Australian Government

Department of Health

Specialist Dementia Care Program framework

Released: December 2018

Updated: March 2020

1. Purpose

This document provides an overview of the Specialist Dementia Care Program (SDCP) model of care, administrative elements, and roles and responsibilities. Please note that this framework may be subject to change as the SDCP is implemented and/or as work is conducted with targeted stakeholders.

2. Background and context

In 2016, the Australian Government committed to establishing at least one specialist dementia care unit in each of the 31 Primary Health Network (PHN) regions.

Since the measure was announced, the Department of Health (the department) has undertaken detailed policy development and consultation. We have used a range of information sources including commissioned research, expert advice, and public consultation feedback to inform the SDCP design.

The SDCP is being implemented using a phased approach, with the first phase of funding for up to 14 specialist dementia care units advertised in early 2019. The selected units are to be operational from early 2020. Subject to evaluation outcomes, a further selection process for the remaining sites will be undertaken in 2021.

The timing and outcomes of grant opportunities and implementation timeframes for selected units will be made available on the Department of Health website and updated as required.

The phased approach to implementation provides a valuable opportunity to test and refine elements of the SDCP model. Any revisions to the SDCP framework as a result of early learnings will be reflected in future updates.

The SDCP objectives are to:

- provide care for people exhibiting very severe behavioural and psychological symptoms of dementia (BPSD)[1] (which may also be described as responsive behaviours associated with dementia) who are unable to be effectively cared for by mainstream aged care services
- enable residential aged care providers to deliver care in a dedicated dementia friendly environment (generally a dedicated unit within a broader residential care service)

[1] Using the Brodaty, Draper and Low (Brodaty et. al.) seven-tiered model of management of behavioural and psychological symptoms of dementia, this includes people who would be classified as Tier 6 or equivalent. Brodaty H, Draper BM, Low, L. 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery.' *The Medical Journal of Australia* 2003; 178(5): 231-234.

- provide intensive, specialised residential care with a focus on stabilising and reducing the person's symptoms over time with the aim of enabling transition to a less intensive care setting
- complement the existing Australian Government-funded Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Teams (SBRTs)
- enhance the existing health and aged care service systems for people with very severe BPSD, including complementing state and territory government services and supports
- generate evidence on best practice care for people exhibiting very severe BPSD that can be adapted for use in mainstream settings to benefit all people with dementia.

3. Key program components

This document describes each of the key elements of the SDCP design as outlined below.

A. Client journey

B. Target group, referral pathways, care recipient assessment and eligibility

- Target group
- Referral pathway
- Assessment framework

C. Key aspects of the proposed model of care

- Philosophy of care and care approach
- Service delivery principles
- Care setting
- Care environment
- Access to specialist and allied health services
- Clinical review and oversight
- Care planning
- Care and services to be provided
- SDCP specific requirements

D. Transition-out

- Duration of stay
- Communicating and planning for transition-out
- Security of tenure
- Leave from care
- Post-discharge transition-out support
- Readmission

E. Funding

- Service delivery grant funding model
- Standard residential aged care funding
- Grant funding
- Grant period
- Care recipient fees
- Care recipient accommodation payments

F. Selection of SDCP providers

- Approved provider status

G. Regulation of SDCP providers

- Approved provider responsibilities
- Quality standards
- Aged Care Complaints

H. Monitoring and evaluation

- Reporting

A. Client journey

The client journey from referral, to assessment, placement and through to transition-out is described below and illustrated in the diagrams at **Appendix A**.

B. Target group, referral pathways, care recipient assessment and eligibility

Target group

People with very severe BPSD (generally behaviours classified as/or equivalent to Tier 6 in the Brodaty et. al. model[2]) who:

- are unable to be appropriately cared for by mainstream aged care services, but
- do not require care more appropriately delivered in other health settings.

Referral pathways

Existing aged care recipients (Commonwealth Home Support Programme services, home care, flexible care or residential care) and people not receiving aged care (i.e. transitioning from hospital or other environments) can be referred for assessment.

Referrals can be made by medical specialists, general practitioners, SBRTs, Aged Care Assessment Teams (ACATs) and residential aged care facility managers. Referrals must include supporting documentation from treating clinicians. Referrers should ensure there is appropriate consent to make the referral. Referrals will be made directly to the SBRT in accordance with SBRT processes. More detailed information on this is available on the Department of Health website and the Dementia Support Australia (DSA) website

Assessment framework

The assessment framework has two steps:

1. needs based assessment
2. placement assessment.

The assessment framework is outlined below and illustrated in the diagrams at **Appendix A**.

[2] Brodaty H, Draper BM, Low, L. Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. *The Medical Journal of Australia* 2003; 178(5): 231-234.

Needs based assessment

A nationally consistent assessment methodology will be used for all assessments. The needs-based assessment includes three phases.

