Ageing in the Outback™

PRELIMINARY REPORT JUNE 2024

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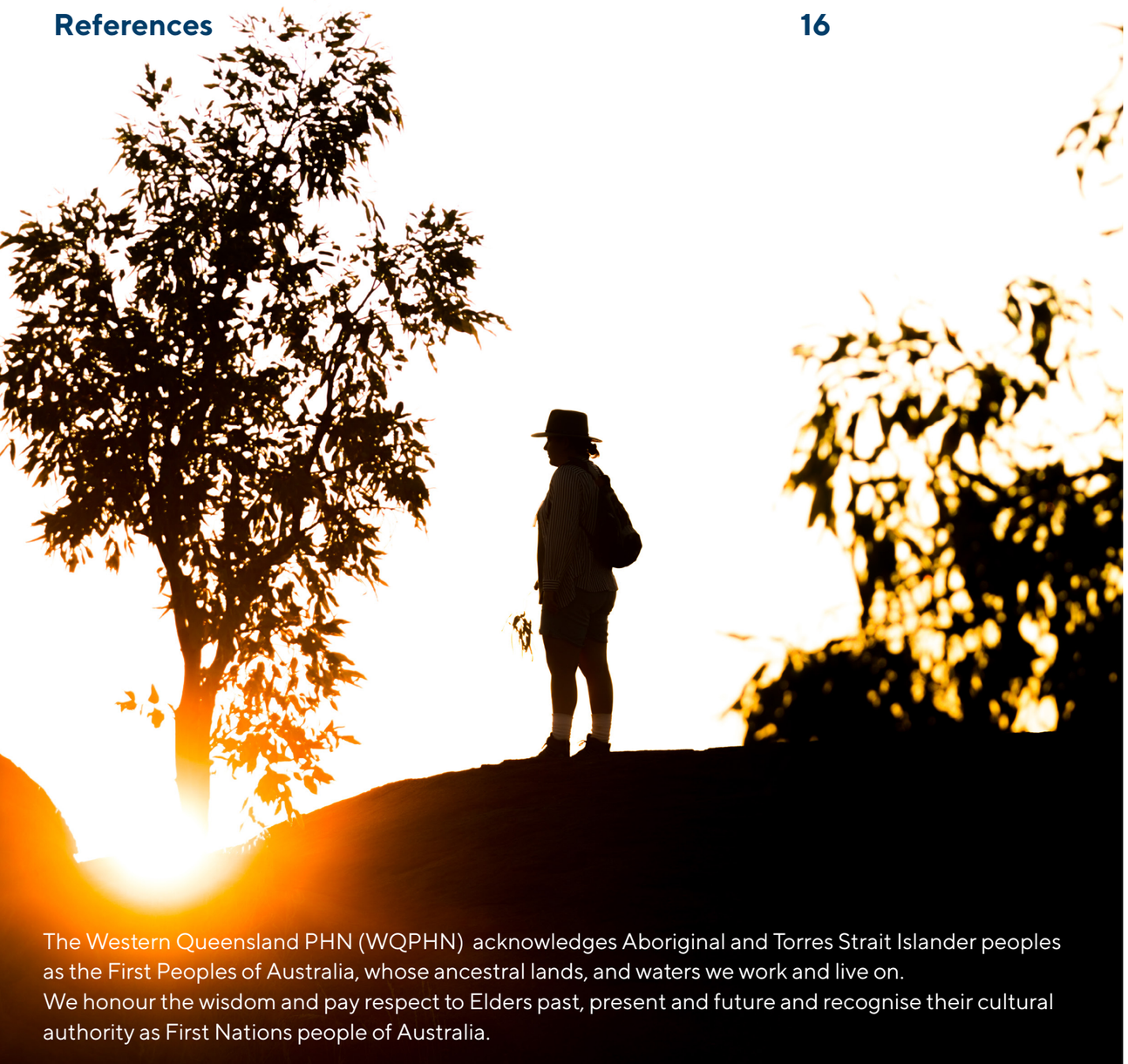
phn WESTERN QUEENSLAND
An Australian Government Initiative

