health 2002)

Psychogeriatric

Care provided for an older person who has either an age-related organic brain impairment with associated behaviour problems, or a psychiatric disturbance, or a physical condition which is associated with severe psychiatric or behavioural problems. The primary treatment goal is health improvement, modification of symptoms and enhanced function, behaviour or quality of life. Care management includes multidisciplinary assessment and/or management of complex medical, psychiatric and functional needs conditions. There are regular reassessments that seek to achieve a realistic goal within a reasonable timeframe. (*Casemix definition of SNAP care – Continuity of Care for Older People in Queensland*, 1998)

Psychogeriatric Service

A component of the mental health service which targets older people with mental illness

who require both specialised mental health and aged care expertise. (*Queensland Mental Health Policy Statement Mental Health Service for Older People*, 1996)

Queensland Dementia Support Team

The Queensland Dementia Support Team (formerly the Behaviour Support Unit) is a statewide Australian Government funded (Psychogeriatric Unit funding) service providing expert intervention and support for people living with dementia and their carers. Clinical services include assessment, advice, advocacy, counselling, diagnosis and case conferencing, with teleconferencing and videoconferencing available to outlying areas. In addition, the team offers a telephone advisory service and education services.

Rehabilitation

Care provided for a person with an impairment, disability or handicap for whom the primary treatment goal is improvement in functional status. The provision of care involves individual, periodic, documented functional assessment and the development of an individualised rehabilitation plan, which includes goals and timeframes. (*Casemix definition of SNAP care – Continuity of Care for Older People in Queensland*, 1998)

Resident Classification Scale (RCS)

A nationally consistent instrument which assesses a resident's care needs. This scale has 8 classification levels ranging from low to high care, with each level having a specified subsidy level which is paid to the providers for providing the required care to the resident. (*Residential Care Manual*, December 2001)

Residential aged care

Personal and/or nursing care for a person in an aged care home in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, furnishings and equipment for providing care and accommodation.

Respite care

Care given as an alternative care arrangement with the primary purpose of giving the carer or a resident a short-term break from their usual care arrangement. (*Residential Care Manual*, December 2001)

Step Down Care

Step Down Care is essentially care provided to facilitate movement of patients from one level of care to a less intensive level of care. An important aspect of this care is discharge planning and coordination. (*Continuity of Care for Older People in Queensland*, 1998)

Sub-acute care

Goal-oriented, individualised, interdisciplinary care that aims to help people regain function and return them to their usual place of residence. It is available to people on a short-term basis either on an in-patient or ambulatory basis. Sub-acute patients generally require:

- assessment and or oversight of their care plan by a specialist medical consultant
- up to 2-4 hours per day of therapy services (e.g. physiotherapy, occupational therapy)
- access to ancillary or diagnostic services such as laboratory, pharmacy, nutrition.

Treatment continues until the older person's rehabilitation goals are achieved and they no longer need that intensive level of treatment. Length of stay depends on the person's condition but generally varies between 2-4 weeks. People usually move to sub-acute care once their acute condition has been stabilised. Services may be delivered in a hospital, residential aged care, community or home setting. (*ACHA Reference Group Report on the Interface between Aged and Acute Care*)

Transition care

Transition Care provides short-term support and active management for older people at the interface of the acute/sub-acute and residential aged care sectors.

It is goal oriented, time-limited and targets older people at the conclusion of a hospital episode who require more time and support in a non hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

The potential for further recovery will vary according to the individual. Therefore, the services provided will vary from individual to individual, ranging from those that further improve physical, cognitive and psycho-social functioning thereby improving the person's capacity for independent living, to those that actively maintain the individual's functioning while assisting them and their family and carers make appropriate long-term care arrangements.

An outcome of transition care is that inappropriate extended hospital lengths of stay and premature admission to residential aged care are minimised. However, it should be stressed that transition care's primary function is therapeutic, rather than administrative.

Unnecessary hospital admission

An admission of a person to hospital even though their condition does not warrant admission. (*Unnecessary and Avoidable Hospital Admissions for Older People (Draft)*, AHMAC, 2003)

Veterans Home Care

Provides eligible veterans with domestic assistance, personal care, home and garden maintenance and respite care. The Veterans Home Care Program commenced in February 2001.

Footnotes

- 1 ABS Population Projections Australia 2002-2101. Cat no. 3222.0.
- 2 Australian Hospital Statistics 1999-00. Health Services Series No. 17. Australian Institute of Health and Welfare.
- 3 Queensland Hospital Admitted Patient Data Collection (QHAPDC) – Qld Health (extracted 7 October 2003).

Further information

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Queensland Health's Directions for Aged Care 2004-2011 is available on line at:
www.health.qld.gov.au

Appendix A

Directions for Aged Care was developed in the light of State and Australian Government policy directions, including:

- *Our Shared Future – Queensland's Framework for Ageing 2000-2004* (Department of Families 1999)
- *National Strategy for an Ageing Australia: An Older Australia, Challenges and Opportunities For All* (Commonwealth of Australia, February 2002)
- *Strategic Directions for Palliative Care Services 2000-2005* (Queensland Health 2000)
- *Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians* (1999)
- *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments July 2003* (Australian Health Ministers Advisory Council 2003)
- *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2003-2008* (Australian Health Ministers Advisory Council 2003).

Related Queensland Health documents include:

- *Smart State: Health 2020 Directions Statement* (Queensland Health 2002)
- *Queensland Mental Health Policy Statement for Aboriginal and Torres Strait Islander People 1996*
- *Queensland Health's Aboriginal and Torres Strait Islander Health Strategy 1994* (under review)
- *Agreement on Aboriginal and Torres Strait Islander Health 2002*
- *Torres Strait Islander Health Framework Agreement 1999*
- *Queensland Health Multicultural Policy Statement* (Queensland Health 2000)
- *Primary Health and Community Health 2002-2007: Position Statement* (Queensland Health, October 2002)
- *Implementing Integration: A Guide for Health Service Integration in Queensland* (Queensland Health, September 2002)
- *Principles of Quality GP/Hospital Communication* (General Practice Advisory Council – Queensland, 2002)
- *Health Outcome Plans* (Queensland Health, 2000-2002)