Phase 1 – Eligibility confirmation, to check that:

- the person has had an ACAT assessment (such that the care recipient is approved to receive residential care under the *Aged Care Act 1997)*
- there is a dementia diagnosis
- the person would not be under a state or territory mental health detention order when entering a specialist dementia care unit
- there is appropriate consent, either from the potential client or their nominated representative.

Phase 2 – Phone based triage, to understand:

- current circumstances – pattern(s) of behaviour, what's happened, what's changed, pattern(s) of incidents, and timeframes
- clinical history, including whether the person's dementia is the major cause of their behaviours (or whether they may be related to another medical condition, co-morbidity, or disability)
- whether the person is medically stable and is not requiring treatment that would be more appropriately delivered in an acute care or other health care setting (for example treatment for delirium or terminal agitation)
- severity of BPSD
- initial risk assessment – to determine the risk that the person presents to themselves and others within their current environment
- the extent to which prior behaviour management strategies (recommended by DBMAS and/or SBRT or other dementia support services) have been implemented within their current care setting, and corresponding outcomes
- likelihood that the person would benefit from care in a specialist dementia care unit and be able to transition back to a less intensive care setting within 6–12 months.

This assessment will build on prior DBMAS/SBRT and/or ACAT assessment(s).

Phase 3 - Comprehensive face-to-face assessment, to validate and build on triage information and assess the person and their current care environment in more detail, using agreed tools and frameworks (currently under development).

The outcome of the needs-based assessment will be either:

- a recommendation from the SBRT that the person should be considered for care under the SDCP. In this case, with the person and their carer's consent, the person's information will be provided to the SDCP provider for the final placement assessment; or
- a decision by the SBRT that the person should not be considered for care under the SDCP at this time. In this case, the person, carer and referring body (and any other parties nominated by the person) will be notified of the decision. Advice will also be

provided on alternative care options. These may include being assisted to find an alternate mainstream aged care provider, referral to an acute service, or remaining within their existing care environment but with additional advice or support.

SBRTs will undertake the above assessment processes for all possible SDCP clients and will ensure that all less intensive support strategies (DBMAS and SBRT) have been exhausted before placement in a specialist dementia care unit is recommended.

The SBRT have established a process will be established to enable people to seek review of the needs based assessment outcome.

Placement assessment

Once the SBRT recommends a person be provided care under the SDCP the next step will be a local service-specific assessment (placement assessment).

All SDCP providers will have their own Clinical Advisory Committee. One of the functions of the Clinical Advisory Committee is to undertake the placement assessments. These local placement assessments are similar to those undertaken by the clinical advisory committees that are in place for similar existing state-supported services. This placement assessment will consider issues such as whether:

- the specialist dementia care unit is a 'good fit' for the person's particular needs and behaviour triggers based on the current mix of clients and staffing profile
- the person presents particular safety risks
- there are complexities in the family and carer dynamics that need to be understood
- there are other relevant external factors that might affect the placement.

The majority of people would be accepted into care following the placement assessment. However, where this is not the case, people should be referred to an alternate SDCP provider, an alternate mainstream provider, or the acute system – as appropriate and with the agreement of all parties. The person could also remain within their existing care arrangements but with additional supports put in place, provided by SBRT.

Consistent with provisions of the *Aged Care Act 1997*, the SDCP provider is the final decision maker on accepting a person into its service, after having regard to the advice of its Clinical Advisory Committee.

Once approved, a person will be required to enter the SDCP within three months or the approval will lapse.

SDCP providers are to manage local wait lists as necessary. Providers need to report to the department on assessment and wait list details as part of routine reporting requirements set out in the grant agreement.

C. Key aspects of the proposed model of care

Philosophy of care and care approach

The SDCP uses a psychosocial, person-centred and goal-oriented philosophy and approach to care that builds on or maintains the strengths and capacity of individuals, based on the service delivery principles. There is a focus on understanding the person in care their life story and how this may contribute to their behavioural expressions.

A restraint-free way of thinking underpins service-level policies and procedures and provision of care. Consistent with standard residential aged care practice, use of restrictive practices are minimised. Any form of restraint is used as a last resort in response to an adverse event to temporarily protect the client and others while restraint-free care strategies are rapidly reviewed and implemented. SDCP providers must comply with relevant Commonwealth standards and guidance.