AGEING in the OUTBACK

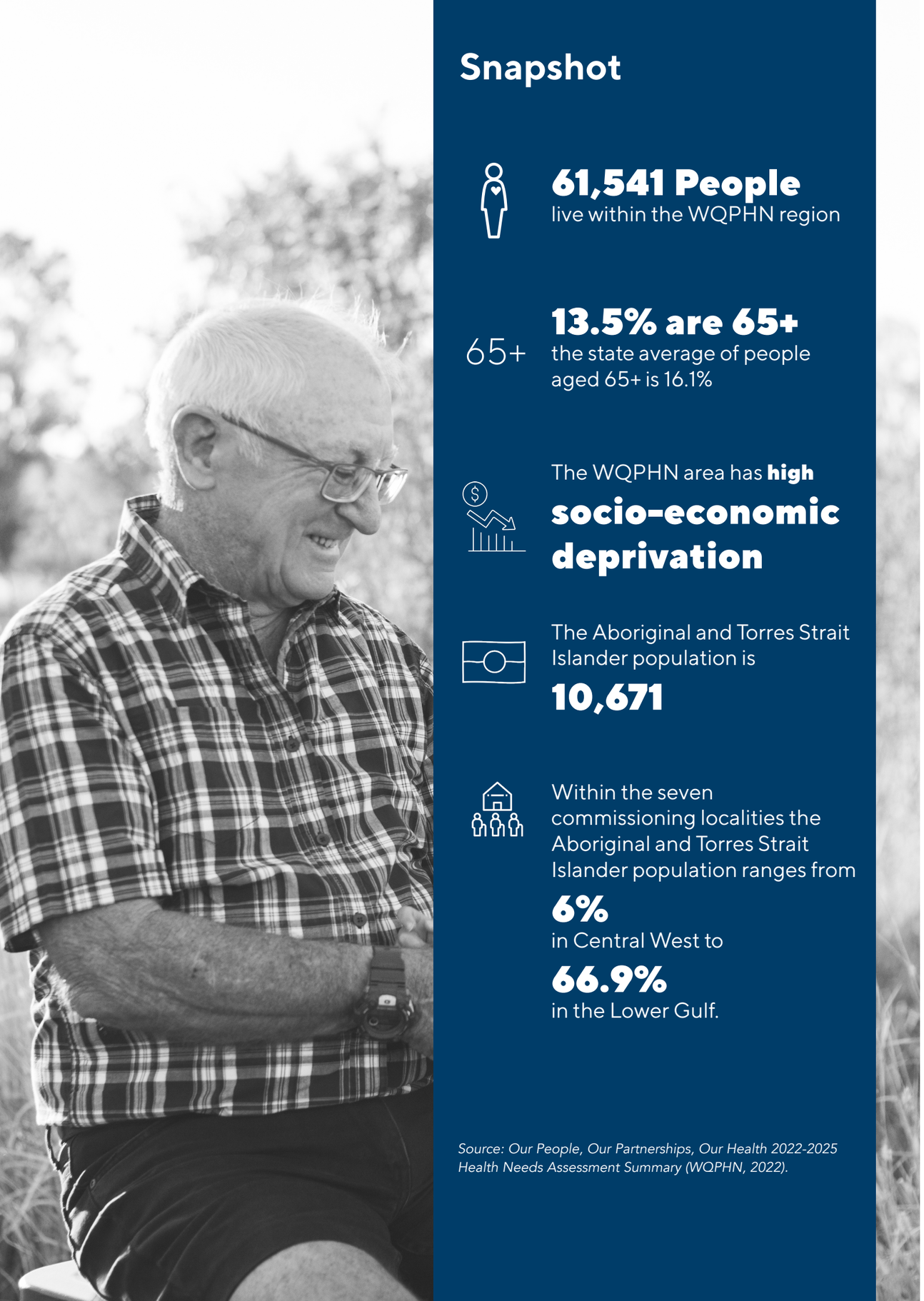
Contents



The Western Queensland PHN (WQPHN) acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia, whose ancestral lands, and waters we work and live on.
We honour the wisdom and pay respect to Elders past, present and future and recognise their cultural authority as First Nations people of Australia.

Acronyms

AAG	Australian Association of Gerontology
ABF	Activity Based Funding
ACAT	Aged Care Assessment Team
ACH	Assistance with Care and Housing
ACP	Advance Care Planning
AHD	Advance Health Directive
ADA	Aged and Disability Advocates
ADNeT	Australian Dementia Network
AG	Australian Government
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and Linguistically Diverse
CGA	Comprehensive Geriatric Assessment
CHSP	Commonwealth Home Support Program
CNC	Clinical Nurse Consultant
COTA	Council on the Ageing
CPI	Consumer Price Index
CWHHS	Central West Hospital and Health Service
DA	Dementia Australia
DoHAC	Department of Health and Aged Care
DSA	Dementia Support Australia
DTA	Dementia Training Australia
GANA	Gerontological Alliance of Nurses Australia
HCP	Home Care Package
HHS	Hospital and Health Service
IHACPA	Independent Health and Aged Care Pricing Authority
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, ntersex, Asexual and others
MAC	My Aged Care
MBS	Medicare Benefits Schedule
MICDA	Mount Isa Community Development Association
MCI	Mild Cognitive Impairment
MMM	Modified Monash Model
MPHS	Muli Purpose Health Service
MSHHS	Metro South Hospital and Health Service
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NN	Nurse Navigator
NWHHS	North West Hospital and Health Service
OCNMO	Office of the Chief Nurse and Midwifery Officer
PAH	Princess Alexandra Hospital
QCAT	Queensland Civil and Administrative Tribunal
QDAF	Queensland Dementia Ageing and Frailty Network
QG	Queensland Government
QH	Queensland Health
RACF	Residential Aged Care Facility
RAS	Regional Assessment Service
RaSS	RACF Support Service
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
STRC	Short Term Restorative Care
SWHHS	South West Hospital and Health Service
TCP	Transition Care Program
THHS	Townsville Hospital and Health Service
UN	United Nations
UTAS	University of Tasmania
WHO	World Health Organisation
WQPHN	Western Queensland Primary Health Network



Snapshot

61,541 People
live within the WQPHN region

65+ **13.5% are 65+**
the state average of people aged 65+ is 16.1%

The WQPHN area has **high**
socio-economic deprivation

The Aboriginal and Torres Strait Islander population is
10,671

Within the seven commissioning localities the Aboriginal and Torres Strait Islander population ranges from
6%
in Central West to
66.9%
in the Lower Gulf.