Service delivery principles

The SDCP:

1. adopts an inclusive, person-centered and goal-oriented philosophy and approach to care that builds on the strengths and capacity of individuals
2. aims to optimise functioning, stabilise behavioural symptoms, improve wellbeing and quality of life through optimal care, with a strong focus on ongoing care assessment, care planning and access to therapeutic and meaningful activities
3. delivers services tailored to the unique circumstances, background, cultural sensitivities and preferences of each client, their family and carers. This includes using supported decision-making rather than substitute decision-making wherever possible and by consulting, valuing and supporting carers and the caring relationship
4. uses a multidisciplinary approach with formalised arrangements for access to specialist services; including clinical and allied health; to support the provision of optimal care and clinical governance. Care and services provided by or on behalf of the provider are reflective of Australian Government clinical practice guidelines
5. delivers care in a safe, stable and enabling environment that reflects dementia friendly / dementia enabling design principles
6. employs adequate numbers of appropriately skilled and trained staff with the capability, commitment and confidence to work with people exhibiting very severe BPSD
7. provides care using the least restrictive practices that promote human rights for people with dementia. Support and planning for the transition of people to the lowest tier of care appropriate to their needs begins at time of admission
8. builds and maintains collaborative partnerships with local hospital networks, acute and subacute services, mainstream aged care providers, primary care professionals and community based services at the regional level to facilitate access and smooth transitions to appropriate services for the target group
9. actively participates in monitoring, evaluation, continuous improvement, and sharing of information to inform best practice and new models of care for people exhibiting very severe BPSD
10. is underpinned by collaboration between the Australian Government and state and territory governments that enhances access to services and facilitate smooth transitions between service systems for the target group.

Care setting

The care setting for the SDCP is a dedicated dementia friendly environment, operating as a unit within a larger residential aged care facility, and as such operates under the *Aged Care Act 1997*. Each specialist dementia care unit will generally comprise of 8 beds plus an

additional ‘bounce back’ bed, to accommodate people who may need to be readmitted if their transition-out is not successful.

Care environment

SDCP providers are required to deliver care in physical environments that reflect dementia friendly / dementia enabling design principles, including the 10 Dementia Enabling Environment Principles.[3]

Access to specialist and allied health services

- Access to medical specialists is critical to ensure appropriate clinical oversight and care for the client group.
- The Commonwealth provides funding directly to state and territory governments for clinician and coordination staff hours to support the SDCP model. These arrangements are set out in a formal agreement with the relevant state or territory government. The intent is that all SDCP providers will be able to access clinical specialists such as a psychogeriatrician, geriatrician, or other suitable clinical specialist under this arrangement free of charge.
- SDCP providers are responsible for directly sourcing and funding allied health services such as psychologists, physiotherapists, occupational therapists, dieticians, dentists, oral hygienists, speech pathologists and any other necessary health professionals as required and for funding these services.

Clinical review and oversight

SDCP providers are to have in place both a:

- Clinical Review Team (or similar), and
- Clinical Advisory Committee.

The respective roles of these groups are outlined below.

Clinical Review Team

The Clinical Review Team is comprised of members of the multidisciplinary care team including specialist clinician(s) (psychogeriatrician or geriatrician), and will meet weekly to oversee the routine care of clients within the specialist dementia care unit. The team’s role includes reviewing and updating care plans; identifying clients whose behaviours have settled and are ready for transition-out of the specialist dementia care unit; and advising the Clinical Advisory Committee of those clients ready to transition-out.

Clinical Advisory Committee

Each SDCP service will establish a Clinical Advisory Committee which is generally expected to meet quarterly (or more frequently as required). The committee is generally comprised of the residential aged care facility manager, program manager, specialist clinician(s) (psychogeriatrician or geriatrician), local health network representative, and other members as relevant. Where appropriate, an SBRT representative may be included in the Clinical Advisory Committee.

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[3] Burton J, Fleming R (2018). Dementia Enabling Environment Principles. *Dementia Enabling Environments website.*

The role of the committee includes:

- advising on the placement assessments and admission of people to the specialist dementia care unit
- providing advice, planning and support for client transitions out of the specialist dementia care unit following stabilisation
- monitoring and advice on clinical practices and activities of the specialist dementia care unit
- providing input to independent program evaluation
- enabling liaison between specialist dementia care unit staff and the broader residential aged care facility, the local health network, SBRT and other relevant parties.
- ensuring SDCP providers are able to access clinicians to serve on the Clinical Advisory Committee through the agreement between the Commonwealth and relevant state or territory government. On-the-ground partnerships between SDCP providers and identified specialists employed within local hospital networks should assist in minimising avoidable hospital admissions, and streamlining admission arrangements when an acute admission is necessary. SDCP providers are responsible for maintaining effective relationships and partnership arrangements in their area to ensure the model is locally supported.

Care planning

Initial and ongoing care planning is overseen by the Clinical Review Team (or similar) and includes:

- involvement of client and carers in care planning and goal setting discussions
- planning for transition-out (as detailed in section D)
- explicit consideration of culturally appropriate care
- a strong program of therapeutic and meaningful activity that reflects individual interests and strengths
- maximisation of opportunities for independent performance of activities of daily living.

Care and services to be provided

The same care and services that must be provided to any residential aged care recipient are required to be provided to clients in specialist dementia care units, including ensuring access to personalised care planning and access to necessary specialist services.

Specified care and services must be delivered in a way that meets the Accreditation Standards (Schedule 2 to the *Quality of Care Principles 2014*) and the Charter of Residents' Rights and Responsibilities (Schedule 1 to the *User Rights Principles 2014)*. Future aged care quality reforms will also apply to specialist dementia care units.

SDCP specific requirements

In recognition of the particular needs of the client group, specific additional requirements will apply, and include:

- availability of a registered nurse on-site 24 hours a day and an expectation of higher staffing levels and expertise in dementia and behaviour management staffing
- establishment and operation of a Clinical Advisory Committee as discussed above

- memorandums of understanding (or similar) are agreed between the SDCP provider, local hospital networks, and any other relevant parties
- provision of transition-out support as described later in this document.

These requirements will be agreed during grant agreement negotiations.

D. Transition-out

Duration of stay

The focus of the SDCP is to stabilise and reduce a person's symptoms with the aim of enabling them to transition to a less intensive care setting. It is expected that the usual length of stay in a specialist dementia care unit will be up to 12 months. This could be extended in specific circumstances on advice from the Clinical Advisory Committee. In these circumstances the SDCP provider will be expected to justify the need for ongoing care and demonstrate efforts to enable supported transition-out to mainstream accommodation.

Communicating and planning for transition-out

As a condition of entering a specialist dementia care unit, the person (or representative) must consent to accept a suitable mainstream residential aged care place when the Clinical Advisory Committee recommends they are ready to transition-out. The specialist dementia care unit provider will assess the receiving residential aged care service to ensure it is appropriate for the client. This may include seeking advice from the SBRT.

Planning for transition-out should commence from admission and involve the SDCP provider, client, and their family and carers. Parties should identify at admission if the client's (or their representative's) preference on discharge is to:

- 'step down' to a mainstream place within the SDCP provider's broader residential aged care facility
- return to a previous residential aged care service
- move to a new residential aged care service.

The SDCP provider is responsible for assisting the client to find a suitable place, and providing in-reach support (in partnership with SBRTs where appropriate) to prepare the care environment ahead of time, for example by upskilling staff to understand behaviour triggers.

Security of tenure

Security of tenure is established in the aged care legislation through the *Aged Care Act 1997* and the User Rights Principles 2014.

Security of tenure to SDCP place

SDCP providers and clients (and their representatives) will work together to ensure a smooth transition following a period of care in a specialist dementia care unit. However, in the case that transition is not smooth, security of tenure requirements will protect the rights of both parties by establishing the circumstances in which a provider can ask a care recipient to leave the specialist dementia care unit.

In addition to the existing security of tenure provisions, and in order to ensure the rights of both parties are clear when a person is receiving care in a specialist dementia care unit, legislative amendments will be made to specifically draw out additional circumstances where a SDCP provider can ask a client to leave the specialist dementia care unit (i.e.

circumstances in which the client will not have security of tenure). This will include where the client is no longer suitable to receive the care provided in the specialist dementia care unit, based on the recommendation of the Clinical Advisory Committee.

Security of tenure to vacated place

As the care period in the specialist dementia care unit is expected to be 12 months, there will be no security of tenure to the vacated place (i.e. the residential aged care service the person was living in before they entered the specialist dementia care unit) as the person will be entering a new residential aged care service (i.e. the specialist dementia care unit). This must be made clear to potential clients and carers considering a SDCP placement.

These arrangements must be discussed with the client and family and included in all documentation. SDCP providers need to strongly emphasise that clients will be assisted and supported to find alternative suitable accommodation and will not be discharged without a suitable place.

Leave from care

A person's leave from a specialist dementia care unit is in line with standard residential aged care provisions, including in relation to access to social and hospital leave.

Post-discharge transition-out support

Post-discharge transition-out support is critical to the success of the program and ensuring that outcomes achieved during the client's time in the program are sustained.

The SDCP provider provides outreach support to receiving mainstream providers to ensure a successful transition. This may include the following actions:

- agreed arrangements between the SDCP provider and receiving mainstream aged care provider, pharmacist and general practitioner
- support underpinned by a formal transition plan for a 3 month period
- a focus on information sharing, avoiding behaviour triggers, and generalised behaviour management skills transfer where necessary
- possible in-reach from a mainstream facility to the service where the specialist dementia care unit operates.

The SBRT may also have a role in supporting transition-out, particularly beyond the defined transition period or where there is significant distance between the specialist dementia care unit and mainstream provider's facility. Funding arrangements include a modest incentive to accept new referrals and achieve successful transition-out.