Source: Our People, Our Partnerships, Our Health 2022-2025 Health Needs Assessment Summary (WQPHN, 2022).

Purpose

This document aims to provide baseline information to inform and guide the development of the Ageing in the Outback ™ Strategy.

The scope of this report is to provide:

- Aged care policy and direction at the international, national, state and local level.
- Western Queensland Primary Health Network (WQPHN) Commonwealth contractual obligations.
- Definitions of contemporary gerontological health care and understanding of geriatric syndromes.
- Recommendations for further consideration by the WQPHN Executive and Board with a view of developing an Ageing in the Outback™ Implementation Plan.

Stakeholder, community and consumer consultation is outside of the scope of this document. However, it is acknowledged that for the successful development and implementation of the Ageing in the Outback™ Strategy a widespread consultation process is a key component.

As part of the strategy, it is proposed that an implementation plan will be developed to identify and work towards the short term, medium term, and long-term goals within responsibilities of the WQPHN. Where appropriate there may be opportunity to work with other key stakeholders to collaboratively achieve broader goals in relation to ageing in rural and remote areas. This implementation plan will support health care delivery for older people across the care continuum with a focus on primary health care and the links to early intervention programs and supports through to My Aged Care and more broadly local community strategies for Ageing.

Background

The WQPHN website provides a detailed overview of the role, responsibilities and strategies of this commissioning organisation.

The Our People Our Partnerships Our Health 2022-2025 Health Needs Assessment Summary (WQPHN, 2022) is a comprehensive document which provides information about the uniqueness of the WQPHN population and profile.

The Health Needs Assessment Summary did not provide specific information about Culturally and Linguistically Diverse (CALD) or Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others (LGBTQIA+) demographics.

Information from the Health Needs Assessment Summary related to assessment, care planning, and service provision for older people has been replicated in this document.

The Federal Government has indicated that a role for the PHNs as part of the aged care reform package announced in the 2021-22 Federal Budget response to the Royal Commission into Aged Care Quality and Safety. The Draft White Paper, Supporting Health Ageing, the Role of PHNs, prepared by the PHN Cooperative flags the increasing role PHNs will play in aged care and the intersection with primary health care services.

The community survey and consultations identified the need for:

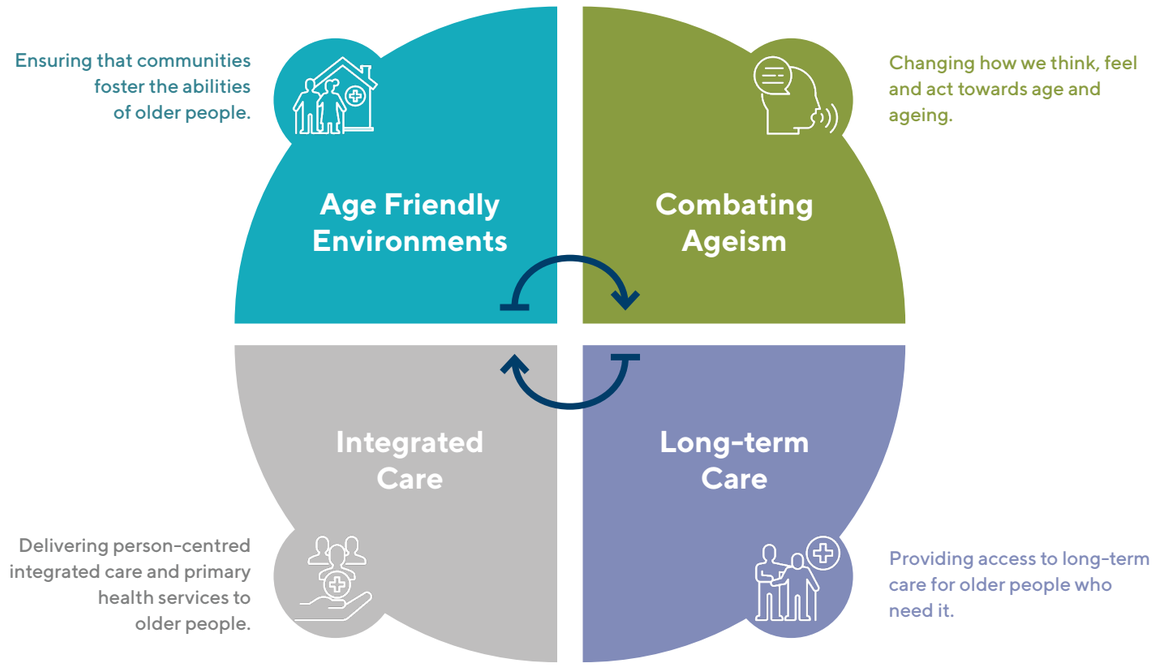
- Increased focus and supports for older people to age in place inclusive of support to navigate My Aged Care; strategies to facilitate community connection, improved mental health support services, strengthening home care services: healthy ageing initiatives and other social supports; community transport options; and better access to home care modification assessments and services.
- Timely access to geriatric assessments and coordination of care to enable living in the community for longer.
- Recruitment and retention of aged care workers and nurses.
- Increased GP attendance to RACF…"

Critical Consideration: Sustainable delivery of services to older people in remote communities is challenged by low client density and 'thin market' in a market-based environment. …Strategies to develop innovative service models, workforce development and employment strategies to span aged care and disability in remote communities is a market-based environment is likely to be an emergent priority for WQPHN, the aged and disability sectors *(WQPHN, 2022)*.