Readmission

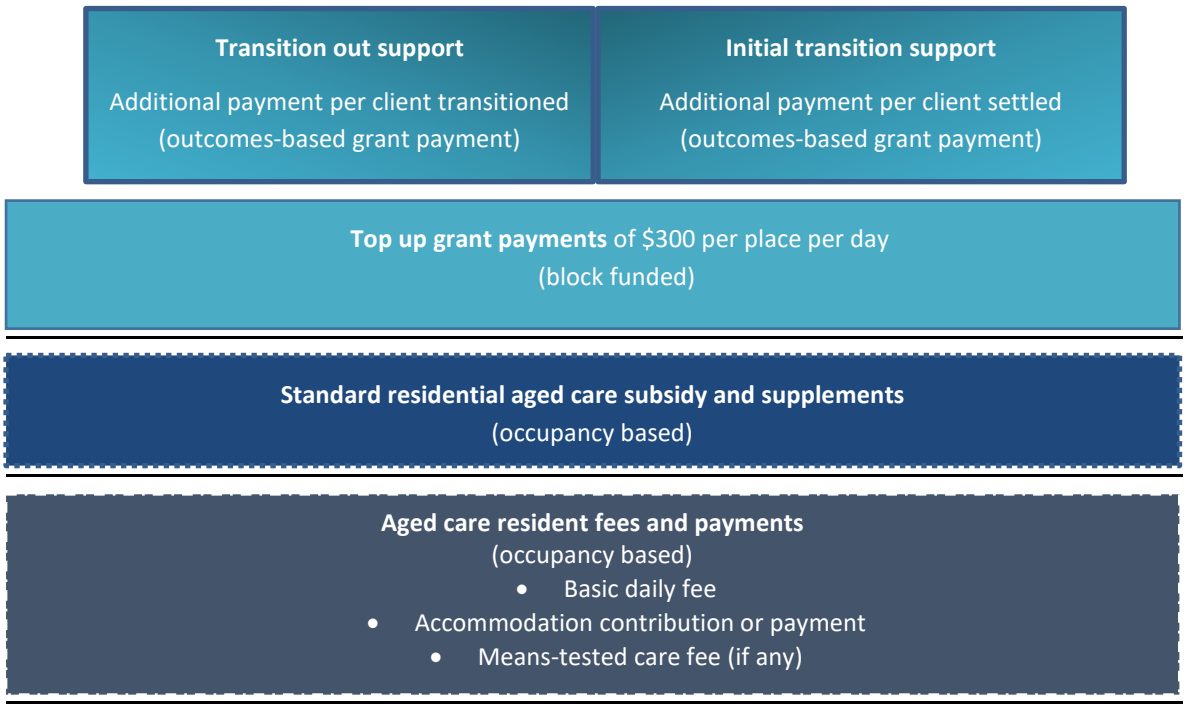
There is no restriction on a person's readmission to a specialist dementia care unit if assessment indicates this is necessary. One bed in each unit must be kept available to accommodate people whose transition-out is not successful. Within the first 12 weeks after discharge from the unit, SDCP providers are expected to readmit clients if needed, without the need for a formal reassessment. There are no restrictions on the number of placements per individual, provided they meet all assessment criteria.

E. Funding

Service delivery grant funding model

The department pays grant funding to SDCP providers according to a mixed funding model, as illustrated in Figure 1. The grant funding is designed to 'top up' standard residential aged care funding.

Figure 1: Specialist Dementia Care Program service delivery funding model



Standard residential aged care funding

All SDCP providers will continue to receive the basic aged care subsidy (currently through the Aged Care Funding Instrument) and relevant supplements (viability, oxygen, enteral feeding) in respect of individual SDCP clients. This funding will vary per client and is occupancy based. Standard aged care claiming and payments systems will continue to apply.

Grant funding

Additional 'top up' funding is provided through a grant between the Commonwealth and the SDCP provider. The top up funding is provided in a 'block' calculated as *$300 per client per day x number of places x 365 days*.

The payment is equivalent for all clients and not occupancy based.

The grant also provides the mechanism for additional outcomes-based payments to support the additional costs each time a client is settled in the specialist dementia care unit and in supporting their transition-out at the end of the placement. The payment amounts are $3600 each time a client is admitted into a specialist dementia care unit (except when a client is readmitted within 12 weeks of discharge) and $3600 each time a client is discharged from a specialist dementia care unit.

This mixed funding model aims to balance a number of objectives including:

- an occupancy based component to ensure funding is linked to care delivered
- block funding to enable providers to meet fixed costs, maintain a skilled workforce and capacity to accept clients at short notice
- provision within the block funding to support capital upgrade and maintenance
- incentives for client throughput to ensure as many clients can be supported as possible within the fixed number of places
- recognising and funding the supports needed to enable clients to successfully transition to mainstream services.

In total, SDCP providers are likely to receive around $1.1 million per annum in Australian Government funding.

Grant period

The expected grant period for SDCP providers is five years. We may approve grant extensions subject to the service outcomes and evaluation of the SDCP as a whole.