International

In the international sphere of health strategy, the United Nations (UN) has commissioned the UN Decade of Health Ageing (2021-2030) The World Health Organisation (WHO) identifies four areas of action:

Four action areas of the United Nations Decade of Healthy Ageing 2021 - 2030



The WHO Progress Report on the UN Decade of Healthy Ageing, 2021-2023 (WHO, 2023) provides the following definitions:

- **Healthy ageing:** the process of developing and maintaining the functional wellbeing in older age.
- **Functional ability:** health related attributes that enable people to be and to do what they have reason to value. It consists of the intrinsic capacity of the individual, relevant environmental characteristics, and the interactions between the individual and those characteristics.
- **Intrinsic capacity:** the composite of the all the physical and mental capacities of an individual.
- **Environment:** all the factors in the extrinsic world that form the context of an individual's life. These include assistive products, home, communities, and broader society.

National

Australia is one of the member states participating in the UN Decade of Healthy Ageing. The Australian Aged Care Council of Elders is the lead stakeholder older persons organisation which provided a formal mechanism for the Council to consult with the Commonwealth Government.

This Aged Care Council of Elders (WHO, 2023) identifies the following priorities for Australian communities:

- Creating an equitable, accessible high-quality care system.
- Supporting older people to age well.
- Tackling the abuse of older people.
- Housing and homelessness.
- Supporting functional ability at all stages of life.

COTA (Council on the Ageing) Australia a leading national organisation that influences policy and promotes advocacy for older people. Some of COTA Australia's priority areas for older people are:

- Aged Care reform (consumer choice and control, transforming aged care, increased home care, dementia friendly communities).
- Digital divide (removing financial and operational barriers, enabling digital literacy, promoting inclusive strategies).
- Elder Abuse (proactive safety measure, legal framework).
- Health (primary, mental, dental, allied, and other health sectors, removing barriers to access).
- Social isolation (supporting and enabling social connection, age friendly communities).

The Australian Government (AG) Department of Health and Aged Care (DoHAC) is responsible for developing and delivering policies and programs on health and aged care.

Accessing residential and community-based aged care services is through the My Aged Care (MAC) portal. To qualify for assessment Aboriginal and Torres Strait Islander people are 50 years of age and older and non-Indigenous people are 65 years of age or older. Through Regional Assessment Services (RAS) and Aged Care Assessment Teams (ACAT) assessments, older people may be given approvals for the following services:

- Commonwealth Home Support Program (CHSP)
- Home Care Packages (HCP) for more complex care
- Short term care:
  - Short-term restorative care (STRC)
  - Transition Care Program (TCP)
  - Residential Respite Care
- Residential Aged Care

This layered assessment system can be complex for people to navigate and even when approvals are granted this does not mean that the service is available when needed. Consumers and /or their representatives often receive notification of approvals and are advised that they are placed in a national queue and then must wait for a package to become available. It may take several months from enrolment through the portal, assessment, and receiving care.

Additionally, HCPs and permanent Residential Aged Care places are income and means assessed.

HCPs are assessed by level of complexity and consumer needs. Each HCP is paid to a provider and the funding is managed through the provider. The funding pays for consumer-directed care services and equipment. However, the package also covers the costs of provider administration fees and care coordination. Some providers also charge the cost of travelling to the consumer from the package as well. The HCP funding is linked to the Consumer Price Index (CPI) and funding is adjusted in line with the aged care pension payments twice a year.

As at September 2023 the funding for HCPs is:

Level 1	$28.14 per day
Level 2	$49.49 per day
Level 3	$107.70 per day
Level 4	$163.27 per day

There are also additional supplements, e.g. the dementia supplement provides an extra 10% of funding to a HCP.

There are also additional daily subsidies based on the Modified Monash Model (MMM) rates. These MMM is classification system based on geographical location. MMM 1 is form major cities while MMM7 is for very remote regions.

MMM 1,2,3, daily supplement	**$0 per day**
MMM 4 daily supplement	**$1.24**
MMM 5 daily supplement	**$2.75**
MMM6 daily supplement	**$18.21**
MMM7 daily supplement	**$21.87**

Furthermore, the AG has advised that in 2025 the HCP and STRC services will be combined into one program and will be called the Support at Home Aged Care Program. The CHSP will transition to the Support and Home Aged Care Program in 2027.

Enrolment, assessment, approvals and wait time for care delivery is a complex process throughout Australia. The concerns are amplified in the context of the geographical vastness, social determinants of health, and comparatively low population within the WQPHN region. The Our People Our Partnerships Our Health 2022-2025 Health Needs Assessment Summary (WQPHN, 2022) specifically refers to the concept of "the 'thin market' in a market-based environment".

In December 2023, DoHAC released the exposure draft of the Aged Care Bill 2023 (AG, DoHAC, 2023). This exposure draft is currently available for public consultation for the proposed new Aged Care Act. Detailed knowledge and understanding of the exposure draft is required as there may be implications for the WQPHN Ageing in the Outback™ Strategy.

State

Healthy Ageing A Strategy for Older Queenslanders (QH, 2019) has two primary objectives. These are:

- Support health ageing
- Drive service effectiveness through identifying priorities for service improvement and innovation in delivery of health care for older Queenslanders.

Priority areas are:

- Identification of frailty
- Residential Aged Care Facility (RACF) Support Service (RaSS)
- Emergency Department care
- Inpatient care
- Advance care planning and care at end of life.

The Queensland Dementia, Ageing and Frailty Network (QDAF) is an initiative of the Queensland Government (QG), Queensland Health (QH), Division of Clinical Excellence. This multidisciplinary network, currently chaired by a Geriatrician, seeks to provide clinical leadership and advocacy at a strategic level for all older persons. This Network partners with Hospital and Health Services (HHS), primary care, community stakeholders, and QH. The focus is on the planning and delivery of high-quality healthcare and services across the continuum of care.

Geriatrician specialist services are available in each of the HHS in the WQPHN region.

- South West Hospital and Health Service (SWHHS) – The Princess Alexandra Hospital (PAH), the tertiary hospital in Metro South Hospital and Health Service (MSHHS), supports an outreach geriatrician-led OPD clinic based in Roma. Once a month the Geriatrician visits Roma and may provide a consultancy service to both RACFs, Roma Hospital inpatients and an outpatient clinic. The Geriatrician also provides a weekly telehealth consultancy clinic on the remaining weeks of the month. The Roma-based Clinical Nurse Consultant Sub-Acute Service coordinates the clinic referrals and workflow.

- Central West Hospital and Health Service (CWHHS) – The PAH supports a twice weekly Geriatrician telehealth clinic. This service may provide consultancy to two RACFs, local hospital inpatients and outpatients. The Barcaldine-based CNC Older People coordinate the clinic referrals and workflow,

- North West Hospital and Health Service (NWHHS) - The Townsville University Hospital Geriatrician Service from the Townsville Hospital and Health Service (THHS) provides a twice a week telehealth clinic to Mount Isa only. The Mount Isa-based CNC Older Persons supports these clinics.

- Currently, there is a DoHAC-led Specialist Dementia Care Program (SDCP) working group including a Geriatrician from Cairns and Hinterland Hospital and Health Service (CHHSS) working on a proposed model of care to be based at the Laura Johnson Home, Mount Isa.

Additionally, the Office of the Chief Nurse and Midwifery Officer (OCNMO), QH commissioned the roles of the Nurse Navigators (NNs). NNs adhere to four principles of care:

- Coordination of care
- Creating partnerships
- Improving patient outcomes
- Facilitating systems improvement (QH, OCNMO, NN, no date).

It is understood that Nurse Navigators (NNs) are employed by the three local HHS with the WQPHN region:

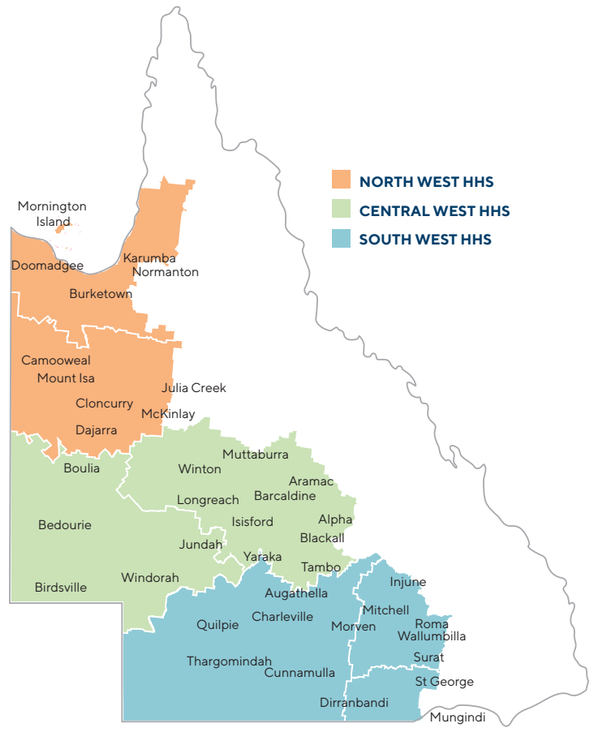
- SWHHS
- CWHHS
- NHHS

While not all NNs are employed to work with older people it is likely that there are positions responsible for the older person cohort within the WQPHN region.

Local

Complexity of aged care service planning and care provision is amplified by the three levels of government involved i.e. Commonwealth, State and Local Government.

Furthermore, the proliferation of non-government aged care services providers and the intersection with the National Disability Insurance Agency (NDIA) and the National Disability Insurance Scheme (NDIS) further compounds this complexity when attempting to meet the needs of the older person in the WQPHN region.



WQPHN Commonwealth Contractual Obligations

Due to Commonwealth contractual obligations the WQPHN has additional responsibilities within the aged care sector. These responsibilities include:

Commissioning early intervention initiatives to support healthy ageing and ongoing management of chronic conditions.

- This activity supports senior Australians to live at home for as long as possible through commissioning early intervention activities and models of care for chronic disease management that support healthy ageing and reduce pressure on local health services.
- This activity also supports the empowering of GPs and other primary health care workers through training, tools and resources which contribute to improved health and care outcomes for older people.
- Our commissioned service providers are required to:
    - Support older people to live at home for longer (including those not currently receiving aged care services) through the commissioning of early intervention initiatives that promote healthy ageing and the ongoing management of chronic conditions. Commissioned services should ensure transparency and be based on findings from the current Needs Assessment and in accordance with the Activity Work Plan;
    - increase awareness in the local primary health care workforce of the needs of the local senior Australian population, and the availability of these initiatives;
    - implement monitoring and evaluation standards and capabilities to ensure that commissioned Services are effective and efficient and meet the needs of the community.