Care recipient fees

Residential aged care recipients are required to contribute to the costs of their care and accommodation, with fees dependent on their ability to pay (means testing). The fees that a residential care recipient (resident/client) may be asked to pay (as outlined in Division 52C of the *Aged Care Act 1997*) include:

- Basic Daily Fee – covers day to day living costs; all residents are asked to pay this.
- Means Tested Care Fee – a contribution toward care costs, depending on means.
- Accommodation Contribution or Payment - a means-tested contribution to the cost of accommodation.
- Other Extra Service or Additional Service Fees – these vary depending on the home.

The above arrangements apply to SDCP clients.

Care recipient accommodation payments

Existing residential aged care recipients transitioning to a specialist dementia care unit will be liable to pay an accommodation payment or contribution in accordance with normal arrangements applying to residential care. If a care recipient has been receiving mainstream residential aged care before transitioning to a specialist dementia care unit, this means that the care recipient will have to exit their existing residential care service. Any refundable deposits paid to the first service have to be refunded to the care recipient in accordance with the law.

An accommodation payment is then paid to the SDCP provider. In some circumstances, the result of moving to a specialist dementia care unit may mean that a care recipient could be asked to pay more or less towards their accommodation compared to what they were previously paying.

F. Selection of SDCP providers

SDCP providers must:

- be approved as a residential aged care provider
- have an allocation of residential care places though which to deliver the program
- have been selected to deliver the program via a grant opportunity process.

Approved provider status

Approved providers of residential care can include corporations and state and territory governments.

Having SDCP providers approved as residential care providers ensures:

- all of the responsibilities applying to residential care providers also apply in respect of the program (see further discussion below)
- the basic subsidy amount and any relevant supplements (such as the oxygen supplement and viability supplement) can be paid to the provider in addition to the SDCP top up payments.

G. Regulation of SDCP providers

Approved provider responsibilities

In addition to any conditions of grant with which the SDCP provider must comply (that will be specific to provision of care under the SDCP); providers will also be subject to the approved provider responsibilities that apply to residential care providers more generally. These responsibilities relate to quality of care, user rights and accountability.

Quality standards

As care is delivered in a residential aged care service, usual arrangements for the approval, accreditation, assessment, monitoring, complaints handling and compliance of Commonwealth subsidised aged care providers apply.

Assessment against the Aged Care Quality Standards will be undertaken by the Aged Care Quality and Safety Commission. Assessment against the standards commenced from 1 July 2019.

Aged Care Complaints

SDCP clients, and their family members, carers and representatives, have access to the Aged Care Complaints Scheme in the same way as all other care recipients and stakeholders.

H. Monitoring and evaluation

Deloitte Access Economics is evaluating the SDCP. The evaluation will assess the impacts and outcomes of the SDCP across three levels:

- Consumers: people with very severe BPSD, their carers, and families
- Providers: SDCP staff, staff of related services (such as the SBRT, allied health professionals)
- System: system integration, networks, processes

Monitoring and evaluation of the SDCP will require a mix of routine clinical and organisational data, as well as evaluation strategies such as interviews, surveys, and observations to address outcomes for consumers, aged care providers and the broader aged care system.

The rollout of the SDCP provides a valuable opportunity to generate and share evidence about the benefits of this type of program for consumers, providers, and the broader aged

care and health systems. SDCP providers are expected to share best practice between sites and act as ‘centres of excellence’ to share learnings with the wider aged care sector.