Support RACFs (Residential Aged Care Facilities) to increase the availability and use of telehealth care for aged care residents.

- This activity is to support participating RACFs in your organisation's PHN Region to have the appropriate virtual consultation facilities and technology so their residents can access clinically appropriate telehealth care with primary health care professionals.
- The PHN will:
    - assist participating RACFs to have appropriate telehealth facilities and equipment to enable their residents to virtually consult with their primary health care professionals. These facilities should be compatible with the existing virtual consult technology used by providers in the PHN Region and should be guided by recognised eHealth standards (e.g. the Australian College of Rural and Remote Medicine telehealth framework1);
    - provide training to participating RACF staff to support them to have the capabilities to assist their residents in accessing virtual consultation services;
    - promote the use of enablers of digital health (such as My Health Record);
    - consult with jurisdictional authorities to ensure the initiative complements, but does not duplicate, efforts underway by state and territory governments to improve technological interoperability between the aged care and health systems; and utilise the funding in accordance with the approved Activity Work Plan and the other provisions of this Schedule.

Health Pathways – Dementia

- This program is to develop dementia specific Clinical referral pathways for use by clinicians and other primary care providers during consultation with patients, to support assessment and referral to local services and supports.
- where an existing dementia Health Pathway is in place, WQPHN is to:
    - review and enhance the pathway to ensure it is comprehensive and reflects contemporary best practice dementia care. This will be informed by broad local consultation including with, but not limited to, local primary care clinicians, other health, allied health, aged care providers and consumers about the current gaps and opportunities in the model of care for people living with dementia;
    - develop, review, maintain and enhance localised consumer resources that support older people and their carers and families to understand and make informed choices about health and aged care services that may be of benefit to them.

Care Finders

- This activity supports PHN to establish and maintain a network of Care Finders to provide specialist and intensive assistance to help people within the Care Finder Target Population to understand and access aged care and connect with other relevant supports in the community.
- The objectives of this activity are to establish and maintain a national care finder network that:
    - provides specialist and intensive assistance to help people in the Care Finder Target Population to understand and access aged care and connect with other relevant supports in the community WQPHN Commissions ADA (Aged & Disability Advocates) and Mount Isa Community Development Assoc (MICDA) to undertake the Care Finder Program;
    - addresses the specific local needs of their region in relation to care finder support;
    - includes a transition of the Assistance with Care and Housing (ACH) program (with the exception of hoarding and squalor services) to the Care Finder Program;
    - is supported to build their knowledge and skills and is an integrated part of the local aged care system collects data and information to support an evaluation of the Care Finder Program;
    - supports and promotes continuous improvement of the Care Finder Programs;
    - supports improved integration between the health, aged care and other systems at the local level within the context of the Care Finder Program.

Enhanced out of hours support for residential aged care

- RACF residents can experience rapid health deterioration during the after-hours period, but immediate transfer to hospital is not always clinically necessary. This activity:
    - supports organisations to address any awareness or utilisation issues of available local out of hours services among participating RACFs in the region;
    - The intended outcome of this activity is to help reduce unnecessary hospital presentations among RACF residents.
- The project is also required to:
    - provide guidance to assist participating RACFs in the region to develop and implement after-hours action plans which will support residents to access the most appropriate medical services out-of-hours;
    - educate participating RACF staff in out-of-hours health care options and processes for residents;
    - encourage participating RACFs to implement procedures for keeping residents' digital medical records up to date, particularly following an episode where after-hours care was required; and
    - support engagement between RACFs and their residents' GPs (and other relevant health professionals), as part of after-hours action plan development." *(WQPHN Document, no date)*

In addition, the WQPHN Executive is also progressing the After-Hours Palliative Care Funding initiative for RACFs which has recently also been distributed.

The WQPHN employs a Coordinator, Aged Care, this position is currently based in Longreach. The primary purpose, role functions and key responsibilities of this position reflect the responsibilities of the Network regarding the Commonwealth contractual obligations. This commissioning role is a significant value-add to older people within the region whether they reside in a RACF or in the community.

In addition to the current initiatives the WQPHN is committed to developing a robust and dynamic Ageing in the Outback™ Strategy.

Gerontological Clinical Context

Gerontology is the study of old age, the process of ageing and the unique concerns impacting older people.

Geriatrics refers to older people with a particular focus on health care.

A *Geriatrician* is a specialist expert doctor who cares for older people, generally 65 years of age and older, and for First Nations people 50 years of age and older.

The Ageing in the Outback™ paradigm identifies that care of older people involves generalist and specialist medical officers, nursing, allied health, management, operational, transport and administration roles within a whole of community framework. The role of informal carers and support in small communities is also critical in sustaining the wellbeing of the frail and unwell older person. Furthermore, health care conditions are considered in the framework of geriatric syndromes rather than purely disability and chronic disease.

Geriatric syndromes are defined as multifactorial health conditions that occur when the accumulated effects of impairments in multiple systems render an older person vulnerable to situational change (Inouye et al., 2007).

Geriatric syndromes may include:

- Cognitive Impairment
- Dementia
- Delirium
- Depression
- Social isolation
- Falls
- Incontinence
- Sarcopenia (the loss of skeletal muscle and mass as a result of ageing)
- Anorexia of ageing (the reduction of appetite and food intake associated with ageing)
- Pain
- Poor sleep
- Sensory deficits (hearing, eyesight, speech)
- Functional decline
- Frailty

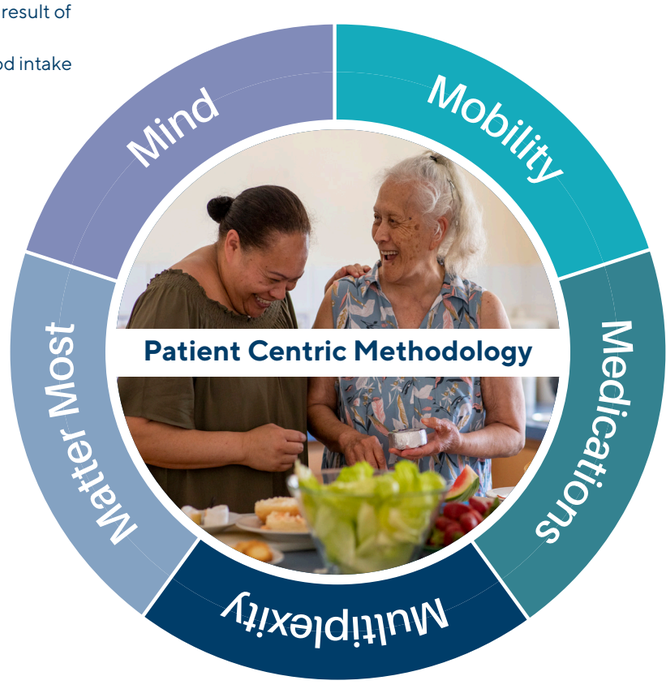
The Royal Australian College of General Practitioners (RACGP) supports the use of the 5M framework (RACGP, Geriatric Syndromes, 2020) to guide assessment and management of the older person. This tool allows for the evolution of geriatric syndromes and care and is a patient-centric methodology. The 5Ms are:

- Mind
- Mobility
- Medications
- Multiplexity
- Matter most.

Frailty can be defined as a multidimensional geriatric syndrome characterised by a decline of physical and cognitive reserves that leads to increased vulnerability. (Victoria Department of Health, Frailty, 2021).

Mild Cognitive Impairment (MCI) is the stage between expected memory and thinking decline associated with ageing and dementia.

Dementia is a collection of symptoms caused by disorders affecting the brain. It is not one specific disease. It can affect thinking, memory, and behaviour. Cognitive function is affected enough to interfere with a person's normal life. Common forms of dementia are Vascular Dementia and Alzheimer's Dementia. It is not a normal part of ageing. (Dementia Australia, 2022).



Based on our Preliminary Ageing in the Outback™ Report, the following recommendations will inform and underpin the development of our WQPHN Ageing in the Outback™ Strategy and Implementation plan.

Recommendations

Service Development

- Support the newly recruited WQPHN Aged Care Coordinator to fulfill workplace objectives.
- Complete comprehensive service mapping of regional Aged Care services.
- Develop a gap analysis report including consumer consultation.
- Understand the implications of Aged Care responsibilities and resources in the context of the proposed new Aged Care Act.
- Understand that development of an action plan must also be considered in the context of geriatric syndromes and their interface with chronic disease, disability, palliative care and mental health care.
- Gain input from GPs and primary health care practice managers, nurses and allied health professionals to understand barriers and limitations to provide best practice geriatric care, diagnosis, treatment and care planning.
- Optimise use of the Care Finder Supplementary Needs Assessment reporting template.
- Develop a robust Health Needs Assessment for people under 75 years of age.
- Map the use and potential under usage of Aged Care bed licences.
- Map the use of long stay beds in local hospitals and multi-purpose health services (MPHS).
- Map the use of community care applications, approvals and uptake through the MAC portal.

Dynamic implementation plans for individual communities.

- Understand the interface between NDIS service provision and aged care service provision.
- Understand specific care requirements for First Nations people.
- Understand the CALD demographic and consider specific strategies for this cohort.
- Understand the LGBTQIA+ diversity within the WQPHN region and develop aged care strategies specific to this cohort.
- Streamline Care Finder processes with RAS and ACAT assessment.
- Explore opportunities with the PAH, MSHHS regarding possible expansion of Geriatric Care Services further west than the current Roma location or potentially increase the frequency of OPD clinics.
- Map any other current clinical interactions and opportunities between GPs and geriatricians.
- Scope potential enhancement of relationship with NNs to reduce duplication and minimise fragmentation of care.
- Map oral health services available to older people, as poor dentition and oral health are known precursors to frailty.
- Consider introducing individual Ageing in the Outback™ health and wellbeing passports.
- Encourage older people to participate in balance, strength and resistance training physical activity to mitigate the effects of ageing and sarcopenia.
- Encourage older people to participate in socially inclusive activities that promote heathy eating and wellbeing.

Funding

- Consider advocating for comprehensive health assessment item number for older people under 75 years of age.
- Understand funding models and access through programs through multiple sources to ensure the older persons' identified needs are addressed in a timely manner.
- When partnering with HHSs where outpatient activity is both MBS and ABF funded, ensure partner organisations can optimise funding mechanisms with increased face-to-face and telehealth service delivery.
- Explore other funding mechanisms around provision of geriatric care.
- Undertake submissions to the DoHAC or the Independent Health and Aged Care Pricing Authority (IHACPA) to promote equity of care for older people in our region.