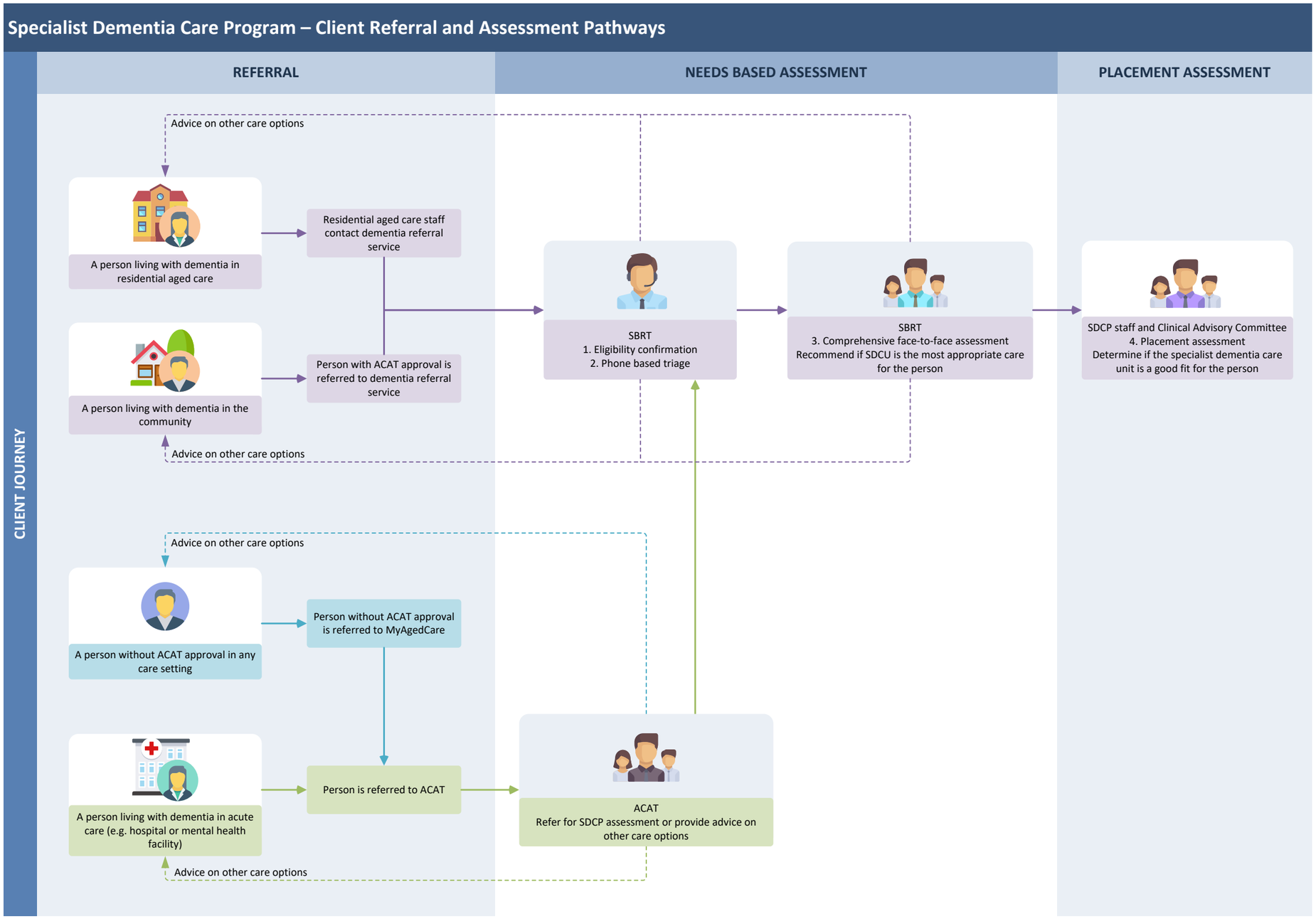
Reporting

Regular reporting is required in order to monitor progress against agreed grant activities, determine outcomes-based payment amounts (for client transitions in and out of a specialist dementia care unit), and to inform evaluation of the SDCP as a whole. Figure 2 provides an outline of reporting requirements. Standard grant agreement reporting arrangements at the end of the grant period will also apply.

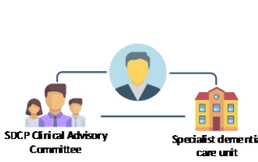
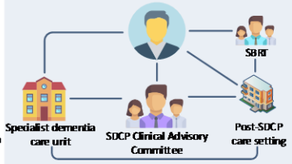
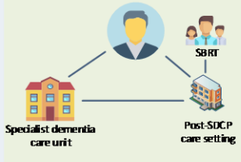
Figure 2: Indicative reporting requirements

Quarterly reports	Six monthly reports	Annual reports
Basic client data (de-identified) for the reporting period, such as: ▪ number and dates of recommendations for placement in a specialist dementia care unit, number of transitions in and out and entry/exit dates, average daily occupancy rate.	Basic client data (de-identified) for the reporting period, such as: ▪ number and dates of recommendations for placement in a specialist dementia care unit, number of transitions in and out and entry/exit dates, average daily occupancy rate.	Basic client data (de-identified) for the reporting period, such as: ▪ number and dates of recommendations for placement in a specialist dementia care unit, number of transitions in and out and entry/exit dates, average daily occupancy rate.
	Information about: ▪ placement assessments and wait list data ▪ readmissions ▪ incidents, hospital admissions ▪ organisational changes ▪ staffing e.g. recruitment and retention, levels and mix of staffing ▪ clinical governance ▪ partnership arrangements including SBRT, local health services.	Information about: ▪ placement assessments and wait list data ▪ readmissions ▪ incidents, hospital admissions ▪ organisational changes ▪ staffing e.g. recruitment and retention, levels and mix of staffing ▪ clinical governance ▪ partnership arrangements including SBRT, local health services.
		Information about: ▪ capacity building, dissemination activities, resource development ▪ consumer and family/carer perceptions ▪ any other relevant details on performance against agreed grant activities ▪ reflections, lessons learned, barriers and enablers, and unintended consequences ▪ total eligible expenditure incurred to date against an agreed budget.