Partnerships

- Strengthen partnerships with QH, HHSs and QDAF to provide increased access to Geriatricians in multimodal care settings
- Consider membership of the Australian Association of Gerontology (AAG) Rural and Remote Special Interest Group.
- Promote the use of best practice organisations such as Dementia Australia (DA), Dementia Support Australia (DSA) and Dementia Training Australia (DTA).

Equity of access for all older people, focusing on inclusivity and recognition of individual circumstances.

- Provide feedback and evidence of the additional stressors in caring for a person with dementia in a rural and remote environment.
- Support primary health staff and consumers to access best practice education, 24/7 phone support and plans of care
- Partner with providers interested in providing community-based services in rural and remote areas.

Research

- Explore partnerships with academia to undertake targeted research in the context of ageing, geriatric syndromes and service delivery.
- Conduct a targeted literature review to aid in informing best practice aged care delivery in rural and remote settings.

Gerentology

- Expand the context of caring for older people beyond the paradigm of chronic disease with a focus on complex geriatric syndromes impacting a person's cognitive, physical and psychological wellbeing and function.
- Commit to actions and language to address ageism against older people.
- Support the introduction of or improve the Dementia Action Plan into local communities.

Build a specialist geriatric-care workforce.

- Support the introduction of or improve Age Friendly Principles into local communities e.g. Dementia Friendly Communities.
- Promote the Australian Dementia Network (ADNeT) Memory and Cognition Clinic Guidelines to improve assessment, diagnosis and care planning for people with MCI or dementia.
- Promote participation in the ADNeT Registry to identify the shared and unique situation of people living with a MVI or dementia.

Education

- Support the use of the RACP geriatric care education to undertake comprehensive geriatric assessments (CGA).
- Encourage RACF nurses and assistants in nursing to join the Gerontological Alliance of Nurses (GANA) providing access to gerontological expert nurses' mentorship and courses.
- Support primary health staff and consumers to access best practice education. For example, enrolment in the Wicking Institute, University of Tasmania (UTAS) free online learning courses, Understanding Dementia and Preventing Dementia.
- Support primary health staff and consumers are supported to understand the concepts of geriatric syndromes and care interventions.

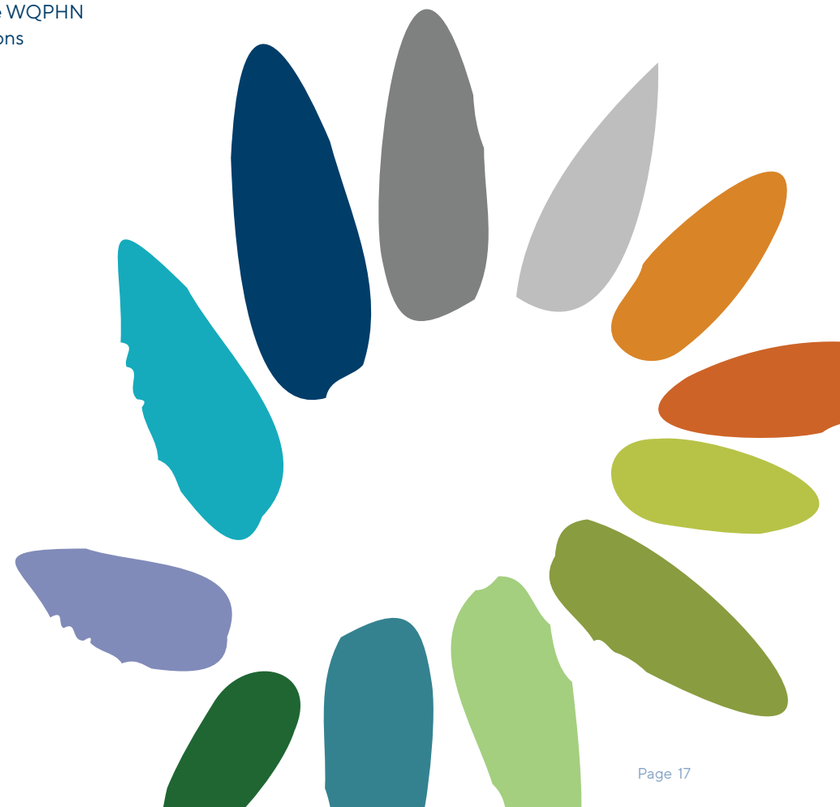
Medico-legal

- Support PHN staff and consumers to identify elder abuse or neglect.
- Gain support from agencies for ongoing assessment and intervention.
- Promote understanding of the responsibilities of health professionals in regard to:
  - Advance Care Planning (ACP)
  - Advance Health Directive (AHD)
  - an older person's decision-making competency and capacity
  - role of the Queensland Civil and Administrative Tribunal (QCAT)
  - the Office of the Public Guardian.

Report Limitations

The scope of this report has inherent limitations. To progress any of the recommendations, it is suggested that the WQPHN Board and Executive Team consider the recommendations in the context of:

- the scope, role and responsibilities of the WQPHN
- feasibility of progressing recommendations
- community consultation and interest.



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Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community. We pay our respect to them and their cultures and to elders past and present.

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