Appendix A


Specialist Dementia Care Program – Client Referral and Assessment Pathways
CLIENT JOURNEY
REFERRAL
NEEDS BASED ASSESSMENT
PLACEMENT ASSESSMENT
Advice on other care options
A person living with dementia in residential aged care
Residential aged care staff contact dementia referral service
A person living with dementia in the community
Person with ACAT approval is referred to dementia referral service
Advice on other care options
SBRT
1. Eligibility confirmation
2. Phone based triage
SBRT
3. Comprehensive face-to-face assessment
Recommend if SDCU is the most appropriate care for the person
SDCP staff and Clinical Advisory Committee
4. Placement assessment
Determine if the specialist dementia care unit is a good fit for the person
Advice on other care options
A person without ACAT approval in any care setting
Person without ACAT approval is referred to MyAgedCare
A person living with dementia in acute care (e.g. hospital or mental health facility)
Person is referred to ACAT
ACAT
Refer for SDCP assessment or provide advice on other care options
Advice on other care options

Specialist Dementia Care Program – Client Journey and Service Process Map

	CONTEXT	REFERRAL	NEEDS BASED ASSESSMENT	PLACEMENT ASSESSMENT	ENTRY	SERVICE PROVISION	TRANSITION	POST-SDCP
CLIENT JOURNEY	 A person living with dementia, their family and carer(s) Residential aged care (RAC) In the community Acute care setting	Person exhibits very severe BPSD and is referred to assessment service	1. Check eligibility and consent 2. Recommend if SDCP is the most appropriate care for the person Not appropriate Advice on other care options	3. Determine if the specialist dementia care unit is a 'good fit' for the person's particular needs Not a good fit Advice on other care options	Person accepts SDCP place (On-boarding to RAC or transfer from another RAC facility) Pre-entry support in current care setting Identify needs for modification and personalisation of SDCP environment Exit current setting and transfer to SDCP	Individual care planning and management (including transition out strategy) developed Delivery of care services in line with agreed principles Ongoing review of progress, adaptation of care plan (and review of transition strategy) Agreement that care in specialist dementia care unit is no longer appropriate / required	Identification (and agreement) of post-SDCP care option Transition support provided to long term care provider	Person is cared for in an appropriate permanent care setting
SERVICE PROCESSES	 Referrer SBRT **Referrer** Must obtain the person's (or representative's) consent for the referral. **SBRT** Accepts referrals for people in residential aged care and people in the community who have appropriate ACAT approval. **My Aged Care** People who do not have appropriate ACAT approval must be referred to MyAgedCare.	 SBRT Assessment will be undertaken by specialists with expertise in the care and management of people with dementia and very severe BPSD. Assessors will use a nationally consistent assessment framework that consists of 3 phases: 1. eligibility confirmation 2. phone based triage 3. comprehensive face-to-face assessment. The outcome will either be: • recommend that the person be considered for SDCP • recommend that the person not be considered for SDCP at this time and advice on other care options.	 SDCP Clinical Advisory Committee Specialist dementia care unit The SDCP staff and Clinical Advisory Committee will determine if the specialist dementia care unit is a good fit for the person's particular needs based on issues such as: • confirming current unit capacity • considering the profile of existing client's within the unit • safety issues • family and carer dynamics. SDCP provider will have final say on admissions. The outcome will either be: • recommend that the specialist dementia care unit is a good fit for the person • recommend that the specialist dementia care unit is not a good fit and advice on other care options.	 Current setting Specialist dementia care unit In accepting an SDCP place, the person and their family / carers will give consent to transition to an alternate care setting once the SDCP provider and Clinical Advisory Committee determine that care in the specialist dementia care unit is no longer appropriate or necessary. SDCP staff will provide services to help the person and their family / carers to prepare for the move to the specialist dementia care unit. SDCP staff will work with the person and their family / carers to identify tailoring and personalisation of the SDCP environment and care routine prior to admission.	 SDCP Clinical Advisory Committee Specialist dementia care unit SDCP staff will work with the person, their family and carers to develop individual care and management plans. The Clinical Advisory Committee will provide guidance and oversight of care planning. SDCP staff will provide and coordinate care according to the person's individual care plan. The Clinical Advisory Committee will regularly review the person's care and progress and help the SDCP provider with recommended adjustments to the care plan where required. The Clinical Advisory Committee and SDCP staff will determine when care in the specialist dementia care unit is no longer appropriate or necessary in line with agreed guidelines.	 Specialist dementia care unit SDCP Clinical Advisory Committee Post-SDCP care setting SBRT SDCP staff and Clinical Advisory Committee will identify appropriate post-SDCP care options for the person which could include: • transfer to a RAC place within the same campus • transfer back to the person's original RAC or alternative RAC • palliative care. SDCP staff will discuss transition arrangements with the person, their family and carers. SDCP provider will provide services to help the long term care provider prepare for the person's admission.	 Specialist dementia care unit Post-SDCP care setting SBRT SDCP provider will provide outreach services to the receiving care provider, underpinned by a transition plan for a defined period. In some instances, the SBRT will also be involved in supporting the person's transition to a new RAC facility. If required, the SDCP provider may readmit the person into the specialist dementia care unit.